

LETTERS

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Cancer prevalence and infrequent consulters

The paper by Summerton *et al*¹ appears to show that the risks of cancer increases with increases in time between consultations. It is generally felt that infrequent consulters may do so because of worry related to symptoms that may be indicative of cancer. Doctors, too, who are consulted by patients who visit their surgeries infrequently, are naturally concerned by the need for the consultation.

However, the prevalences of the seven cancers reported in the paper are at considerable variance from that in my surgery, The Ongar Surgery (TOS).

The patient populations of both practices are located in mixed urban and rural settings, with a low annual turnover of patients in both sites. The differences in prevalence may be owing to differing populations (unlikely), patients with cancer awaiting diagnoses in Winterton Medical Practice (WMP), overdiagnosis of cancer at TOS or database errors in both practices. A review of the 44 patients with the above cancers at TOS show the diagnoses to be correct (Table 1).

Table 1. Cancer prevalence at the The Ongar Surgery (TOS) and Winterton Medical Practice (WMP).

	WMP	TOS
Practice population	11200	2200
Cancer		
Breast	47	20
Colorectal	21	6
Prostate	7	12
Bladder	3	3
Lung	2	2
Stomach	2	0
Throat	1	1
Total	83	44

Are the conclusions in Summerton *et al*'s paper, therefore, valid? While there may be some merit in the view that patients with increased intervals between new consultations may have a greater chance of having a diagnosis of cancer, I believe that in all consultations a high index of suspicion needs to be maintained if cancer is to be diagnosed early.

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Reference

- Summerton N, Rigby AS, Mann S, Summerton AM. The general practitioner-patient consultation pattern as a tool for cancer diagnosis in general practice. *Br J Gen Pract* 2003; **53**: 50-52.

Diagnostic ability among non-psychiatrists

Although there has been considerable work on the ability of GPs to diagnose depression, there has been little on non-psychiatrists' abilities to differentiate between diagnoses. We would like to report the results of our study measuring agreement across diagnostic category by referrers to that of the con-

sultant psychiatrist who assessed the patient.

All new outpatients that were seen over a 23-year period (1973 to 1996) by the psychiatrist were included in the study. Three hundred and forty-five patients were identified, of whom 304 had sufficient data regarding referral letter, referral diagnosis, and psychiatrist's diagnosis. The patients were allocated to eight diagnostic groups that were independent of revisions in the psychiatric classification (ICD currently in its tenth revision) over this time. If the referral letter did not tender a diagnosis (approximately one-quarter of the total) then the symptoms and mental state mentioned in the letter were used to blindly allocate the most reasonable diagnosis.

The κ statistic was used as a measure of inter-rater agreement. A κ -value of less than 0.4 indicates poor agreement, $\kappa = 0.4$ to 0.75 is fair to good, and 0.75 represents excellent agreement.

There were 191 women and 154 men included whose ages ranged from 14 to 78 years. Referrers were: general practitioners (177); hospital doctors (98); and others (45), consisting of the courts, police social workers, and the day hospital.

For men, there was no significant

Table 2. Inter-rater agreement on diagnoses.

Diagnostic groups (absolute numbers)	Men (κ -value)	Women (κ -value)	Meta-analysis (κ -value)
Learning disability (1)	–	–	0.72
Organic brain syndrome (5)	–	–	0.77
Personality disorder ^a (34)	0.52	0.32	0.32
Psychosomatic (12)	0.56	0.44	0.38
Psychosis (40)	0.64	0.58	0.55
Depression (143)	0.66	0.60	0.26
Neurosis (29)	0.39	0.58	0.40
Nil psychiatric (40)	0.48	0.22	–

^aPersonality disorder includes substance misuse.

difference across diagnostic categories. For women, non-psychiatrists were poorer at diagnosing nil psychiatric disorder ($P < 0.001$ and personality disorder ($P < 0.05$), compared with depression. There were no significant differences in agreement between the referrer groups (GP, $\kappa = 0.57$; hospital doctor, $\kappa = 0.52$; other, $\kappa = 0.50$)

The patients were divided into two time periods — from 1973 to 1983 and from 1984 to 1996 — to assess any impact of improved psychiatric training among general practitioners, but no significant difference was found.

