Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

SPREAD initiative

Sir,

The paper 'Primary care research — the truth' (May *Journal;* Back Pages)[1] struck a chord in our hearts and spurred us to share our own experiences from the coalface of primary care research.

Recent emphasis on encouraging research in primary care[2] resulted in the North West Regional NHS Executive establishing a research and development initiative. The initiative, Stimulating Practice-based Research and Development (SPREAD), supports primary health care professionals in developing research and development skills. As a SPREAD practice, we are currently embroiled in the research process.

Many of the areas highlighted as vital to successful research[1] have been addressed by SPREAD; however, despite this, we still empathize with the views and challenges described.

Our practice supports a population of approximately 2000 people. Within this there is considerable ethnic diversity: 60% of the population are of South Asian origin and 40% Caucasian.

Our research focuses on two clinical areas: iron deficiency and anaemia in children, and diabetes. At the outset we were clear that our projects should be relevant to the health needs of our practice population and be useful in general practice.

The iron deficiency anaemia project will determine iron levels in a group of preschool children. Lifestyle and dietary variables will then be examined to determine if these can be used within primary care as firstline indicators for children at risk of iron deficiency.

The diabetes project reflects our concern for the ethnic minority population's increased risk of developing type 2 diabetes.[3] This risk is further increased if a first degree relative has diabetes. We aim therefore to determine the glucose tolerance of people who have either a parent or sibling with diabetes and to intervene with health promotion initiatives. We recognize that the numbers involved may not be large enough to achieve 'statistical significance', however, we hope the study will lead to improved outcomes for this group.

We are novice researchers and, despite support, have found this a challenging process. Ideas have been no problem; being realistic, practical, and specific has. We have found difficulty in formulating research questions and have spent many hours striving to be focused and clear in our thinking. This is not 'blue skies research' but we hope our small contribution will influence service delivery and improve health for the population we support.

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Screening for cervical chlamydial infection in general practice

Sir,

Stokes *et al* provide an excellent discussion of the issues concerning chlamydia screening in primary care (June *Journal*).[1] We agree with them, and the Expert Advisory Group,[2] that the priority cases for screening are sexually active teenagers and women requesting termination of pregnancy. But who else should be screened in general practice?

In 1994–1995, we conducted a study of opportunistic screening for chlamydial infection at the time of cervical smear testing in 30 London general practices.[3] (This is currently the only UK general practice-based study in which over 1000 women were screened and multivariate analysis of risk factors was performed.) Chlamydial infection was associated with an age of less than 25 years, being of black African or Afro Caribbean ethnic origin, having had two or more sexual partners in the previous year, and the presence of mucopurulent vaginal discharge or friable cervix.

Since routinely asking about numbers of sexual partners may not be realistic in general practice, we suggest offering screening to women aged under 25 years, black women, and those with clinical signs on speculum examination. Using these criteria in our study, 52% of women would have been screened to detect 87% of cases.

Stokes *et al* also observe that GPs may need guidelines on the management of women with chlamydial infection, as follows:

- Appropriate antibiotics (e.g. doxycycline 100 mg bd for seven days or azithromycin 1 g stat, or, if pregnant or lactating, erythromycin 500 mg qds for seven days).
- Advise that the partner must be treated.
- Refer to a genitourinary clinic for follow-up.

The evidence for such recommendations has been examined.[4,5] Furthermore, a randomized controlled trail in 28 inner London practices showed similar guidelines produced an improvement in GPs' management of roughly 40% (although too few women were diagnosed with chlamydial infection to reach statistical significance).[6]

United Kingdom GPs have been shown to be willing and able to screen and treat women for chlamydial infection in co-operation with our hospital colleagues.[7] What we now need is routine access to sensitive non-invasive screening tests, such as ligase chain reaction, on first pass urines instead of the currently available insensitive enzyme immunoassay on endocervical specimens.

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Locum doctors in general practice: motivation and experiences

Sir,

The article on locum doctors (July *Journal*)[1] highlights the need for a new vision for GP locums. As the article states, GP locums have an important role, but they are often invisible in the sense that no one knows who they are, or where they are. This is poor personnel management. Many are isolated and not regularly involved in local medical networks. This is poor team building. Being a GP locum should be seen by GPs who are graduating from vocational training (VTS) as a constructive career move lying between VTS and partnership. Moreover, being a GP locum offers flexible working, which is what the majority of younger GPs want. We need to be aware of these issues when developing an effective recruitment and retention strategy for GP locums.

