Postings to the BJGP’s Discussion Forum include responses to articles in the journal or any other issues of relevance to primary care. This document contains previous comments posted on the forum.
What you said in 2009

Date: 29 Dec 2009  
Topic: Response to 'Practitioners' views on managing childhood obesity in primary care: a qualitative study'  
Comments by: Professor Peter Schwarz, TU University, Dresden, Germany; Anne-Marie Felton, President, Federation of European Nurses in Diabetes; Dr Michael Hall, International Diabetes Federation – Europe

Turner et al showed that primary care practitioners are unaware of guidance provided by the department of health and NICE on the management of childhood obesity. Even if GPs and practice nurses believed primary care was an appropriate treatment setting for childhood obesity, they questioned the extent to which they could effectively intervene. Furthermore they felt unprepared to manage childhood obesity and perceived their efforts as ineffective.

The study raises important issues shared by other non-communicable disease (NCD) prevention/management initiatives. As a part of the European funded IMAGE project (Development and Implementation of a European Guideline and Training Standards for Diabetes Prevention - IMAGE), a European evidence-based and practice guideline for the prevention of type 2 diabetes including obesity will be prepared and will be freely available online and printed. Parallel to this, a curriculum for the training of prevention managers will be released in April next year. The IMAGE concept is that appropriately trained personnel can deliver efficient and effective prevention strategies to those at risk of diabetes. A similar approach may be effective for other NCDs, including obesity.

We are involved with IMAGE, a major EU sponsored multidisciplinary multinational project, which aims to address the prevention of diabetes through evidence-based guidelines which recommend interventions implemented by trained prevention managers. The project is reaching completion, courses for prevention managers are currently being piloted in several European centres, and a full report on the whole IMAGE project will be given at the World Diabetes Prevention Conference in Dresden in April 2010. Details can be found at http://www.image-project.eu/

Reference

Date: 29 Dec 2009  
Topic: Response to ‘The present state and future direction of primary care: a qualitative study of GPs’ views’  
Comments by: Jim Newmark

As a former senior partner of twenty years and a salaried doctor of four, the conclusions of this rather interesting piece of research are no surprise. We are left with the impression of smug partners and embittered salaried GPs. My sympathies are with the latter.

My plea is for those partners who are perhaps half a decade, or even a decade, away from retirement, to make the brave step of changing directions. Perhaps it is time to voluntarily step down to a salaried position? Why not act as a grandparent to our younger colleagues? To be happy to hold the baby while your sons/daughters are out shopping, but to be even happier
handing him/her back at the end of the day for them to go through those sleepless nights. We are still there for advice, and are still going to be paid more than the vast majority of people in this country. We still have our savings, our paid-for house, our comfortable living. And now perhaps a chance to expand to do what we always wanted to do – hobbies or another field of medicine. What are you waiting for?

I know this because I did it. I have never regretted a second of leaving my well-established and increasingly successful practice. I love watching it expand and I think I actually would have held it back if I remained. We remain on friendly terms, and perhaps there is a bit of a feeling that it was my child, but it now needs to grow up. Meanwhile, I am learning and working in other areas of medicine that I never really knew existed.

Reference

Date: 19 Nov 2009  
Topic: Response to ‘Genes, gender, sport, and justice’  
Comments by: Edoardo Cervoni

I totally share Peter Toon’s question on how should we judge athletes. Should this be based on the effort or performance? In fact, he quite correctly adds: ‘It’s not just genes carried on the XY chromosomes that affect performance; people with particular body types as a result of their genetic inheritance perform very differently in many sports ... Why should we accept these differences but not chromosomal anomalies?’.

We may argue that assessing effort is almost impossible and most certainly people are generally more interested in performances. Thus, performance should be the answer.

But then, it is also true what Peter says: ‘If stronger muscles result from an anomaly we can describe and name, we might consider this unfair and exclude the athlete; if it comes from a fortuitous combination of many genes, not all well understood, we may not’.

Overall, I think it would be fair assessing people based on performances and looking at their wellbeing above all. Ultimately, I am sure that performances would drop should their wellbeing be compromised.