The results of our study compare favourably with levels of agreement found in a meta-analysis of psychiatrists' diagnosis by Spitzer and Fleiss (Table 2).¹ Of note, non-psychiatrists were able to diagnose depression relatively accurately, which may have been a function of the difference in settings. As our study was carried out on an inner-London population where the prevalence of psychiatric morbidity is very high, the referrers may be relatively experienced and may only refer on when they are confident of the diagnosis. Personality disorder may have been underdiagnosed, owing to the lack of knowledge and confidence of non-psychiatrists. In our study, nil psychiatric diagnosis in men was largely impotence, which may have been why referrers were better at this diagnosis in men compared with women.

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Reference

1. Spitzer RL, Fleiss JL. A re-analysis of the reliability of psychiatric diagnosis. *Br J Psychiatry* 1974; **125**: 341-347.

Acknowledgement

We wish to acknowledge Professor RG Priest and Dr A Roberts for their participation in this research.

Do medical students want to become GPs?

We report the results of a study that aimed to estimate the level of interest in general practice as a career for medical students and to investigate the factors that influence this choice. This study was done as part of an intercalated BSc in primary health care.

Since the 1960s there have been reports of a shortage of GPs. Recently, the NHS plan has proposed to recruit an additional 2000 GPs.¹ However, it is a dearth of applicants, rather than a lack of places available, that is limiting recruitment.² Currently, only 7% of male and 13% of female graduates say they want a career in general practice;³ however, it is thought that approximately half of these graduates will eventually become GPs.⁴ There is a changing profile in the way that GPs work, with many (both male and female) becoming part-time, which is having an important influence on the NHS GP workforce capability. This study therefore aimed to assess undergraduates' career intentions regarding general practice.

The study design was a cross-sectional questionnaire survey of students' attitudes towards a career in general practice, their demography, and factors that influence their decisions. Six hundred medical students across all years at University College London Medical School (pre merger with the Royal Free Hospital) were sequentially sampled in 2001, via the university e-mail system, from a complete list of students.⁵ The results were as follows: of the 479 (79.8%) who replied, the most popular specialty was medicine (19.0%), followed by surgery (18.6%), and general practice (13.8%); 23.8% were unsure about their future career.

General practice is more popular among female (50/206 [32.1%]) than male (16/136 [10.5%]) students ($P = 0.001$). Of the students that had had teaching in general practice, 307 (64.1%) females and 176 (54.5%) males felt that this made general practice more likely as a career. Cross-tabulation of exposure to GP teaching with career choice revealed an increased preference for a GP career (22% versus 9.6%, $P = 0.03$) with GP teaching. Mature entry, doing a BSc, or current year of medical school did not seem to have significant impact on career preference.

Students' perceptions of general practice reveal that 55.7% (267/479) feel it is reasonably paid, 54.7%

(262/479) that it is reasonably respected, and 57.5% (280/487) feel that GPs' workload is reasonable. These perceptions had no associations with career choice.

This study reveals low numbers of students expressing an early GP career preference (although a large number were undecided). Student gender and GP teaching may have an important effect on this choice, but students' perceptions of GPs' workload, respect, and remuneration appear not to be overriding issues.

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Macroscopic haematuria and urological cancer

Bruyninckx *et al* have published important, useful data on the sensitivity and positive predictive value of macroscopic haematuria in general practice and are right to point out the paucity of such data derived from primary care.¹

However, we are concerned at the authors' conclusion that, in men or women between 40 and 59 years of age presenting to primary care with macroscopic haematuria, either watchful waiting or referral are appropriate. Our concern relates to four points.

First, the post-test probability of 4% for these patients is the point estimate, and examination of the 95% confidence limits shows that as many as 13.4% (one in eight) of patients between 40 and 59 years with macroscopic haematuria might have urological cancer. We

believe this probability is too high to merit watchful waiting.

