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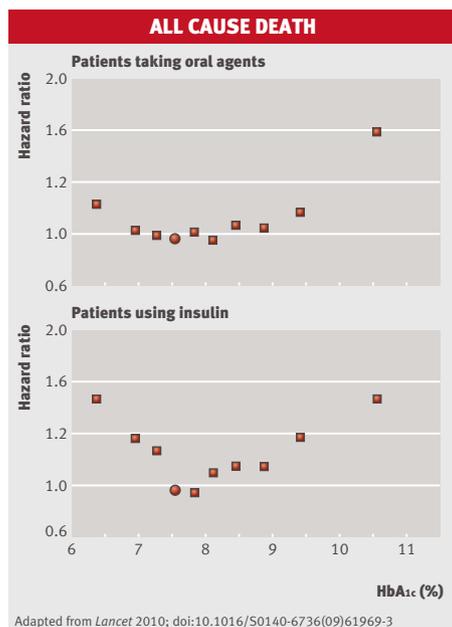
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LETTERS

GLYCATED HAEMOGLOBIN BELOW 7%

No to QOF target of <7%, again

A large observational study examining the effect of additional glucose lowering treatment in nearly 28 000 primary care patients with type 2 diabetes in the UK was published last month.^{1,2} A glycated haemoglobin concentration of 7.5% was associated with the lowest mortality. Concentrations below 7% were associated with a higher mortality—matched only by concentrations above 9%—whether the additional treatment was another oral drug or insulin.



This observational evidence, though not definitive in its own right, is consistent with the interventional evidence suggesting a possibility of harm from lowering glycated haemoglobin below 7% in patients with established type 2 diabetes.³ This evidence, with that of two negative trials, led us in March last year to call for this target to be abandoned in the quality and outcomes framework.⁴ At this point, it still stands.

Proponents of a target for glycated haemoglobin of under 7% often cite the long term results of the UK prospective diabetes trial, in which tight glycaemic control in the first years after diagnosis of type 2 diabetes seemed to produce cardiovascular benefits many years later.⁵ However, these subjects

did not reach a mean glycated haemoglobin concentration of under 7%.

We in the UK should follow the lead of the National Committee on Quality Assurance in the United States and suspend this target. We cannot risk harm by incentives that encourage practice patterns which the evidence does not support and which may even compromise patient safety.

Richard Lehman general practitioner, Hightown Surgery, Banbury OX16 9DB edgar.lehman@btinternet.com
Harlan M Krumholz Harold H Hines Junior professor of medicine and epidemiology and public health, Section of Cardiovascular Medicine and Robert Wood Johnson Clinical Scholars Program, Department of Medicine, Section of Health Policy and Administration, School of Public Health, Yale University School of Medicine, PO Box 208088, New Haven, CT 06520-8088, USA

Competing interests: None declared.

- 1 Currie CJ, Peters JR, Tynan A, Evans M, Heine RJ, Bracco OL, et al. Survival as a function of HbA1c in people with type 2 diabetes: a retrospective cohort study. *Lancet* 2010;375:481-9.
- 2 Short cuts. U shaped association between glycaemic control and mortality in type 2 diabetes. *BMJ* 2010;340:c580. (2 February.)
- 3 Action to Control Cardiovascular Risk in Diabetes Study Group. Effects of intensive glucose lowering in type 2 diabetes. *N Engl J Med* 2008;358:2545-59.
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Cite this as: *BMJ* 2010;340:c985

CHECKLIST CULTURE

WHO checklist needs changing

Vats and colleagues fail to recognise the intrinsic faults of the current checklist.¹ If adherence to the checklist is to be improved, it must be workable and acceptable to all staff. One limiting factor to adherence was that it caused embarrassment—this would not occur if it didn't contain some inappropriate points. Rigidly enforcing an inappropriate checklist is counterproductive, and it is no surprise that once supervision decreases compliance falls. The current version does not ask questions early enough to enable corrective action to be taken. For example it is too late to wait until the patient is anaesthetised and draped before asking if the patient's position is correct, or whether extra equipment or blood transfusion is needed.

It is not impractical to have a briefing before starting the list as Vats and colleagues claim: it takes place informally already. If

this is strengthened as part of the checklist then theatres will run more smoothly, with everything in place in a timely fashion. Continued duplication of checks is unnecessary.