Reference

Date: 18 Nov 2009  
Topic: Response to 'GPs’ views on the practice of physician-assisted suicide and their role in proposed UK legalisation: a qualitative study'  
Comments by: Mr B Cosway, Mr D Arnold, Intercalated BSc medical students; Dr Iain J Robbé, Clinical Senior Lecturer, School of Medicine, Cardiff University

We would like to congratulate Hussain and White¹ for their paper regarding the views of general practitioners on physician-assisted suicide. We agree that this qualitative approach has filled what was previously a void in current understanding.
However, we do have concerns regarding the inclusion of only GPs who had a specific interest in medical ethics or terminal care. While we agree that a higher quality of data may come from GPs with these special interests than those who may have given the topic less thought, we question whether those without an interest in these fields have not considered their opinions regarding this current and controversial topic. Furthermore, if a revised bill is passed into law then it seems likely that all GPs will play some role in the implementation. We therefore suggest a more typical sample of GPs would be required for a true representation of views.

We hope that research into this topic continues and we propose a quantitative analysis of the proportion of GPs willing to support the bill and the extent to which they would involve themselves in assisted suicide. This could then be expanded to other healthcare professionals that may be affected.

Reference

Date: 8 Nov 2009
Topic: Response to ‘Health inequalities in the UK: remedy requires action beyond redistribution of wealth’
Comments by: Dr Fergus Dignan, Frampton Mansell, Gloucestershire

I read with great interest the article on health inequalities in the UK by Edin Lakasing in the October edition of the BJGP, but I was surprised that no reference was made to 'The Spirit Level: Why more equal societies almost always do better'.

Lakasing emphasises the main ailment of our society, that is the obscene wealth divide between the top 20% and bottom 20%, and he is right in saying that: ‘It is clear that there are limits to what medicine can achieve in redressing health inequalities’.

The Spirit Level describes the effect of widening wealth gaps in western societies. The UK and the USA have a 10-fold difference in income between the top 20% and bottom 20% and also have some of the worst parameters in the western world. Interestingly, the Scandinavian countries and Japan have the narrowest income gap and also the best health and social statistics.

What is this connection between income gap and societal health? The clue is in the title of the book. It is what happens to people’s spirits when they exist in an unequal society. I am not talking on a supernatural or religious level. I am talking about feelings of well being and personal contentment. One can imagine how someone on a sink estate in a major city feels when looking at the lives of the very wealthy. No chance of ever aspiring to that life, so why bother making any effort at all?

The solution therefore is to dramatically narrow the income divide in our society. No easy task, I know! I would commend all GPs, and other healthcare workers for that matter, to read 'The Spirit Level'.

References
Date: 8 Oct 2009  
Topic: Response to ‘The Commercialisation of GP services’  
Comments by: Tim Parkin

This interesting paper¹ discusses the award of GP service contracts to commercial organisations and the lack of evidence of the impact of this on value for money and quality of service. We believe our paper ‘Quality of care in a franchised GP group’² does present such evidence as applied to the awarding of contracts to existing local GPs. We would invite the authors to consider this information.

References  

Date: 7 Oct 2009  
Topic: Response to ‘London Allergy Show 2009: an exhibition of black magic’  
Comments by Lindsey McManus, Education Executive, Allergy UK

I would like to add my comment to this discussion on the London Allergy Show. I work for Allergy UK, we are a Patient Information Organisation, a charity, backed by some of the leading experts in the field of allergy, and we cover all aspects of allergy.

When the Allergy Show first started we had stands there ourselves. Sadly after a couple of years we chose not to continue, for exactly this reason. Although we may have been the ‘voice of reason’ at the show we did not feel comfortable being associated with the kind of exhibitors that you have mentioned. We now know however that the show is in new hands and we have been in talks with them. Hopefully this will make a difference to future show.

What I would like to say is that if there are any GPs who would like any help or advice on Allergy please do not hesitate in contacting me at Allergy UK. We do have an excellent education programme for Health Care Professionals alongside a wealth of information for members of the public.

Date: 22 September 2009  
Topic: Response to ‘James Mackenzie lecture: Practice, politics, and possibilities’¹  
Comments by: Dr Victoria Hartnell

Where is all the discussion? If ever there was a rallying call to the apathetic and apolitical, this is it. Is there any discussion between the RCGP leadership and the BMA leadership to coordinate ‘marketing’ of generalists? I am convinced perhaps by the humour as much as the clarity of the arguments, that Martin Marshall does the same job as me; not always a familiar feeling in this august publication.