The time is ripe to formulate new terms and conditions for GP locums. Aspects that should be considered are:

- In order to practice as a GP locum their name must be on a local locum database, which includes checking of professional details. Currently it is left to practices to check these details, but in reality is this done regularly?
- They receive all relevant mailings, such as clinical updates (including BNF), and information about medical meetings, as currently sent to all GP principals.
- There is a mechanism for sorting things out when serious problems emerge with locums. Currently, if a practice has grave doubts about the competence of a locum, the locum is simply not offered further work, but they are still free to find work elsewhere.

Primary care groups (PCG) and primary care trusts in Scotland (PCT) should take a lead here. It is in their interests to maintain a local pool of motivated, educated, competent, safe GP locums.

As a further development, each PCG/PCT might consider the setting up a core group of salaried part-time flexible GP locum posts in their area. Each GP locum in this core group would be responsible for a few practices in their area and cover the principals in these practices for such events as practice away days, PCG/PCT meetings, and other committee work.

Everyone would gain from such a pool of salaried GPs. Patients would benefit because there would be one regular locum, rather than multiple locums who float in and out. The practice would benefit as the locum would know the practice set-up, where to find equipment, how to use the phone system and computer, and local prescribing/referral patterns. The partners would benefit as they would have a known and, hopefully, trusted locum, requiring minimal induction. The practice managers would benefit as they would no longer have to spend hours on the phone ringing around for a locum.

One of the positive benefits of the new Health Act is the possibility of clearer responsibility, through PCG/PCTs and clinical governance, for GP locums. Let's hope improving terms and conditions for this previously neglected group of GPs is high on their agenda.

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'Uncertain clarity': Confusion, nonsense, and misunderstanding

Sir,

After reading Dr Iona Heath's 1999 Williams Pickles Lecture (August *Journal*),[1] I believe Dr Heath is trying to tell us 'not to miss the wood for the trees; and not to miss the trees for the wood', but I am not certain.

I was lost among quotations from poets and playwrights like Zbigniew Herbert, Berger, Chekhov, and Michael Frayn; and sages such as Kant, Isaiah Berlin, Pellegrino, Rudebeck, Bakhtin, and, the never to be forgotten, Giambastista Vico. Sadly, only Kant merited an inclusion in Monty Python's list of philosophers.

Dr Heath quotes William Pickles: 'I come to speak about simple things.' Perhaps the lecture should have followed this excellent precept. Most GPs follow this proven maxim daily.

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Reference

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The need for an e*BJGP*

Sir,

Prompted by the letter by John Gillies calling for debate on the future of the *Journal* (August *Journal*),[1] I would like to present arguments in favour of the *Journal* being published in both electronic and paper versions — as is the case with the *BMJ*. Readers who have not yet taken the opportunity should check out the features that make the e*BMJ* the world's most sophisticated online medical journal. These features could be incorporated into the 'e*BJGP*' in a way that would ensure it remains the most cited primary care journals through this era of rapid change in publishing technology.

The e*BJGP*'s website could allow access to the *Journal*'s archive (either starting from the time of going electronic or with retrospective publication of older material). Readers could then search all articles or refer to themed collections — downloading the results of their searches into reference management software for future study or citation.

An advantage of electronic publishing is that there is no real limitation on space. This means that the e*BJGP* could publish aspects of research papers — such as the questionnaires used in questionnaire surveys — for which there is usually insufficient room in the paper version.[2] We could also have links to MEDLINE abstracts of referenced papers and allow readers to make rapid electronic responses to articles rather than wait several months for formal publication.

I am sure that the editorial board has thought about much of this and pondered over how to finance what would be an expensive venture. Can I make a final plea — that the full-text version be available free of charge to anyone who wants to consult it? Charging for the e*BJGP* may bring in little extra revenue — not charging will cause few to stop paying their RCGP dues. Low-key advertising would be an accept-

able compromise. That the full-text e*BMJ* remains free to the world sends a positive message about the profession in Britain. Having the full-text freely available online creates the potential to have more readers making more citations and more contributions and generally enhancing the vitality of the *Journal*.

With a bit of imagination the e*BJGP* could be an important resource for primary care, not merely an electronic version of the paper *Journal*, but a rich new medium for interprofessional communication. There is a sense in which moves in this direction are inevitable;[3] the important thing is not to get left behind.