A theatre checklist enhances compliance with established safe practice. The checklist format shouldn't be adopted and then adapted. It needs to be revised to an acceptable format and then used appropriately, nationwide, as soon as possible.

Kate Hancorn ST2 general surgery katehancorn@hotmail.com
Stephen Blair consultant general surgeon, Wirral University Teaching Hospital NHS Foundation Trust, Upton, Wirral CH49 5PE

Competing interests: None declared.

- 1 Vats A, Vincent CA, Nagpal K, Davies RW, Darzi A, Moorthy K. Practical challenges of introducing WHO surgical checklist: UK pilot experience. *BMJ* 2010;340:b5433. (13 January.)

Cite this as: *BMJ* 2010;340:c909

Seductions of the WHO safe surgery checklist

It is worrying that those furthest from surgical practice seem to be embracing the new WHO surgical checklist most enthusiastically. Thus, it is ironic that Atul Gawande's book *The Checklist Manifesto* is reviewed by a physician rather than a surgeon.¹ In espousing its philosophy, the reviewer omits to tell us that its author was one of the participants in the study,² which quotes improvements in mortality and morbidity of just 0.7% and 7% (not the 47% and 36% quoted in the review).

Little evidence exists for Gawande's proposal that the WHO checklist is appropriate for modern Western surgical practice. The original article, which showed small overall improvements in outcomes, included Third World hospitals where safety parameters improved from levels unthinkable in European or American practice.

Only two weeks earlier in the *BMJ*, Vats and colleagues' UK pilot study found no significant change in overall morbidity or mortality in their hospital, and that use of the checklist was difficult to maintain.³

The checklist has been promoted internationally by a supranational quango (WHO) and imposed in the UK by a national quango (National Patient Safety Agency). Operative procedures and outcomes undoubtedly need improving, but the checklist

is little more than a distraction. It does nothing to tackle the most pressing issue of ensuring that the surgeon is adequate for the task and it is no more likely to identify incompetence than revalidation is to uncover the next Harold Shipman.

Peter J Mahaffey consultant (plastic and hand surgery), Bedford Hospital, Bedford MK42 9DJ
peter.mahaffey@bedfordhospital.nhs.uk

Competing interests: None declared.

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We need a safety system

The recent editorial by Vincent and colleagues struck a chord as I have experience as an anaesthetist and an airline pilot.¹ All high reliability organisations have a safety management system, featuring basically the same requirements as clinical governance, with one important addition—an operations manual, which provides concise but authoritative information and instructions on who does what, when, and how. When backed up by good communications and training, the result is a flexible and resilient organisation.

As the authors say, such reliability and resilience may be approached in some teams and in some parts of health care. But safety systems are important because they are implemented across organisations. Perhaps the absence of an operations manual is indicative of the failure to understand.

The recent implementation of the WHO surgical safety checklist is a good example. Checklists, used at a crucial point to confirm that vital actions are complete, are familiar to pilots, who assume that such actions have already occurred as part of clearly defined procedures. Unfortunately, this is often not the case. The junior doctor may know that the consultant “likes” antibiotic prophylaxis written up and a protocol may even exist; the anaesthetist will “probably” check the drug

chart and may “remember” to give them. Now, if all else fails, it will be caught by the checklist, but I wouldn’t like to be a passenger on an aircraft operated like this.

I agree that methods and concepts used in aviation and other industries must be applied intelligently and appropriately to health care, and that the healthcare system may be unique in some respects. But I do not agree that health care is so complex that this cannot be done. Unravelling the effects of multiple reforms on management structures, clinical staffing, and training will be challenging, but a systematic approach is possible—there may even be gain without pain, but not without change.

Nicholas J Toff airline pilot, Cambridge CB22 4XU
nt@toffmail.com

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- 1 Vincent C, Benn J, Hanna GB. High reliability in healthcare. *BMJ* 2010;340:c84. (19 January.)

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RISING HOSPITAL ADMISSIONS

Fuelled by risk avoidance

Gillam’s editorial ignores the elephant in the room—the increasing attempt to avoid risk, whether by patients, general practitioners (GPs), NHS Direct, triage services, or staff in the accident and emergency department.¹ Thus, instead of an emergency admission being for suspected myocardial infarction, any chest pain requires emergency attendance—a publicity campaign has even been mounted to encourage this. Any pain in the leg may be sent up as a “deep vein thrombosis” to protect the referrer. Many other examples exist, relating to all organs and specialties. The risk of a decision is thus deferred until it reaches the consultant on the post-take round.

