patients should have investigations in hospital (for example, lumbar puncture) and important therapeutic interventions (for example, steroids) before or at the same time as they receive antibiotic therapy. At present such interventions are not available in most community settings. So for these individuals the priority is to provide rapid access to hospital and minimise the time from presentation to appropriate management. This is discussed in the full version of the NICE guideline where GPs are advised to send such cases to hospital urgently.[2]

The NICE guideline development group searched the evidence for the use of pre-hospital antibiotic use in meningococcal disease and concluded that there was insufficient high quality evidence to recommend antibiotic therapy in this setting (some studies indicated a worse outcome when antibiotics were used pre-hospital, and others implied improved outcomes but all were inadequate to draw firm conclusions) and, therefore, the NICE guideline has emphasised urgent transfer to hospital for children with a non-blanching rash. Despite the lack of supportive evidence, the recommendation to administer parenteral penicillin as previously recommended by the CMO[3] was not rescinded as it was also considered that there was insufficient evidence to change the current practice. The NICE guideline therefore changes the emphasis for GPs seeing cases of suspected meningococcal disease. Where previously all such cases should have received penicillin prior to transfer to hospital, the emphasis is now on urgent transfer to hospital with opportunistic use of penicillin where this can be done without incurring any delay.

The appearance of antibiotic resistant bacteria in the community is a concern but is best managed by limiting antibiotic use rather than wider use of broad spectrum agents. With regard to the moderate penicillin resistance that the authors note was documented by Kyaw *et al*[4] (and elsewhere), it is important to monitor through good surveillance (best achieved by obtaining blood and cerebrospinal fluid cultures in hospital) but, as Kyaw *et al* say in their paper, the clinical significance of moderate resistance among meningococci remains unknown.[4]

Meeting a case of meningococcal disease is thankfully a once in a lifetime experience for most GPs and, carriage of ceftriaxone over a GPs' career is unnecessary and wasteful, especially as we are still uncertain whether antibiotic therapy outside a hospital environment even helps. We recommend that GPs continue to carry benzylpenicillin, at minimal cost, and to administer it if its use will not delay hospital admission.

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Methadone keeps people alive

We were surprised and disappointed to read Mike Fitzpatrick's review column 'Older addicts', as we feel it is inaccurate and ill-judged.[1] We have no problem with The Review articles being controversial but we do expect some attempt to justify controversial views with evidence.

Fitzpatrick makes sweeping statements about one of the therapeutic mainstays of drug dependency. The evidence base for methadone as an opiate substitution therapy is strong and recognised by the national guidelines and the recently published RCGP guidance.[2,3] On an individual level a person on methadone is less likely to die, commit crimes, or get blood-borne viruses.[4]

In contrast, Fitzpatrick's piece is largely rhetorical and it is flawed rhetoric at that. He argues that because there are people who have been on methadone for many years, this 'confirms the spectacular ineffectiveness of the (methadone) treatment'. This is illogical, contrary, and is it not actually the reverse? The ageing demographic of those on methadone shows how well it has kept them alive, something that the RCGP's *2010 Research Paper of the Year* confirmed in a cohort of injecting drug users in Edinburgh.[5] There is also little evidence that methadone maintenance increases the overall length of dependence.[6]

Fitzpatrick comments on 'the substantial mortality arising from methadone overdose (among the children of users as well as their parents)'. There are risks, as with any medication, but deaths in users on scripts are rare and often related to polydrug use. Only 0.1% of drug deaths are under 15 years.[7] Careful attention to prescribing guidelines has mitigated the risk and, ultimately, methadone clearly reduces drug-related deaths.

Finally, Fitzpatrick stands in moral judgement of those on methadone with the pejorative comments that users have been consigned to 'lives of idleness and dependency'. He also suggests that medicalisation is 'robbing drug users of their dignity as well as their health'. We fundamentally disagree with Fitzpatrick's opinions, and it is utterly wrong and baseless to suggest methadone worsens health.

Many GPs have worked hard over many years to address the social exclusion and health inequalities of those with substance misuse health issues. It is perfectly reasonable to have a debate about medicalisation, and there is no reason why the prescribing of opiate substitution therapy shouldn't be included in that debate. However, we would prefer to see a debate that made some attempt to formulate opinions that go beyond a superficial kneejerk anti-methadone approach that has merely served to reinforce an ill-informed stereotype and deepen stigma.

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Ubi Scientia in the midst of the cosy cardigans of *Caritas*?

Daniel Edgcumbe makes an eloquent plea for GPs to engage with the body of knowledge relating to health services, systems, and policy-making,[1] As a GP engaged in research in this area I can only wholeheartedly agree with his analysis. However, I believe there are significant problems within the world of general practice research that militate against this occurring.

First, established disciplinary boundaries render much of the work that my colleagues and I do invisible. Journals such as the *BMJ* and, on occasion, the *BJGP*, are often unsympathetic to research that is qualitative, emergent, and theory generating. Much of the work in this field is cross-disciplinary, and finds a home in journals such as *Sociology of Health and Illness*, *Social Policy and Administration*, and the excellent *Journal of Health Services Research and Policy*. However, such journals have lower impact factors than biomedical journals (typical social science journal impact factors are less than 2, compared with a figure of 13 for the *BMJ*), and this means that our work is undervalued within university medical faculties. Furthermore, it has been my experience (as a reviewer and as an applicant) that the scoring systems used to decide which abstracts are worthy of a presentation slot at academic conferences, such as the Society for Academic Primary Care, are biased in favour of clinical and quantitative research, making it difficult to find an audience for the work that we do.

Second, and leading on from this, even academic medics appear to be unaware of the wide ranging and excellent body of research that exists in the field of social sciences. As an illustration of this, my colleagues and I undertook a large and detailed study of practice-based commissioning; work that is clearly relevant in the current political context. This work was extensively published in journals that appear on PubMed and Medline, and a simple search for 'practice-based commissioning' on Google Scholar™ retrieves many of these papers and the project reports within the first few pages of results. Indeed, we (along with colleagues from the London School of Hygiene and Tropical Medicine) are so well recognised as experts in the field of commissioning research that we were recently awarded a contract to set up a Policy Research Unit on Commissioning and the Healthcare System, funded by the Department of Health. In spite of this, when the RCGP decided to set up a Centre for Commissioning not only were we not contacted, but an email offering support went unanswered for nearly 6 months.

I straddle two worlds, being a practising GP and an active researcher in the field of social science and health policy. As such I both know the literature and know the reality of life on the ground. While I am only too aware that busy GPs do not have time to wade through long papers in sociology journals, those journals with a mass GP audience such as the *BJGP* and the *BMJ* owe it to us to at least attempt to signpost and summarise the relevant research. In addition, I would encourage our academic institutions such as the RCGP and the SAPC to engage more fully with the wider world of research, acknowledging our junior place in a well-established academic field and signalling our openness to learn and engage with research paradigms beyond the randomised controlled trial.

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Conflict of interest: I am a member of the Editorial Board of the *BJGP*.

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