Reference  
UK government policy in recent years has been advocating and encouraging patients to take a more active role in managing their own healthcare. The outcome of the recent Lord Darzi review, High Quality Care for All, 2008 together with various other NHS policies like the IT initiative Connecting for Health, has supported the introduction of new technologies known as Point of Care Testing (POCT).

Many of these devices can now be purchased by patients over the counter for home testing in high street pharmacies and even supermarkets. Whilst in the hands of a trained physician these devices may be useful in assisting a GP to perform a patient diagnosis faster, as a patient I am concerned that their use by untrained lay users may lead to more harm than good.

Interestingly, when I last visited my GP, I asked him whether the practice itself would use POCT more widely, apart from the usual dipstick tests, such glucose, cholesterol coagulation, and urine testing. He explained that POCT would not be further used in primary care for the following reasons:

1. Primary Care Trusts already have an arrangement with their local hospital based Pathology Service for carrying out patient test requests.
2. There is no available funding in primary care to cover the additional cost of POCT.
3. Due to the daily patient workload here is no available staff or time to carry out POCT more widely.
4. For more advanced testing and diagnosis GPs prefer to refer patients on to specialists outpatients clinics.

As a patient I can see the obvious benefit of having an earlier test result by POCT instead of having to telephone the GP clinic, a week later. If patients could be told their test results on the same day of their appointment they would prefer it, also presumably GPs would be able to make an earlier decision regarding their treatment. In the light of these constraints, I wonder whether POCT will ever reach its maximum beneficial potential.

Date: 12 August 2009
Topic: Response to ‘Do the Quality and Outcomes Framework patient experience indicators reward practices that offer improved access?’
Comments by: Dr John Orchard

This paper asks the wrong question. The correct question is why do patient surveys not reflect improved access. Since 2003 we have taken over the management of two local failing practices. Despite achieving maximum clinical QOF points, providing instant access, myriad increased services, including increasing the medical and nursing staff by 500%, we cannot change patient perception sufficiently to reach target patient satisfaction scores.

A nearby practice has done nothing to change its attitude or accessibility but has moved into a LIFT centre: result, increased patient satisfaction. Patient surveys measure perception not performance and should be scrapped. Practices in deprived areas that require most funding to improve health care will be penalised by illiterate and uninformed patients: the same patients who fail to attend same day appointments in practice, urgent hospital out-patients, and who are verbally and physically aggressive to staff.
Reference

Topic: London Allergy Show 2009: an exhibition of black magic
Comments by: David J Jackson, BSc MBBS MRCP, Department of Respiratory Medicine, Imperial College London

The 6th annual ‘Allergy and Gluten Free Show’ took place this weekend at the Olympia hall in London. Unfortunately, the majority of stands selling allergy tests and treatments were promoting products with as much in common with allergy as flying pigs has with swine flu.

For a small fortune members of the public were ‘tested’ for a range of allergies with machines measuring muscle energy levels, and told that spraying your skin with oxygen reduces an allergic reaction. Others were sold home blood test kits for measuring their Immunoglobulin G levels despite the fact that Immunoglobulin E is the most important marker of allergy.

Asthma sufferers were shown ways to cure their asthma through a series of manoeuvres with their thumb and finger described as ‘identical’ to the value of salbutamol. Thousands of the general public parted with their hard earned money on tests that have no biologic plausibility let alone an evidence base to them.

There was a deafening silence from the Department of Health who failed to provide a representative and in so doing ignored a fantastic opportunity to educate the public on a group of diseases that affects about 20 million of them. Instead the public were educated by individuals with no understanding.

Date: 8 Jun 2009
Topic: Fairy Fabric Care advertorial
Comments by: Dr Nigel Walsh MRCGP

I am writing to you in regard to the ‘article’ by Dr David Atherton which appeared in the BJGP dated June 2009.* Dr Atherton is stated to be Consultant Paediatric Dermatologist at Great Ormond St. Hospital and is skincare advisor to Fairy Non Bio and Fabric Softener.

The ‘article’ seems to be an advertisement endorsing the use of Fairy Fabric Care products which he states have been evaluated for skin safety but have also been shown by the manufacturer to be as ‘gentle next to skin as clothes washed in water alone’.

