

Letters

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Learning disability

It is quite natural that key experiences from our family life show transference to our professional relationships. I certainly draw on personal feelings from childhood to aid empathy for children receiving health care. However, such anecdotal recollections¹ can give an unreliable picture of general systems, such as primary medical care for people with learning disabilities, across Britain.

Inequalities in GPs' involvement with these patients were first drawn to my attention while collecting 1-month diaries of patient contacts from 40 GPs, for the ICD-10 primary health care field trial.² Most GPs saw no people with learning disabilities (code F70) in that month, although a minority had several patients (mean 0.28 cases per month).³ Based on population prevalence, one would expect about one case per day. About the same time, we found that the women with learning disabilities living in the community who managed to see their GP (for a cervical smear) often had unhappy experiences that they were reluctant to repeat.⁴

Fitzpatrick¹ is off target comparing this problem to prejudice like racism (marked by xenophobic fear or hatred): a decade's primary care research has confirmed that indifference really is the problem, with most of the population with disabilities invisible to clinicians. We found staff in schools very open to assessing and checking the health needs associated with learning disabilities, when the 'health facilitation' proposed by the Department of Health was introduced.⁵ A minority of GPs responded very positively when we tried to introduce health facilitation to general

practice.⁶ Their patients (in varied settings) gained individual Health Action Plans, including development of some quite new services. Sadly, a substantial majority of GPs were not interested in the local residents with learning disabilities, let alone prepared to initiate seeing those patients annually.

Such indifference is not just found frequently in medical practice. It is also common in our academic ivory towers.⁷

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Author's response

The parallel between racial prejudice and the treatment of people with learning disabilities is not mine but the central theme of the 2007 Mencap report which blames 'institutional discrimination' in the NHS for the deaths of six patients. This concept was adopted from the 1999

Macpherson report which attributed the failure to prosecute the killers of Stephen Lawrence to 'institutional discrimination' within the Metropolitan Police. Although there is a long history of racial discrimination in Britain, it is doubtful whether this remains a significant force now that 'anti-racism' has become the official ideology leading to extensive police activity on the streets, on the football terraces, and in workplaces.

No doubt people with learning disabilities, like many other people, suffer from neglect and sub-standard treatment in the NHS. What I doubt is whether they suffer from systematic discrimination, and I dispute the value of trying to tackle the specific problems they face by promoting this posture of victimhood and grievance.

It is not surprising that people who have difficulties in articulating their demands experience difficulties in gaining access to general practice: traditionally a demand-led service. There are real problems in providing satisfactory medical care for people with learning difficulties — including the mediating role of family and professional carers — but these are not improved by the sort of posturing and token gestures (like annual health checks) currently being introduced.

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Usual care in back pain trials

