'brown–yellow dot inhaler' regularly.

Colour has always been used to aid recognition, this convention is not new in medicine. A standardised colour code for user-applied syringe labels for anaesthetic drugs exist in the US, Australia, New Zealand, South Africa, and Canada.[2] A single standard system for syringe labelling in critical care areas has been adopted in the UK as well.[3]

There is always a problem in reading the labels as instructions are often written at a level too complex for low literacy patients.[4,5,6] Inadequate literacy, without any doubt, is a barrier to asthma knowledge and proper self-care.[6,7] Moreover, patients who have a different first language than the healthcare provider can raise additional issues.

So there will be a large group of patients who can identify their inhalers only by the colour. Older people who have difficulty identifying colours will have difficulty reading fine print as well and will need assistance. People who are colour blind should continue to read the labels or identify their inhalers by the design or size. We, therefore, believe that adding universal colour dots to the current system will only do good in creating uniformity without causing any additional limitations.

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Visual loss

We would like to highlight the problems that patients with significant visual loss have in detecting clinically important signs. Two male patients aged 71 and 75 years, who were registered blind due to retinitis pigmentosa, were late presentations with bladder carcinoma. It was clear that these patients had haematuria for some time prior to presentation but were unable to detect this due to severe visual loss.

The purpose of this letter is to draw attention to the difficulty that patients with visual loss have in detecting signs that are easily apparent to patients without visual loss.

It is difficult to see how these problems can be avoided. One suggestion would be a protocol in place where patients who are placed on the Blind Register and their relatives are advised on their inability to detect clinical signs such as haematuria, malaena, and haemoptysis and therefore need regular assessment by a third party to detect such signs.

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The physician assistant

In answer to Olumide Elegbe's question 'is there a role for physician assistants (PAs) in routine care?'[1] my answer, currently, would be no. I would much prefer an experienced nurse or even, dare I suggest it, another doctor. Mr Elegbe obviously has confidence in the evidence he has referenced, however, the majority of this is from the US and given the differences between our two healthcare systems and respective primary care, I would not rush to apply the same conclusions from the data collected there, to here.

A pilot of PAs has already been undertaken in Scotland[2] and this highlighted some important points. The PAs involved felt that they were unable to demonstrate their full capacity within primary care and this was attributed to the fact that there was no identifiable gap in the care of patients for them to fill, presumably this was because the pre-existing primary care team was already sufficient and as the PAs put it 'family medicine/general practice differed from the US to Scotland'.

Any issue regarding the cost-effectiveness of PAs was also underlined by the study, reporting that within the primary care setting, an individual PA would cost approximately £15 000 more to employ than a practice nurse (PA salary defined as Agenda for Change Band 7, £29 091–£38 353).

I remain unconvinced that a science graduate with 2 years training would complement the current primary care team, at least not for that price.

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Antidepressant prescribing

The appropriateness of antidepressant

prescribing in primary care continues to elicit debate and regular research contributions.[1,2] I carried out a single practice survey of depression management at a practice in south east London. The surgery's electronic records were searched for patients who had been treated for a diagnosis of depression, with or without anxiety between the dates of 1 January 2000 to 21 February 2007. These subject-records were then searched for aspects of management that had been put in place with demographic details and management recorded. A total of 91 patients were returned from the search population by the electronic records database search engine, this amounted to 4.5% of the 2031 registered patients. The ratio of females to males in the cases was 2:1. The majority of patients were between the ages of 30 and 49 years, and more than three-quarters of the sample were of either of black or white ethnicity, with Asians making up 7% of the cohort. In terms of management, most (86%) of the patients had been treated with an antidepressant at some point. Interestingly, the most commonly prescribed agent was dothiepin, a tricyclic, which was prescribed in 27 of the cases.

This finding was interesting in relation to the NICE guidelines on management of depression, whose recommendations at the time of the study were that dothiepin should be commenced only by mental health professionals. The next most commonly used drug was the SSRI, paroxetine, used for 23 cases. Other agents used, in order of reducing frequency were: fluoxetine, venlafaxine, citalopram, mirtazepine, sertraline, and escitalopram. Of four patients on venlafaxine, two patients were found to have been in contact with secondary care, with two patients having no electronic record of secondary service contact. Thirty-six of the 91 patients received some form of further care after their initial point of contact with the GP, 19 receiving an outpatient psychiatric referral, eight being referred for counseling, and the rest being referred either to a CRISIS team, PCT psychotherapy services, Victim Support, Gamblers Anonymous, or an outpatient liaison psychiatry clinic. Overall, it appears that the pattern of UK antidepressant prescribing, even in relatively well resourced areas, remains patchy.

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Academic general practice

I really appreciated the Back Pages paper on academic general practice.[1] It emphasises not only the history but the importance of academic general practice. John Howie warns that the increase in renaming general practice as primary care could mean that general practice may not be a GP-led service in the future. Also, I would strongly underline what Howie writes, 'academic general practice has contributed significantly to the evolving understanding of the relationships between medicine and society'.

I think that this understanding is a key political point to spread worldwide of the importance of teaching in undergraduate academic general practice. National and international GP organisations should help political developments in other countries, at least the European ones.

Howie mentioned some international organisations also naming the Leeuwenhorst Group. This became EURACT (European Academy of Teachers of Family Medicine). EURACT is really the most active network (and academy with a legal body) in the WONCA context. During these years EURACT worked with national representatives from 40 different European countries to write key basilar documents for family medicine.[2] They are: the European Definition, the EURACT Educational Agenda, the EURACT Performance Agenda, the Statement on Selection of Teachers and Practices, and the Checklist for Course Organizers. EURACT Educational Agenda, with its core competences, describes the content and the way for teaching and learning in a general practice context so effectively that it was used by the RCGP in its official documents and is used in other European countries. This is not the same in all countries and I think it is a duty for the strong national and international academies and organisations of family medicine to spread academic general practice in each country with the obvious positive consequences on family medicine and the population.[3,4,5]

As the EURACT Basic Medical Education Committee, we are now at the point of publishing some research, based on the Delphi process, a minimal teaching core curriculum in general practice which will hopefully be useful in introducing a minimal homogeneity in programmes, but mainly to help less established countries open general practice departments and courses for all the students in medicine.[6]

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