Second, while the probability of disease is important when making the decision to refer, other factors must be considered; namely, the seriousness of the target disorder and its treatability. Urological cancer is one of the few cancers where early diagnosis is clearly beneficial. For example, 15% to 25% of transitional cell carcinomas are potentially life threatening² and early diagnosis improves prognosis.^{3,4} In these circumstances, even a 4% risk may be unacceptably high.

Third, the authors are correct to acknowledge the limitation of combining prospective and retrospective data, which led to the discrepancy of 33 patients with urological cancer between the two arms of the study. This meant that the authors could only estimate the negative predictive value, specificity, and likelihood ratios based on an assumption about the number of patients without haematuria who subsequently develop urological cancer. This assumption has previously been challenged⁵ in a similar study of rectal bleeding.⁶ As the authors point out, the discrepancy may be because patients with haematuria in Belgium can access a urologist directly. It is possible that those selecting secondary care had more severe symptoms and so were more likely to have urological cancer. This means that the results cannot be generalised to a country such as the United Kingdom with a single point of access, because the post-test probabilities could be even higher.

Finally, it is not uncommon for associations found in one population to disappear when examined in other populations.⁷ In summary, then, we do not believe that the results of this study can be applied to UK clinical practice, because they are not precise enough, they cannot be generalised to other healthcare systems, and they require further validation.

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I read with interest and alarm the paper from Belgium in January's issue regarding the importance of frank haematuria.¹ I was particularly concerned by the statement in their closing paragraph, which was reiterated in the key points box that for 'patients over 40 [and up to 60] years of age of either sex [with frank haematuria], referral or watchful waiting can be justified'.

A study of nearly 2000 patients attending haematuria clinics in Leeds² found that approximately 10% of women with frank haematuria between the ages of 40 and 59 years had a urological cancer, and for men the corresponding figures were 16% between 40 and 49 years, and 20% between 50 and 59 years. Also, 21% of patients with frank haematuria were found to have significant benign surgical diseases,

such as urinary calculi.

We know intuitively that any delay in diagnosing and treating bladder cancer (the most common urological cancer found in patients with haematuria) will adversely affect the patients' outcome. This has been shown in the past³ and more recently in a study from the West Midlands, which demonstrated that there was significantly better survival for patients with bladder cancer who were referred to hospital by their GP within 14 days of the onset of symptoms.⁴

I sincerely hope that GPs in Britain will therefore ignore the closing comments of this interesting Belgian study and continue to adhere to our suspected cancer referral guidelines.

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Author's response

Paul Anderson challenges our conclusions,¹ based on results from haematuria clinics in which far higher rates of cancer were found in gross haematuria patients, aged between 40 and 60 years old (16% to 20% in men and 10% in women, versus 3.6% and 6.4% in our group). These results are in line with what was identified during a previous meta-analysis that only included results of referred patients and was the initial reason for this study.² In our view, this large difference would be expected as a normal result of selection by referral, and probably also by the relative absence of patients suffering only one episode in secondary care study groups. The difference is not likely to result from incomplete case ascertainment by direct contact with the specialist, as supposed by Alastair Hay *et al*,³ as such cases are also normally

reported to the GP, and so are included in the registration.

No rules exist to guide the decision on the point at which positive predictive value (PPV) referral and extensive testing should be advised. Both correspondents suggest that the decision criteria should be more conservative than the ones we proposed, to which they have a perfect right. Urological cancers are diseases that are both serious and treatable. Additionally, it should be taken into account that other causes of gross haematuria (e.g. calculus) may also be detected by such testing. One should also consider, however, the burden to the large numbers of patients who would be tested unnecessarily. A cystoscopy is not a pleasant experience for patients, especially when they know that there is a 95% likelihood that it is unnecessary. One should also consider the large number of urologists that would be required to analyse these tests. For a population of 100 000 people we would be talking about around 170 tests each year for this indication and in this age group alone. Finally, 'watchful waiting' doesn't mean 'not doing anything' or 'forgetting the whole story'. These patients should be followed and referred for further testing in case of repeated haematuria or additional signs or symptoms.

