general practice. The career aspirations of students change during training and after graduation and are affected by their experiences and by the role models they encounter. Students need to experience these environments early and through their undergraduate training.[2–4]

The apprenticeship model of general practice teaching also has its advantages and must remain a key element of training. Environmental, social, and economic crises put a great responsibility on medical educationalists to prepare young doctors and strengthen their resilience and resolve to face these challenges.

The General Medical Council with the latest version of *Tomorrow's doctors* underlines a danger that undergraduate assessment would become more a record of competency than that of understanding and a broad education.[5]

The development and assessment of professionalism would allow wider thought on behaviour and reflection. In this context we must simply underline and reinforce what The European Academy of Teachers in General Practice and Family Medicine (EURACT) did, and what the Royal College of General Practitioners agreed.

In the European Definition and the EURACT Educational Agenda we fully describe the comprehensive, community orientation, and holistic aspects.[6] We have these documents and we must use them to define clearly the actual and future family doctor. We need to be guided and helped to teach these topics, and assess the level of learning by students who are the next family doctors in the community.

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Self-monitored blood pressure measurements

I wish to make a few comments on a paper published in the September issue of the *BJGP*[1] that question its methodology and, therefore, the reliability of its conclusions.

First, the number of patients is small at 163 participants. This study is a secondary retrospective analysis of data from a failed clinical trial of a herbal product (asparagus) that was being tested for an antihypertensive effect.[1] The participants were not randomly selected from the population, but were recruited by advertisements and word of mouth. The assessments occurred in 'a small city-centre clinic'.

Second, I have searched the British Hypertension Society list of validated home blood pressure measurement devices and cannot find the 'Boso-Medicus Prestige' device that was used in the trial. Is it possible that this machine has not been clinically validated and, therefore, may be inaccurate?

Third, I have not seen the coefficient of variation used in other blood pressure studies. I suspect that it was used here mainly to reduce the level of variability of the results and, therefore, help to get the figures to look more respectable.

Fourth, Table 3 is very difficult to understand with the columns showing duration of monitoring, and the rows displaying intervals.

Last, in the discussion section it is worrying to see that the authors try to explain their findings using a made up 'example' rather than using data from the trial to explain itself.

For all these reasons I do not believe that the unusual findings from this trial are real and applicable to my patients.

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Diagnostic classification in patients with deep venous thrombosis

I enjoyed and learned from the paper in the October issue comparing GPs' judgement with the Oudega decision rule for referring patients with suspected deep venous thrombosis for ultrasonography.[1] One technical point about the Oudega rule variables puzzles me (see Table 1). The caption to the Table states, 'The score could range from 0 to 14…'. The heaviest weightings are given to abnormal D-dimer results (6 points) and calf swelling ≥3 cm (2 points). The six remaining variables are weighted as one point each. Scoring on all eight variables indeed produces a score of 14, but to do so a patient would need to be of male sex and also use oral contraceptives.

Perhaps the range of the Oudega rule should be stated as 0 to 13, with one point scored for male sex OR oral contraceptive use.

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