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Antibiotic prescribing patterns

Sir,

Majeed and Moser (September *Journal*)[1] report on antibiotic prescribing patterns in general practice in 1996. They discuss the use of quinolones and the fact that prescription for quinolones accounted for less than 3% of all antibiotic prescriptions. This figure is similar to the value of 2.56% reported by Avery *et al*[2] who examined Prescribing Analysis and Cost (PACT) data for 809 general practices for 1995/96. One would perhaps expect the use of quinolones to have grown over the intervening years.

In connection with HSC 199/107,[3] we identified that, from PACT data for our 76 practices for the quarter from January to March 1999, prescriptions for quinolones represented, on average, less than 4% of all antibiotic prescriptions. As observed by Majeed and Moser, there was a large interpractice variation around this average (ranging from less than 0.5% to greater than 10% of all antibiotic prescriptions). This slight increase in the use of quinolones has to be viewed in the context of a decline in the total number of antibiotic prescriptions written by GPs in Cornwall and Isles of Scilly Health Authority over the period 1995 to 1998, as seen with the national trend.[4]

With the increasing availability of this type of information at a primary care group level, it is indeed important that use of any data happens in a rational and sensitive way to maximize the potential gains and reduce the associated risks.[5]

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PACT quarterly returns

Sir,

I have always found PACT data very informative, especially the graphs showing our prescribing costs over the past two years. What I did not know was that these graphs were 'political' rather than true graphs as taught by my statistics teacher at school. 'Always plot the vertical axis starting from zero' was the order of the day, unless you wished to lie with statistics.

Political parties frequently resort to a non-zero axis and squashing or stretching a graph to emphasize a point that may blur the underlying truth. To make matters worse, each of the six graphs presented have different scales, and trends cannot be compared across therapeutic groups.

Figure 1 shows our one therapeutic group as illustrated in our latest PACT return. The conclusion from this graph is that we are prescribing more than the health authority equivalent by a significant amount; the divergence is becoming alarming, and the regression suggests we are getting worse with time. As a practice we are alarmed and conclude that we need to seriously address our prescribing, and expect our PCG prescribing adviser to be breathing down our necks fairly soon.

By comparison, the graph as shown in Figure 2, with a vertical axis starting at zero, conveys a different message. We appear to be slightly above the health

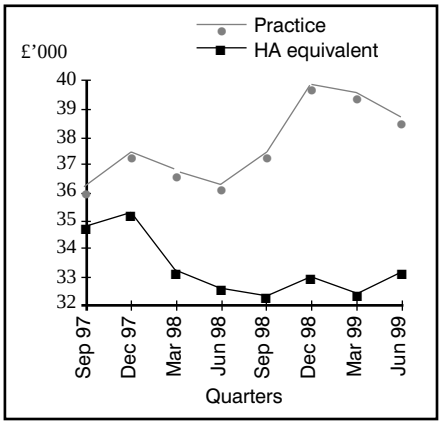

Figure 1. Total practice prescribing costs by the BNF gastrointestinal system therapeutic group for the past two years.

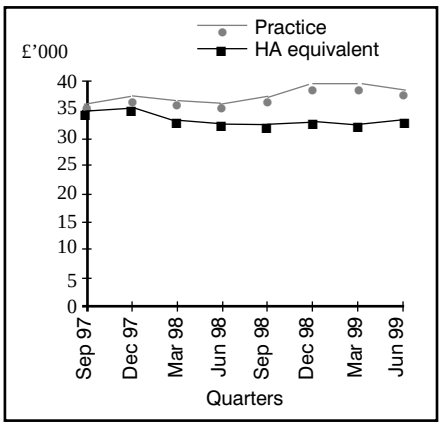

Figure 2. Total practice prescribing costs by the BNF gastrointestinal therapeutic group for the past two years.

authority average, with a slight overspend over the past year that appears to be correcting itself; the regression suggests were are back on target. As a practice we are satisfied with our prescribing and conclude that measures we have taken are beginning to take effect and we just need to monitor the situation. There is no need to ask advice from the prescribing adviser in this instance.

I would recommend that practices who are interested in understanding their prescribing should re-plot the more extreme graphs starting from zero. The interpretation may be quite different from what the NHS Prescribing Information Centre would like you to believe.

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