We agree with Hay *et al* that our results require further validation in different primary care populations. If more results become available then the discussion about how to deal with them will gradually become easier. At least we now have primary care results to discuss.

We also hope that this discussion does not distract the attention from our main message, which refers to a larger group of haematuria patients and, partly, to a far more dangerous situation: although all patients aged over 40 years are suspect, patients over the age of 60 years who have gross haematuria are at high risk of urological cancer and should systematically be referred for thorough investigation.

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The video component of the MRCGP examination

Compiling videos for the MRCGP examination is, for many GP registrars, a laborious and time-consuming task. I have seen how some GP registrars now devote weeks, sometimes months, of their surgery consulting sessions to video in a prolonged attempt to catch suitable cases on tape.

I am aware that many trainers and registrars find the MRCGP video performance criteria not only over-complicated but sometimes even irrelevant to their consultations.

In order not to miss a potential mark, some registrars now stick a list of these criteria to the surgery wall near to where their patient will sit (but out of camera view) so that they can check them off as the consultation develops. More alarming, in my view, is a different technique, in which the registrar undertakes a contrived 'video consultation' with their patient before starting again 'for real'. To start a consultation by saying 'I'm sorry Mrs Smith, but I've got to pass an exam. Would you mind if I asked you some rather odd questions in front of the camera, then I'll turn it off and sort out your problem properly?' is, I am sure, not what the designers of the examination intended. More worrying still is the possibility that registrars may arrange for a fake patient to act for them in a consultation that has been designed purely to meet the performance criteria.

I believe that the examination video now takes many registrars so much time to compile that in some cases it may be to the detriment of their year's learning in general practice. It should be simplified or replaced.

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What's in a word?

In recent years, references to titles such as 'naturopathic physicians' and 'doctors of chiropractic' have emerged in the lay¹ as well as in the professional² literature. Dictionaries state that a 'physician' is a 'person licensed to practise medicine'³ or a 'person legally qualified to practise medicine'.⁴ Similarly, a doctor is defined as 'a person who has been trained in medical science'³ or 'a person licensed to practise medicine'.⁴ 'Physician' and 'doctor' are often used as synonyms, but the term 'doctor' also has, of course, a non-medical meaning, i.e. 'a person who has been awarded a higher academic degree in any field of knowledge'.⁴ To avoid confusion; section 49 of the Medical Act 1983 provides that any person who 'wilfully and falsely pretends to be a physician or doctor of medicine' commits an offence. This law is designed to protect consumers from those who falsely hold themselves out to be medical doctors. The onus is on the person who uses the title to ensure that he or she does not imply that they are a registered medical practitioner when he or she is not.

I have recently written to several UK organisations in an attempt to clarify their use of the term 'physician'. The Craniosacral Therapy Association of the United Kingdom stated that they 'would certainly not support [their] members calling themselves "physicians", unless they happen also to be qualified medical doctors. Indeed [their] code of practice specifically prohibits members calling themselves doctors' (personal communication from the CTA, 23 January 2002). The British Osteopathic Council replied that their organisation also does not support its members calling themselves 'physician[s]'. (personal communication from the BOC, 16 January 2002). The Craniosacral Society stated that anyone using the title physician 'would have to be at least either a registered medical practitioner, or a member of a recognised qualifying College of Physicians' (personal communication from the CSS, 14 January 2002). The British Chiropractic Association replied that 'the title "chiropractic physician" is protected under Section 32(1) of the

Chiropractors Act 1994. Members of the BCA are entitled therefore, under the Act to use this title if they so wish' (personal communication from the BCA, 18 February 2002).

The code of practice of the General Chiropractic Council states the following: 'chiropractors shall not use any title or qualification in such a way that the public may be misled as to its meaning or significance. In particular, chiropractors who use the title 'doctor' and who are not registered medical practitioners shall ensure that, where appropriate (for example, in any advertisements and in their dealings with patients and other health professionals) they make it clear that they are registered chiropractors and not registered medical practitioners'.⁵ The British Medical Association states that 'impersonating a medical doctor is illegal ... It is therefore an offence for somebody who is not medically qualified to use the title "doctor" or "physician" with the intention to mislead' (personal communication from J Sheather, Medical Ethics, BMA, 2002).