Dr Atherton’s article includes a colour photograph of himself. I could hardly believe to read that an eminent physician at a teaching hospital would descend to promoting a commercial product in this fashion. The general advice on baby skin care is most informative but the juxtaposition of the product photographs is objectionable.

I note that the article is not stated to be an advertisement, that the products are not therapeutic substances (and therefore not subject to government regulations) but unlike other opinions in the journal there is no reference as to funding or competing interests.
Date: 8 Jun 2009  
Topic: Response to ‘The end of practice-based research?’ — craft innovation versus practice-based research  
Comments by: Nigel Masters, GP, Highfield Surgery, High Wycombe, Buckinghamshire

I would like to contribute to the debate in the letters section about modern day practice based research. As full-time general medical practitioner over 27 years I have been generating ideas and ways to help patients at the frontline of primary care. Some of these ideas which I refer to as a craft innovation have been used throughout the world to improve patient care, and some have been published in peer review journals. It may help to describe some of this work as it can slip across academic borders from time to time and so could then be considered proper clinical research.

While doing my GP training I developed the foot pump nebuliser which has been widely used in the UK and world and it is still manufactured 27 years later. I wrote an article in Modern Medicine (now defunct) which resulted in an article in the Observer Business news and eventually a peer reviewed journal.

Later I explored nebulised opiate delivery and the myth of medication caries. These papers explored issues of affecting everyday work: safety in drug delivery and whether medicines prescribing was causing tooth decay. Admittedly, at this time I was a part time lecturer in an academic department and this was helpful in providing some support for these papers. Further research explored housing design and mental ill health and this was published in the Journal of Psychiatry. Later I tracked the spread of hepatitis carriage through my Vietnamese patients which resulted in an editorial in the British Medical Journal.

After I left my inner city environment and went for a normal shire county practice where I continued to try and innovate and improve patient care. In 2004 I won the national GP enterprise award and the BUPA communication prize for clinical indications on prescription. This work has never been peer reviewed but can be seen on the web and is widely used by many practices to inform modern medicine delivery. Our practice won a national award for holistic care of chronic obstructive pulmonary disease (COPD) patients in 2006 and is delivering a COPD disease strategy across a collaborative of 33 practices.

New tools have been developed which include the world’s first smoking pack year calculator. This website was launched in June 2007 and has over 200,000 calculations performed! The websites have been funded from prize money and are free to view. Just recently I have become once again a finalist in the GP enterprise awards for the croup calculator a new exemplar for dose prescribing in children by increasing confidence and safety in prescribing dexamethasone for croup in young children. This dexamethasone calculator is free from me by contacting me at my email address.

This work is really a hobby and I have never received any academic funding which in any case might be difficult to obtain as I am not linked to any university department! Thus although my work is practice based it cannot be considered academic but at times and with support it can reach peer reviewed journals. I consider that this innovative craft seam at the primary care coal face is under threat and needs to be nurtured and I am grateful for
competitions such as the GP enterprise award that try to highlight these hidden nuggets that can really benefit patients.

References
2. RCGP occasional paper 29. Trainee projects 1985: 42.
3. http://www.asthmarelief.co.uk/
10. Tutt C, Masters N. Recording 'pack years' aids assessment of risk and diagnosis of COPD. http://www.eguidelines.co.uk/

Date: Jun 2009
Topic: Is it time to say farewell to oxytetracycline and tetracycline?
Comments by: Angus Thompson, a former Prescribing Advisor from Somerset with an interest in antimicrobial prescribing; recently joined the Unit for Medication Outcomes Research and Education (UMORE), University of Tasmania, Australia.

For decades oxytetracycline and tetracycline have been part of many prescribers' armamentarium in the fight against infection, but do they still have a role today?

Most often prescribed in 4 times a day regimes, requiring dosing on an empty stomach, away from milk, indigestion remedies, iron, and zinc which may impair their absorption — let's face it, they are hardly the simplest of drugs to take effectively! In an era when promoting best practice in the use of antibiotics is a priority, continuing to use drugs where there is a high probability of poor compliance and consequently a risk of sub-optimally effective therapy seems rather irrational.

So if we do not use oxytetracycline or tetracycline, what would be used instead? If a member of the tetracycline family is indicated specifically, for example in acne or certain respiratory tract infections, then doxycycline is the clear alternative. With no need to take on an empty stomach or avoid milk, and its patient-friendly, concordance promoting, once-daily dosing; surely it's a closed case?

