

questions this may be of little interest but in studies investigating triggers of acute conditions or assessing direct toxic effects of pharmacological agents, timing is important and inconsistencies in the accuracy of an event date could be cause for concern.

In acute conditions (for example, myocardial infarction) with definite event dates, differences between the electronic record and the GP's own notes have a straightforward interpretation of simple errors in the recording of the date. However, when validating the timing of non-acute conditions the authors of validation studies should state whether the GP was asked to provide the date when the index of suspicion was first raised or the date of a definite diagnosis, to enable interpretation of any differences.

The relative lack of data on this aspect of validation and the resulting uncertainty in the timing of acute events highlight the benefits of linkage of the GPRD with other datasets. As discussed in both of our papers, linkage to disease registries could bring additional information with which to validate the diagnosis and its timing. For some conditions this may negate the need to obtain additional information from the GPs that, as we both point out, is expensive and limits the number of patients validated to a selected and potentially unrepresentative group.

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## GPs at the Deep End

I am a GP working in a deprived urban area in Ireland. I would like to express my enormous appreciation of the Deep End series that has been running in the Journal since January. I would describe it as having been thrown a lifeline, if that's not overstating the analogy. To see one's experience named and, indeed, validated in this way has been very liberating. It must be a bit like a patient with an uncommon illness finding a support group. One of the many insights of the work has been to point out that it is not just governments who do not appreciate the issues, but our own unions, colleges, and indeed GP colleagues.

This was eloquently demonstrated by the letter from Steven and Jackson in the April Journal.<sup>1</sup> This is a critical time for general practice in both the UK and Ireland as funding mechanisms come under review. Here in Ireland the average capitation payment in newer deprived suburban areas is 60% of the norm, because it is based on age (despite the greater than twofold mortality). It would be good to have some tools we could use to accurately describe and quantify the nature of the work, as opposed to the health outcomes that are well documented.

We need to persuade the sources of funding, and society as a whole, that it makes sense to address not just health inequality, but inequality of health service provision.

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## GPs' views in five European countries of interventions to promote prudent antibiotic use

The paper by Tonkin-Crine *et al* illustrates

the views of GPs regarding interventions to promote prudent antibiotic use.<sup>1</sup> It was demonstrated that GPs preferred educational meetings where comparison with colleagues reassured them that prudent antibiotic prescribing was possible, and appreciated having evidence-based guidelines to follow.

To follow on from this, if one were to look at the quarter of the population visiting their GP with respiratory tract infections each year, it becomes apparent why a large proportion of antibiotic prescribing is in primary care. Despite guidelines advising against their routine use, in 2000 antibiotics were prescribed to 49% of those with an upper respiratory tract infection (URTI).<sup>2</sup>

The natural history of an untreated sore throat is resolution by day 3 in 40%, and by day 7 in 85%. Antibiotics reduce the duration of symptoms by just 16 hours, while the number needed to treat to prevent one sore throat at day 3 was fewer than six, at week 1 it was 21.<sup>2</sup> There is no benefit of antibiotics for the common cold and although there is a protective effect against serious complications<sup>3</sup>, over 4000 courses are needed to prevent one complication.<sup>4</sup> In addition, antibiotics cause many side effects, and communities build resistance to them.<sup>5</sup> Therefore, with insufficient evidence of the benefit to warrant the use of antibiotics, why do GPs continue to prescribe them for the common and uncomplicated URTI?

Possible explanations for varied GP prescribing behaviour is the GPs' own fear of complications developing, along with their lack of certainty in their decision to prescribe.<sup>6</sup> As patients expect to receive antibiotics,<sup>7</sup> supported by Tonkin-Crine *et al*, along with 85% of patients believing that antibiotics relieve symptoms,<sup>8</sup> a further explanation could be that GPs are unwilling to challenge patient health beliefs. As suggested by the GPs involved in Tonkin-Crine *et al*'s article, the use of educational materials for patients with public campaigns could reduce demand.

Therefore, is it ethical to prescribe antibiotics for URIs? If a GP is concerned about complications developing, prescribing antibiotics is aimed to manage the fear within the doctor, rather than to treat the patient. This will expose the patient to unwanted side effects where they ultimately feel worse. In addition, by prescribing antibiotics GPs are increasing patient attendance rates and are using up scarce resources in an already financially stricken NHS, on balance doing more

harm than good. GPs should consider whether prescribing antibiotics for a URTI is ethically justifiable, in view of guidelines, evidence, and ethics.

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## Minimal undergraduate teaching curriculum in Europe

Elizabeth Brown and colleagues have pointed out significant differences across the European Union in GP-training and in family medicine (FM) teaching.<sup>1</sup> GP-training and the choice of general practice as a profession depend, to a large extent, on the level of FM teaching at undergraduate level. Only if we teach FM at this stage, can we introduce all of them to this discipline as framed by the European Definition. Only if we introduce students for

a short clerkship in the practices, will we get new doctors who are really willing to train as GPs. Also, all doctors, whatever their final speciality, will understand the place of FM in the healthcare system.

As the EURACT Basic Medical Education Committee, we produced and presented research on FM undergraduate teaching in Europe,<sup>2,3</sup> using a Delphi study to determine a minimal curriculum.

The length of the FM/general practice clerkships/undergraduate programmes range from 1 to 12 weeks in different countries, and among different universities in a single country. Inter-country and intra-country variations are seen not only in the length of the programme but also in its content. Since there is no uniform curriculum for FM/general practice across Europe, the aim of this study was to create and suggest one.

The Delphi method was used among the national representatives ( $n = 40$ ) in the EURACT Council. A total of 25 responses were obtained on the first round (62.5% response rate). The 375 themes suggested were then reduced by the researchers to a list of 87. This list was sent again by email. On the second round, 27 responses were obtained (67.5% response rate). A final list was generated after ranking. The third round closed the final 15-item list. 'Final tuning' voting was performed during the council meeting to ensure maximal consensus.

This list could be used in the future for the development of a uniform undergraduate curriculum for FM/general practice across Europe, to promote its development in countries at a lower academic level in FM, and to achieve the reputed uniformity required for high levels of teaching for better free movement of future doctors across the labour market.

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Please contact the Journal office for the 15-item list at [journal@rcgp.org.uk](mailto:journal@rcgp.org.uk)

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## The diagnostic value of symptoms for colorectal cancer in primary care

I was most impressed with the paper by Astin *et al* on the diagnostic value of symptoms for colorectal cancer in primary care.<sup>1</sup> This is such important research, as each day we see patients with gastrointestinal symptoms and I find myself always concerned about missing the bowel cancer (where the prognosis is excellent when found early). My comment to Astin *et al* is that their abstract is confusing. Change in bowel habit (with rectal bleeding?) has a positive likelihood ratio but the bottom line of the results says the positive likelihood ratio (PLR) is 1 or less for diarrhoea or constipation (change in bowel habit). I am not sure which 'advice to follow' and I wonder how many of my colleagues are fully conversant with likelihood ratios, and for the sake of good communication, perhaps these should be translated in to text. Otherwise, well done to their team.

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Knowing the accuracy of clinical tests in practice is useful to any clinician hoping to take an evidence-based approach to their practice, and the work of Astin and colleagues<sup>1</sup> provides a useful summary on the performance of clinical tests used to diagnose colorectal cancer in primary care. However, I believe there are two shortcomings to their analysis.