The Yellow Pages directory lists many chiropractors who use 'Dr' in front of their names, often in conjunction with the logo of the British Chiropractic Association. Daily newspapers confront us with 'naturopathic physicians'.¹ I believe that this confusion is as regrettable as it is avoidable. Most importantly, it has the potential to seriously mislead patients — we should try to clear it up.

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Recruitment in general practice

As a partner in a practice that has recently been actively involved in the recruitment of new partners, I have been made aware of the difficulties in attracting new doctors. I am aware through the media that there is a national shortage of general practitioners, and locally in Northamptonshire this is a particular problem.

I am interested to note that although there are many practices looking for new GPs, there seem to be fewer adverts in the medical press than when I looked nearly ten years ago. It may be that the medical press puts a ceiling on the number of advertisements it publishes; however, my feeling is that it is the considerable cost of advertising, coupled with lack of results, which deters practices from repeated advertising. Our practice has spent about £700 on advertising on two occasions. I am aware that some Primary Care Trusts will help practices towards the cost of advertising and some have been involved in career fairs to aid recruitment.

It seems to me that the RCGP, as the central body in general practice, could help out. I feel that a national website could be organised for the sole purpose of advertising GP vacancies. Practices could pay a nominal charge in advance for the privilege of advertising on the site and the advert would remain until notification for its removal by the practice concerned. The advantage of this would be a cost-effective way for practices to advertise for as long as they want and a central accessing point to job-seeking GPs, where they know they can find information 24 hours a day, seven days a week. The website could be accessed by doctors from abroad with the same ease.

I appreciate that some of the medical press might not approve of such a venture, owing to a potential loss in their income, but I do feel that the RCGP and the medical press should help those practices that are having trouble recruiting.

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Qualitative survey on nursing and residential homes

It is astonishing that researchers keep publishing consumer viewpoints *ad nauseum* from nursing and residential homes,¹ but never ask the primary care providers what the real difficulties are in relation to medical service provision for the elderly. I have been a GP for almost 20 years and am surrounded by these institutions, set up by private entrepreneurs, simply because the property prices in our deprived surroundings allowed them to do so unchecked. They run businesses employing the cheapest staff with a very high turnover. The message of this statement is self-explanatory. With 20 years' experience of medical problems in the elderly, our practice has simply refused visiting to such institutions and elderly patients in their homes, except where the situation is terminal. We are not concerned about pay issues. Even a ten-fold higher fee would not change my view.

The National Service Framework for the elderly entitles these residents to the same level of care as the under-65s without any compromise of diagnostic facilities. I would openly challenge any scientific medical body to prove to me that high quality care is deliverable within a patient's home (an institutional or the patient's own home for that matter), where there are no examination facilities to enable diagnostic work to take place. Such residents have complex chronic medical problems, often with insurmountable acute crises, that demand, more often than not, a hot-house (accident and emergency) assessment rather than a call-out.

Having done weekly surgeries in my first ten years in many of these homes, I stopped when I realised that there was no clear evidence of benefit to residents from a medical perspective. Yes, it was wonderfully convenient for the residents, but scientifically useless.

I remember the monthly social visits to the elderly by my predecessors. These have disappeared, but nobody seems to have missed them. Nobody is complaining about this missing service!

Evidence-based medicine and the medico-legal climate should force us to be honest to ourselves as GPs, and to the residents, that we cannot achieve high-quality care at their bedside and that diagnostic mistakes are in the making. Has Sally Jacobs ever asked consultant geriatricians to assess such

individuals in their homes? They simply admit the resident, as they cannot do any better in these settings. I have not asked for any form of domiciliary visits for over 15 years. Is it really right to have 'call-outs for minor ailments', which should be within the expertise management of so-called qualified nursing staff? After all, such minor ailments are being dealt with by triage nurses over the telephone every day for the rest of the population, without any further involvement by GPs.