Attempts to deal with the rise in emergency admissions will be futile unless risk avoidance behaviour can be discouraged, which is more easily said than done. Indeed, it might be seen as progress that we now refuse to accept the risks that doctors and patients once did. The organisational and financial mechanisms that Gillam suggests are unlikely to succeed, although providing alternatives—whether GPs in accident and emergency departments, community assessments of deep vein thrombosis, same day clinics and investigations, or more senior input to decisions to admit from accident and emergency—may divert some of the demand into other channels.

Edmund J Dunstan consultant geriatrician, Selly Oak Hospital, Birmingham B29 6JD
edmund.dunstan@uhb.nhs.uk

Competing interests: None declared.

- 1 Gillam S. Rising hospital admissions. *BMJ* 2010;340:c636. (2 February.)

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Support the new gatekeepers

In his editorial, Gillam explains the reasons for the erosion of the gatekeeping function of general practitioners (GPs).¹ Consequently, a large proportion of these patients are seen in the emergency department by junior doctors (such as foundation year 2 doctors) who may have had as few as 8-10 days of acute medical experience before taking their current job. If the junior doctor in the accident and emergency department seeks a specialist opinion, this is often provided by an equally junior doctor in that speciality.

Appropriate support must be provided for these juniors (often in the emergency department) to fulfil the gatekeeping role performed by more clinically experienced and confident GPs. Such support could include trusts ensuring all referrals for inpatient admission are directly discussed by the referrer with a senior clinician (such as the medical or surgical registrar or consultant), and that junior doctors have ready access to senior clinicians to determine which patients require admission and how the remainder can be appropriately managed in the community.

The increasing role of junior doctors as hospital gatekeepers must be recognised and supported by trusts and directorates to help stem the current increasing tide of inpatient admissions.

Faisal R Ali core trainee, year 1, Royal Marsden Hospital, London SW3 6JJ
f.r.ali.01@cantab.net

Competing interests: None declared

- 1 Gillam S. Rising hospital admissions. *BMJ* 2010;340:c636. (2 February.)

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Costs and costing systems

Gillam makes the important point that fragmentation of primary care “is compromising continuity of care and reducing access to just those practitioners who may be able to manage comorbidities in the community.”¹ This hypothesis calls for systematic prospective research.

The suggestion that integration may be a solution is unlikely to work. Talbot-Smith and colleagues showed that, in the US, the Kaiser highly integrated system was associated with much higher costs than in the NHS.²

The comment about the new costing system for emergency admissions to hospital needs discussion because it has profound ethical and clinical implications. Hospitals are about to be punished, in effect fined, for admitting as emergencies, people—many of whom are old with multiple illnesses—who need specialist



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care. Such frail and vulnerable patients will become financial burdens to hospitals and they will be unwelcome. Increasing pressures will probably be exerted on hospital doctors and general practitioners not to admit emergencies to hospital. Is this either wise or ethical?

Denis J Pereira Gray consultant, St Leonard's Research Practice, Exeter EX1 1SB denis.pereiragray@btinternet.com

Competing interests: None declared

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Cite this as: *BMJ* 2010;340:c1049

BAD MEDICINE: OSTEOPOROSIS

Oversimplification is dangerous

Spence makes some important points about osteoporosis¹:

- A DEXA result should not be considered in isolation but only in conjunction with all of the other risk factors for fracture²
 - Be alert to how the pharmaceutical industry might influence the presentation of diseases, treatments, and research outcomes
 - Overuse of any drug, including bisphosphonates, without good evidence is dangerous to patients
 - Some practices and doctors who use bisphosphonates inappropriately need training and educational sessions on the subject and probably more guidance from experts.
- However:
- The National Osteoporosis Society does not "say" things about osteoporosis: it quotes the risk of fractures on the basis of decent epidemiological studies, many from the UK, by people who devote much of their time to the subject³
 - Don't underestimate the role of adequate nutrition, including vitamin D.⁴ To say that these factors play little part is easy from the comfort of the developed world, but it ignores less affluent and informed people and those with a genetic predisposition to low body mass index or low vitamin D values.