But what about the budget some may ask? The implication being that as oxytetracycline and tetracycline have been around for decades they must be inexpensive. Certainly at just £1 for a week long course oxytetracycline is; but the same cannot be said of tetracycline which costs around £9 for the same quantity. This makes it significantly more costly than virtually any other oral antibiotic used in primary care these days, including doxycycline which is now similarly priced to oxytetracycline.¹

And what about microbiological appropriateness? The current version of the Health Protection Agency antibiotic prescribing guidance for primary care includes doxycycline in all those
scenarios where a tetracycline is indicated.\textsuperscript{2} Consistent with this is the statement in the British National Formulary that ‘microbiologically there is little to choose between the various tetracyclines…’.\textsuperscript{3}

A further potential advantage of doxycycline is that, unlike oxytetracycline and tetracycline, it is not prone to accumulation in renal impairment and can therefore be used, with care, in this significant group of patients.

It would seem the only potential down sides to the use of doxycycline when compared to oxytetracycline and tetracycline are possible photosensitivity reactions and the need to swallow the capsules with plenty of water to reduce the risk of oesophageal irritation. But when considered against the other arguments to make doxycycline the tetracycline of choice, these are of modest significance.

In other areas of prescribing long established drugs have stood the test of time and in some cases found new niches, but in the case of the older tetracyclines, there would now seem to be a good case to drop them from our primary care formularies.

References

Date: 29 May 2009
Topic: Response to ‘Frailty: an emerging concept for general practice’
Comments by: Avril Danczak, GP, Manchester

Jan De Lepeleire et al\textsuperscript{1} have highlighted a very important area in the assessment of older patients. I fully endorse their emphasis on the ways that frailty may be reversed. However, frailty can be a prognostic indicator that should alert us to other issues, such as effective planning for end-of-life care. Frailty can be useful as a component in the identification of an irreversible decline.

Patients and relatives often need clear information about this state, which is also crucial for carers (professional or laypersons). At the end of life, frailty increases and may alert us to:
* the need to stop active or inappropriate interventions,
* to plan the place of end of life care,
* to ensure proper symptom control,
* to stop the revolving door cycle of fruitless admissions that can mar the final days/weeks of some elderly patients,
* to prepare relatives and carers that death is approaching, and
* to help relatives/carers prepare for death and appropriate grieving.

I was a little disappointed that the paper did not discuss this area in more detail. We are already moving away from the idea that palliative care/terminal care only applies to malignant conditions. Death is, at some point, inevitable. Part of our duty to patients and carers is to ensure that death is managed appropriately and with dignity. We need better understanding of when frailty is irreversible as well as an optimistic and rehabilitative approach to reversible factors.

Reference
Date: 6 May 2009  
Topic: Website for GPs with colour vision deficiency  
Comments by: J Anthony B Spalding, formerly a GP, UK. Barry H Cole, Emeritus Professor of Optometry, University of Melbourne, Australia. Fraz A Mir, Consultant Physician, Addenbrooke’s Hospital, Cambridge, UK.

It remains a common opinion in the medical profession that colour vision deficiency has little or no effect on the work of the doctor. In fact this is not true. There is now much evidence that doctors with this deficiency can misread colour codes and physical signs that involve colour and that they can be unaware at the time that an error has been made.

Advice is needed to avoid this situation. But the problem remains that there are few teachers with the knowledge to advise in the necessary detail. Advice is frequently inadequate or is not given. Some doctors may find their own way to adapt and, of course, those with a mild deficiency will be little affected.

However, a website is now available that gives the evidence that confirms the above statements and this includes the previously unpublished comments of medical students with the deficiency. It offers advice to doctors, medical students, and prospective medical students who have colour vision deficiency. It aims is to explain how to be aware of the difficulties, how to respond to them, and how to make an informed choice of specialty. Access to the website is via: www.colourmed.com

Date: 20 April 2009  
Topic: The patient–doctor relationship: a synthesis of the qualitative literature on patients' perspectives  
Comments by: Sarah Ryan

I am currently a sixth form student, interested in the issue of what patients consider to be a good doctor. In February this year I produced a questionnaire administered in a highly-regarded local general practice, to about 80 patients over 3 days, specifying that patients be selected for the questionnaire only if they had requested to see a particular doctor, and asking them to rate the attributes of that doctor and comment on what they valued in their relationship with the doctor.