It beggars belief that the same residents are taken by taxis to hospital departments for their routine medical follow-ups. From our personal perspective, we have, over the last 18 months or so, invited elderly patients to make appointments at our surgery, rather than ask for call-outs. I would invite Sally Jacobs to survey our practice elderly population and then explain to the rest of the world why these wonderful and equally deserving folk now prefer to make surgery appointments. They never ask for home visits. We are able to deal with the medical problems with profound reduction in referral to A&E. The homes are much happier with this outcome, as they save staff time, which is wasted in the endless hours in the A&E.

Finally, GPs are also highly experienced and are able to judge on the phone when a resident should be taken directly to A&E, without a call-out or having to visit the practice premises. I disagree that nursing homes know better. No wonder this disagreement was a common theme. Let us be honest: visiting, except for the terminally ill, is scientifically invalid and is only of benefit to the government. Why does the rest of the world not visit these same patients?

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Reference

1. Jacobs S. Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study. *Br J Gen Pract* 2003; **53**: 120-125.

Combining work and research

I am writing to share my experience, as well as hopefully to receive advice and possibly encouragement to further my cause.

I recently completed the Substance Misuse Certificate in which I had to undertake an audit of a clinic to which I was attending. This audit identified the need for a hepatitis B immunisation programme at the clinic, as per the Department of Health ('Orange Book') Guidelines. I undertook this training when I was a locum. This meant that instead of working in a locum surgery I diverted the time to attending a clinic on an unpaid basis. We were paid a bursary for the certificate training, but this was to cover the travel expenses for attendance and lost earnings incurred on the days of the Master Classes, of which there were three in total, for which we received £1000.

After completing the certificate and feeling inspired by the experience I decided that I would undertake a research project in which I would look further into the problems of immunising substance misusers against hepatitis B, with a view to improving service delivery at the clinic where I had attended. To this end I embarked on a 'Primary Care Supported Research Training Programme'. This is an excellent course in which, over a period of 10 half-days, the rudimentary elements of research were taught. I was still a locum, and attending the course's half-days resulted in a further financial loss, as rather than working I would be attending the classes.

My situation then changed when I embarked on a general practice partnership. I deliberately chose to work seven sessions: a full-time GP. If I wish to maintain my interest in research, I would have to use my annual/study leave allowance, as the partnership offers the standard five weeks' annual leave, plus one week's study leave. These half-day study days combined with other courses resulted in my free 'non-surgery time' being diverted to continuing the research training course, which at the time was helping me develop my hepatitis B research training project. Six months into the partnership and almost half-way through the research training pro-

gramme, I have to abandon my research training project lest it consume all my annual leave.

Some readers may think that taking on or getting involved in research is a choice on my part and that research has always been done in one's 'own time'. I feel that this is not the way for it to continue if it is to progress. For those of us who do express an interest, programmes such as the Primary Care Supported Research Training Programme should be funded so that, from the start of a project to its completion, it is more supportive of 'jobbing' GPs, by at least fully reimbursing the GP for their locum cover while attending research training. Also, the Primary Care Trust could be reimbursing GPs' release — but not at the expense of the interested doctor's annual leave — on a sessional basis to continue research, without the GP having to change to being a salaried doctor. I do not feel that this should have to be done as a sabbatical, nor as something that should be done in the evenings at the cost to jobbing GPs' family lives.

I feel that I have identified here the reason why there is paucity of full-time practising GPs who engage in research while doing the job in general practice. One only has to look at any of the recent editions of the *BJGP* to see that most authors come from the protected environment of academic general practice units, rather than from the frontline.

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Corrections

In the 'Our Contributors' column on page 1056 of the December 2002 issue, we referred to one of the contributors as 'Richard J Huntsman'; in fact his correct name is Richard G Huntsman. We apologise to Dr Huntsman for the error.

The paper by Whitford *et al*, entitled 'Influences on the variation in prevalence of type 2 diabetes between general practices: practice, patient or socioeconomic factors?' in the January 2003 issue (pages 9-14) shows 2002 as the year of publication in the copyright line — the correct year should of course be 2003. We apologise for this error — an amended paper will be posted shortly on www.rcgp.org.uk.