By all means work towards clarifying risk factors and towards proper, safe use of drugs without the influence of the drug industry. But oversimplifying osteoporosis and ignoring its tragic and fatal consequences is dangerous.

J Joseph consultant physician and rheumatologist, Nicosia, Cyprus drjoseph@cytanet.com.cy

Competing interests: JJ is vice chairman and head of the scientific committee of Cyprus Society against Osteoporosis, a voluntary organisation raising awareness among public and doctors on issues, including the appropriate use of drugs for osteoporosis.

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Cite this as: *BMJ* 2010;340:c1062

LIFE AFTER PROSTATE CANCER

Time to evaluate focal therapy

Smith and colleagues' findings on quality of life after diagnosis and treatment of localised prostate cancer¹ are neither new nor unexpected.^{2,3}

While much resource has gone into refining both radiotherapeutic and surgical approaches to care, the key question is: has increased specification decreased the toxicity of prostate cancer treatment? Current evidence suggests not. For example, long term incontinence and erectile dysfunction was significantly higher after minimally invasive surgery than after conventional open surgery,⁴ and gastrointestinal and genitourinary toxicity after radiotherapy remains as high as 12%, even with intensity modulated radiotherapy.³

Might the limits of tolerability of radical treatment of the whole gland have been reached? In nearly all other surgical treatment of cancer there has been a move away from whole organ treatment to organ preservation. This was seen in breast cancer many years ago, and has become common place for cancers such as kidney cancer.

Treatment of prostate cancer that preserves the organ has been termed focal therapy and seems tenable on face value because most prostate cancers occupy only 5% of prostate volume.⁵ Its formal evaluation should be prioritised because it is the only strategy currently available that might result in an acceptable balance of harms and benefits for most patients.

Paul Cathcart academic clinical lecturer in urology pjccathcart@hotmail.com

Hashim Uddin Ahmed MRC research fellow and specialist registrar in urology

Caroline Moore academic clinical lecturer in urology

Mark Emberton reader in interventional oncology, Division of Surgery and Interventional Sciences, University College London and University College Hospital London, London NW1 2BU

Competing interests: HUA, CM, and ME are lead clinicians for four clinical trials evaluating the role of focal therapy for prostate cancer treatment and are paid consultants for Steba Biotech. ME is also a paid consultant for Misonix, USHIFU, and Advanced Medical Diagnostics.

- 1 Smith DP, King MT, Egger S, Berry MP, Stricker PD, Cozzi P, et al. Quality of life three years after diagnosis of localised prostate cancer: population based cohort study. *BMJ* 2009;339:b4817. (27 November.)

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Cite this as: *BMJ* 2010;340:c1057

ANTIHYPERTENSIVE REGIMENS

Should β blockers be second line treatment?

Boger-Megiddo and colleagues' article implies that β blockers are a better second line agent for management of hypertension than calcium channel blockers,¹ but we disagree.

After myocardial infarction, β blockade, but not calcium channel blockade, confers prognostic benefit through reduction in infarct size, risk of reinfarction, and mortality.^{2,3} Thus, it is not ideal to judge optimal blood pressure control by studying the risk of reinfarction in patients on β blockers, because these drugs reduce reinfarction rates independently of blood pressure.

In addition, a large meta-analysis (n=133 348) found that β blockers are suboptimal for blood pressure control and that they increased the risk of stroke compared with other agents (n=27 433).⁴ The British Hypertension Society (BHS) came to the same conclusion, prompting a revision of management guidelines for hypertension by the National Institute for Health and Clinical Excellence (NICE). As a result, β blockers were removed from the list of first line agents in 2006.⁵

Finally, Boger-Megiddo and colleagues found no difference in reduction in systolic blood pressure between the β blocker and calcium channel blocker groups. We thus agree with BHS and NICE that β blockers are not superior to calcium channel blockers for hypertension and should not be used routinely as second line antihypertensives.