The findings of my research broadly confirmed the conclusions of the Ridd et al article in the April BJGP. However, in this area of research a finite conclusion is hard to come by. This may be due to humans' intrinsic nature, as patients will always have their own opinions. The study of doctor–patient relationships is really a study of the way human beings interact, and although there are obvious professional boundaries, many of characteristics that the research concludes deepen this relationship (such as trust, understanding, equal participation, and loyalty) are congruent with any relationship. Maybe the key to a having a healthy patient–doctor relationship is for both sides to view each other how they would view any other person.

Reference
Date: 3 April 2009  
Topic: Response to: ‘Ordering blood tests for patients with unexplained fatigue in general practice: what does it yield? Results of the VAMPIRE trial’  
Comments by: Jacqui Footman BA(Hons) PGCE, Information Officer, South Molton ME Support Group, North Devon

I am concerned that this article by Koch et al\(^1\) may discourage GPs from thorough testing for patients with CFS/ME. At the ME Research UK conference in 2008 Dr Gavin Spickett, consultant leading one of the NHS specialist CFS/ME services, stated that significant numbers of patients referred to the service in fact turned out to have other (more treatable) conditions.

I have a particular and personal interest in this topic in so far as I languished under a diagnosis of CFS/ME for 4 years without further medical testing. I did receive what could be considered the best NHS care currently available for ‘CFS/ME’ but nevertheless in my prime at age 43 waved goodbye to a promising teaching/management career. I was subsequently found (sort of by accident) to have Crohn's disease, which had clearly gone undiagnosed for many years.

When lupus tests had come back negative, raised plasma viscosity tests had been ignored as unexplainable and few further tests done for several years. Now, some months on from an ileal resection (but after 5 years on Incapacity Benefit) I am eventually less disabled by fatigue. With testing, I recently discovered I also have osteoporosis and low Vitamin D. Many patients with chronic pain are being found to have low vitamin D, and what a simple thing to resolve once the test is done! How much better would my bone density now be if I had been tested and treated 5 years sooner?

I write to urge GPs to take testing and investigation more seriously and to avoid jumping to conclusions of somatoform illness, particularly when fatigue extends to CFS/ME, in order to help prevent further tragic and possibly avoidable losses. Most patient support groups recommend Health Canada's Clinical Guideline for help with this.\(^2\)

References

Date: 1 Apr 2009  
Topic: Response to ‘The contraceptive revolution’: slow progress in provision of modern contraception  
Comments by: David Metson, Easthampstead Surgery, Bracknell, Berkshire

In Hannaford and Belfield's recent editorial on 'The contraceptive revolution', they state that there has been some excellent progress but there was 'work still to be done'.\(^1\) One aspect of this is surely the implementation of the 2005 NICE guidelines which recommend greater provision of long-acting reversible contraception (LARC).\(^2\)

NICE stated that LARC methods were more cost effective than the combined pill and increased intake would reduce the number of unintended pregnancies. Action is needed to
reduce the figure of 30% of births being unplanned and 200,000 terminations of pregnancy occurring annually in England and Wales.³

How are we doing? A Family Planning Association (FPA) survey in 2006/7 found that only 14% of women using contraceptives chose LARC methods.⁴ In contrast, the use of LARC is greater elsewhere; for example, in France 32% of contraceptive users choose coils.

In 2008, 90 randomly selected GP practices in the Thames Valley were asked whether they fitted LARC. Thirty-two (36%) practices replied. The number fitting IUCDs, IUSs, and implants was 14 (44%). A further nine (28%) practices fitted only IUCDs and IUSs, and 5 (16%) of practices fitted only IUCDs or only implants. Four practices (13%) fitted no LARC.

It is disappointing that 3 years after the NICE guidelines were published, less than half of the practices who responded to the survey were fitting the full range of LARC. Reasons given for not fitting LARC include 'the high risk of problems and complications' and one practice said they would stop fitting if funding was withdrawn.

It is surprising that fewer practices fitted implants than coils when implants need less skill to fit than coils. The new QOF points may increase provision of LARC but GPs will be rewarded for merely suggesting these methods and not actually fitting them.

This small study suggests that while there has been some progress in implementing the NICE guidelines, there is much work still to be done.

Reference