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Editor's choice

Clinical skills training in UK GP training schemes

Having spent time examining primary care training in a number of countries outside the UK, there does seem to be less emphasis on clinical skills training for GP trainees in the UK than for primary care physicians in other countries with well-developed training programmes. I would therefore support Rachel Brettell's call for better clinical skills training during the period that doctors spend as GP trainees.¹ Once they finish their training, GPs in the UK often also see many more patients in a typical working day and have shorter consultation lengths than primary care physicians in many other developed countries; this also hampers the retention and development of the clinical skills of GPs in the UK.

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Competing interests

Azeem Majeed's department hosts the Imperial GP Specialty Training Programme.

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The Calais 'jungle'

The Calais 'jungle' is a shocking indictment of governmental policy towards refugees in 2016.¹ Medical assistance to the inhabitants of the unofficial refugee camp, many of whom are unaccompanied children, is at

best scanty and uncoordinated.

Most of the refugees live in deplorable conditions under tarpaulin sheets on the former dumping sites, which are also home to sizeable rat populations. Many sleep close to the ground and are forced to endure squalid toilet facilities. Some suffer with infectious diseases such as malaria and tuberculosis, and are in need of urgent medical treatment. They are exposed to assault, ethnic and police violence, sexual exploitation, infectious disease, and psychological illness.

Non-governmental organisations (NGOs), for example MSF, and local charities such as the Salam Association are on hand to provide a level of primary care, yet what is needed is an orchestrated medical campaign to include screening for infectious disease and even secondary care for certain cases. We contend that a joint Franco-British programme is needed urgently to augment public and environmental health measures in the refugee camps around Calais and to liaise with the NGOs already in operation there.

The British and French Armed Forces benefit from unparalleled resources to provide medical aid in adverse situations — both contributed admirably to containing the recent Ebola epidemic in West Africa — and have a history of collaboration. Could we invite their respective medical services, with their wealth of experience, staff, and supplies, to become fully engaged in assessing and addressing the refugees' health needs in the camps?

In these days of extreme global inequality, a compassionate governmental response could powerfully counter the narrative of violence we appear to have grown accustomed to.

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General practice workload

Des seems to have been working in an alternative universe of general practice.¹

Numerous pressures from outside general practice control have driven up workload. Computers have allowed identification of all of one's patients to be tested, checked, and ripened for preventive medication. Chronic disease clinics in practice have driven up attendances, tests, and workload. Cancer detection systems, which require 98 fit people out of a 100 (to detect two with cancer) to be referred, caused rising referrals. Ineffective anti-anxiety medications remain a major obstacle to removing the worried frequent attender. As far as depression is concerned it is well known that societal malaise drives up depression rates in communities. At present the practice has been asked to identify more dementia patients by the local CCG but explaining that the practice has no nursing homes in its patient catchment fails to assuage the relentless work to find what is not there. An older population with multimorbidity creates work: in the 1960s your surgery did not need a lift to get patients to first-floor consulting rooms. Finally, what about those checks on non-diseases such as the ill-named chronic kidney disease register, a sort of modern-day general practice Hans Christian Andersen's *Emperor's New Clothes* story. Please Des, come back into reality and start knocking the issues that really have caused the rising workload and professional deskilling.

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Bad medicine: the menopause

I completely concur with Dr Des Spence: Big Pharma is manipulating doctors and exploiting patients, and Big Medicine is neglecting its role to protect patients.¹

I can remember, shortly after becoming a GP Principal in 1987, a drug representative trying to persuade us to prescribe evening primrose oil capsules for itching in eczema. The glossy presentation and neurolinguistic programming attempts to persuade failed because of my training. A study of $n = 20$ can prove anything. So how did it get a licence? Of course, after many years its licence was withdrawn as there was no evidence of positive effect.

Later I asked drug representatives two questions: What is the number needed to treat (NNT)? And what is the number needed to harm (NNH)? The response was mostly gobbledygook, or I'll get back to you, which they never did.

Looking at this more seriously, if referees and journal editors insisted on NNT and NNH figures in research/review papers, instead of relative risk everybody would understand the results more easily. It is depressing that many health media correspondents do not know the difference between actual risk and relative risk, and so misinform the public on the effectiveness of treatments. Unfortunately this is unlikely to happen as even NICE refuses to adopt NNT and NNH as a type of outcome description.

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Chronic fatigue syndrome: is the biopsychosocial model responsible for patient dissatisfaction and harm?

Geraghty and Esmail have done well to draw attention to the substantial biomedical literature now extant around chronic fatigue syndrome (CFS).¹ They are right to point out that the dominant model has been a biopsychosocial (BPS) one, and that this has led to persistent disagreement between doctors and patients. What is particularly salutary is the absence of any advance in therapy, so that they recommend, for example, cognitive behavioural therapy (CBT), but with the caveat that it might not be helpful in individual cases. CFS continues to challenge GPs by its resilience to treatment, but colleagues will be well advised to take on board the changing evidence for pathophysiology set out in this article. Many of the cited papers are accessible and worth reading, such as the authors' reference 8,² and in that paper, reference 38.³

The bottom line for me is respect for the patient, and humility in the face of lack of knowledge about the precise causes of CFS, which is clearly anyway a heterogeneous group of conditions.

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Chronic fatigue syndrome and the biopsychosocial model

I was pleased to see this article highlight the potential harms of graded exercise therapy (GET) and CBT for patients with myalgic encephalopathy (ME).¹ I myself was diagnosed with ME as a 20-year-old student in early 1984 by a consultant neurologist in Glasgow. My illness was triggered by Coxsackie B4 virus — there was an outbreak of Coxsackie in the West of Scotland at this time. Since my own diagnosis with this poorly understood illness, I have been baffled — and shocked — to see the criteria of ME diluted in the early 1990s and the consequent conflation with unexplained 'chronic fatigue'. Moreover, the adoption of the biopsychosocial model of 'ME/CFS' has certainly not been beneficial to my own experience of illness. I am hopeful that, with the dedicated international biomedical researchers we now have, there will be effective therapies in my lifetime. There are many, many people who truly suffer with this dreadful illness.

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Hypertension in surgical patients: the role of beta-blockers

We read the editorial on 'Preoperative blood pressure measurement: what should GPs be doing?' with great interest.¹ In support of the lack of evidence that reducing blood pressure helps, the authors quote the POISE study,² stating that beta-blockers were used to reduce blood pressure preoperatively and the data suggested that it did more harm than good. POISE was not designed to test the effects of reducing blood pressure before