We also agree that a large trial of second line antihypertensive treatments in patients already taking low dose diuretics is needed to provide a solid basis for treatment recommendations.¹

Jamal N Khan specialist registrar in cardiology
Abhishek Chauhan, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham B18 7QH

Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c1065

LONG QT SYNDROME

Don't forget antipsychotics

Abrams and colleagues did not mention that antipsychotics can prolong the QT interval.^{1,2} Such adverse cardiac reactions to psychopharmacological drugs are not uncommon and can be dangerous and life threatening. Women, older patients, patients with other cardiac diseases, and those taking high doses of antipsychotics are at increased risk.

Alvarez and Pahissa reported prolongation of the QTc interval in about 8% of all psychiatric patients.³ After the introduction of sertindole, this problem was discussed intensely.⁴ The main antipsychotics can induce QTc alterations.⁵ Thioridazine, droperidol, pimozide, haloperidol, ziprasidone, and olanzapine seem to be the most potent and can lead to fatal complications, especially in combination treatment. Postmarketing surveillance of antipsychotics (using electrocardiography) and better communication between general practitioners, psychiatrists, and cardiologists are necessary.

Dettef Degner senior consultant, Department of Psychiatry, University of Göttingen, Germany
ddegner@gwdg.de

Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c1061

LEADERSHIP WITH A SMALL "L"

Are there too many clinical leaders?

I disagree with Bohmer that "practising doctors simply do not think of themselves as leaders."¹ In the UK at least, being a clinical leader is the new, most competed for badge.

A plethora of leadership schemes exists for doctors, mainly tailored towards the big "L" but with a fair splattering of small "l" endeavours and including online leadership courses and the like. The range of courses, fellowships, and other entities linked to leadership in some way is vast.

What we are going to do with all these leaders in 5-15 years' time is not clear. The chief executive officer of the NHS wants to see a doctor's name on every shortlist for the chief executive officer in every hospital. I think his vision will be realised, but with such a mosaic of leadership experiences and training that I'm unclear where it will take us.

Many years ago in the NHS I am led to believe that doctors had a lot of control, which was scaled back by non-medical managers. This paradigm is quickly changing. But are the new clinical leaders up to the challenge that awaits them? I dread the possible media headlines as we say goodbye to the next government around 2020: "So called clinical leaders ruin health service—new cadre of non-medical managers harness control to protect patients."

Douglas J Noble public health registrar, London Deanery, London WC1B 5DN douglas.noble@doctors.org.uk

Competing interests: None declared.

- 1 Bohmer R. Leadership with a small "l" *BMJ* 2010;340:c483. (27 January.)

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PRIMARY CARE'S LOST CAUSE?

Primary care research lives

Del Mar thinks that research in primary care is a lost cause¹: not so.

One of us (JGH) instituted a glaucoma screening programme in a four partner general practice during 1991-4 using basic equipment (Snellen's chart with and without a pinhole, ophthalmoscope, Perkins' tonometer for intraocular pressure, and oculokinetic perimetry charts for visual fields). An additional hope was that screening with these methods might be applied in the developing world, where glaucoma is more prevalent and batteries may be the only energy supply. The findings—more than a doubling of confirmed diagnoses of primary open angle glaucoma in this stable population—were reported in the *BMJ*² and aroused the interest of consultant ophthalmologists.



So we set up a community eye screening programme for the whole town—the Bridlington Eye Assessment Project—specifically for residents aged 65 and over. Screening was carried out in the local hospital by local optometrists who were given extra training and referred directly to consultant ophthalmologists. In addition to traditional methods of detection, patients were scanned by Heidelberg retinal tomography, digital retinal photography, and ultrasound pachymetry.

Over 3500 patients were seen, and the results are still being analysed. We have already reported, however, that the size of neuroretinal rims varies in women and men³ and that central corneal thickness is greater in diabetic people.⁴ To our knowledge, it is the largest community based eye project undertaken in the UK.

It was funded not only by drug companies but also by many local charities and individual patients. Pipe bands marched down the main street to collect donations. It was a registered charity until after the last patient was seen.

The idea and the initial research came wholly out of primary care and is an example of what further achievements can be made when primary and secondary care cooperate. The project has been overseen and results have been analysed by Professor S A Vernon at the Queen's Medical Centre, Nottingham.

Research will continue to be carried out in primary care by curious doctors who wish "to make a difference."

Jonathan G Hillman general practitioner
jghillman@doctors.org.uk

Hamish K MacNab general practitioner, Medical Centre, Bridlington, East Yorkshire YO16 4LZ

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