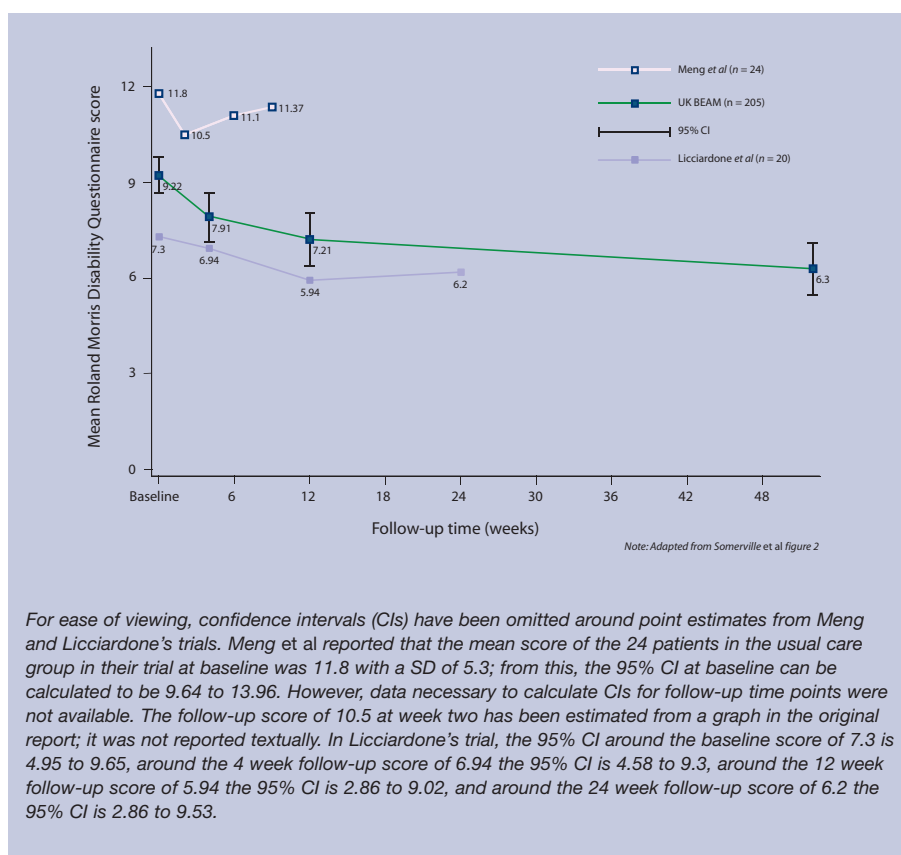
In the November issue of the *BJGP*,

Somerville *et al* report an interesting systematic review of usual care in low back pain primary care trials.¹ They highlight the variability that currently exists in the usual care packages, which function as the comparator treatment in many trials, and point out that the content of treatment in this arm is often inadequately described. They draw our attention to the difficulties associated with the interpretation of results when this comparator treatment is poorly described. We hope their message does not fall on deaf ears.

Notwithstanding this, we feel that their interpretation that the speed at which the Roland Morris Disability Questionnaire (RMDQ) score changes over time is dependent on the duration of low back pain, may be inaccurate. The clinical trajectories in several acute/sub-acute trial arms to trajectories from two small chronic low back pain trials were compared and Somerville *et al* note a more rapidly improving trajectory in the acute/sub-acute arms.^{2,3} Meng *et al*'s report² on a trial of acupuncture ($n = 24$) for chronic low back pain in older patients describes follow-up results at 2, 6, and 9 weeks; rather than the 30 week follow-up period indicated by Somerville *et al*. Licciardone's report of a trial of osteopathic manipulation ($n = 20$)³ did not provide point estimates for follow-up RMDQ scores in their usual care group; rather, it was stated 'there was no significant decrease'. This was represented as Figure 1 in Somerville *et al*'s report as a stable trajectory.¹

We have done a new analysis of data from the UK BEAM trial⁴ (Brealey *et al*)⁵ in the original paper, extracting data on outcomes for those in the usual care group of this trial with pain lasting for more than 3 months ($n = 205$). Furthermore, we obtained data from the usual care arm of Licciardone *et al*'s trial of osteopathic manipulation (thanks to John Licciardone). For completeness, we present a figure including these data (Figure 1).

The usual care arm in the UK BEAM trial was nearly eight times the size of the



For ease of viewing, confidence intervals (CIs) have been omitted around point estimates from Meng and Licciardone's trials. Meng *et al* reported that the mean score of the 24 patients in the usual care group in their trial at baseline was 11.8 with a SD of 5.3; from this, the 95% CI at baseline can be calculated to be 9.64 to 13.96. However, data necessary to calculate CIs for follow-up time points were not available. The follow-up score of 10.5 at week two has been estimated from a graph in the original report; it was not reported textually. In Licciardone's trial, the 95% CI around the baseline score of 7.3 is 4.95 to 9.65, around the 4 week follow-up score of 6.94 the 95% CI is 4.58 to 9.3, around the 12 week follow-up score of 5.94 the 95% CI is 2.86 to 9.02, and around the 24 week follow-up score of 6.2 the 95% CI is 2.86 to 9.53.

two previously included studies combined. Data from patients with chronic pain show a markedly different trajectory from those described in Somerville *et al*'s report (Figures 1 and 2). It more closely mimics the acute/sub-acute trajectories they presented. In contrast to their conclusion, we conclude that patients in usual care arms are likely to improve in trials of both acute and chronic back pain.

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Author's response

I welcome the comments and additional data provided by Froud and Underwood. I quite agree with them that the endpoint for data collection in Meng *et al*'s report¹ was at 9 weeks rather than 30 weeks as represented in the published version of Figure 2b of our paper.² The version of our paper that was accepted for