

point. Moreover, he correctly concludes that near-patient testing has a number of potential benefits beyond patient satisfaction, although the full potential of its integration and implementation has not been exploited, while he specifically calls for rigorous evaluations to determine improvements in harder outcomes and cost-effectiveness. Yet, we noticed that he mainly focused on near-patient testing opportunities in the field of cardiovascular medicine. A recent review, not included in this editorial, showed unsatisfactory results of near-patient tests for monitoring patients with diabetes, with hyperlipidaemia, or requiring anticoagulant therapy.<sup>2</sup> But the same research group also showed that patients managed with near-patient tests had similar or superior medication adherence: that is an important finding in patients who often use multiple medications.<sup>3</sup>

The potential of near-patient testing for acute conditions in general practice is largely neglected in the editorial. Yet, in our opinion this is where near-patient testing can have the most effect. GPs preferably want to decide on management within the 10-minute-consultation for an acute condition. Recently it was shown that using a clinical decision rule combined with a point of care D-dimer reduces the need for referral to secondary care of patients with clinically suspected deep venous thrombosis (DVT) by almost 50% and is associated with a low risk for subsequent venous thromboembolic events. Point of care D-dimer tests can therefore contribute important information and guide patient management, notably in low risk DVT patients.<sup>4,5</sup> A second example of a near-patient test with immediate consequences for management is the use of point of care C-reactive protein (CRP) testing in lower respiratory tract infections. A recent trial showed a dramatic decrease in antibiotic prescriptions when GPs used CRP testing to guide antibiotic management.<sup>6</sup> Both biomarkers now have a solid evidence-base of their use, with multiple studies showing robustness, effectiveness on hard outcomes, and cost-effectiveness. So contrary to what Khunti claims, we

contend that there has been quite some progress in terms of rigorous evaluations of near-patient testing initiatives in primary care in the past decennium, especially when focusing at their use in acute conditions. And this is exactly where near-patient tests will benefit GPs and patients most.

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## GPs and minor ailments

In recent years there have been a number of reports of GPs being troubled by patients with minor ailments, while at the same time concerns have been expressed about the iceberg of unreported illness in the community.

When the perceptions of people are taken into account, one study showed that 26% had symptoms that to them

were serious, but did not seek medical advice for. In contrast 11% had symptoms that they did not think were serious but that were referred to a GP. The iceberg of significant symptoms in the community was therefore more than twice the size of so called trivial complaints.<sup>1</sup>

This begs the question of 'trivial to whom?' GPs are extensively trained and paid to distinguish minor ailments from those that may be more serious. It is therefore disappointing that prominent members of the profession have recently promoted the view that doctors are overwhelmed with minor ailments, with the implication that patients should seek advice elsewhere and spend more on over-the-counter medicines.

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## GP training 'schemes'

I would like to bring to mind an alternative viewpoint to that brought up in the May Focus regarding length of GP training 'schemes'.<sup>1</sup> Length of training for a GP is compared unfavourably with those elsewhere, on the basis that it involves only 3 years (2 in hospital and 1 in 'registrar' posts) compared to longer, far more defined schemes in other specialties. I am not sure that this very short standard GP training scheme is in fact the standard, and I am not sure the 'standard' differs so very much really from that in other specialties in Britain.

GP training has always been more flexible than other speciality schemes, allowing trainees far more opportunity for more mature self-evaluation, self-directed learning, and practical experience organisation. It may be possible to satisfy the requirements of the