

by the pharmaceutical industry in exactly the same way as general practitioners and so it is likely that this effect spills over into the advice given to general practitioners. Furthermore, there is a commercial interest in that many hospitals are able to buy drugs at a difference price to that charged in the community and this 'loss leader' approach to pharmaceutical selling has a profound influence on the patterns of prescribing by general practitioners.

It is rather sad to see that more unbiased sources of information, such as the *British national formulary*, ranked low down on the list of influences on doctors' prescribing. Therapeutics is an important subject, which is highly undervalued in schemes of both undergraduate and postgraduate medical training. It seems a pity that the same techniques used to sell washing powder are still more successful than providing more detailed, unbiased and factual information.

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Patient participation

Sir,

We read with interest the paper on patient participation in general practice (*May Journal*, p.198). Dr Agass and colleagues suggest that the level of awareness of their patient participation group might have been higher had patients over 65 years of age been included in the study. Why were they excluded? Results from the study show that awareness and interest tended to be greatest in older women and among those who consulted more than four times per year. Older people are known to consult more frequently, so why were they not asked to participate in the survey? Will not this kind of discrimination against elderly people perpetuate inequalities in health in the practice population?

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Patient education and attendance rates

Sir,

Dr Grundy-Wheeler's excellent paper (*May Journal*, p.210) has confirmed my own findings that effective patient and

parent education, provided in comprehensive care programmes for children under five years of age, reduces both out of hours attendance rates and total attendance rates in practices running such programmes.

However, I suspect that at least some of the beneficial effects found in this study may have been reduced by the one doctor who continued to prescribe antibiotics for 80% of the children presenting with upper respiratory tract infection. Although not in the results I suspect that he or she may also have had the highest consulting rates for this age group.

As more and more partnerships start to use indicative drug budgets and PACT (prescribing analyses and cost) data, such prescribing patterns may be recognized and dealt with appropriately. For can we, as a profession, allow such behaviour to go unchallenged, especially when it affects costs and probably workload adversely? Or will we continue to claim clinical freedom as a reason for this behaviour?

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Sampling endocervical cells on cervical smears

Sir,

The issue of improved performance of cervical smears in terms of endocervical sampling is an interesting one. The presence of endocervical cells indicates that the transformation zone, where most cancers begin, has been sampled and that the sample is therefore a good one. The paper by the Cumbrian practice research group (*May Journal*, p.192) confirms the results of a number of previous studies on the use of the brush for cervical sampling in primary care settings demonstrating superiority over the swab/spatula technique.¹⁻⁴ These report the presence of endocervical cells in between 84% and 90% of smears. The rate reported by the Cumbrian practice research group is still quite a bit lower than this and may be due to the position of the patient and the more limited visualization of the cervix that occurs in the 'frog leg' position often used in the UK. I had low rates of cervical smear adequacy (72%) despite using the brush until I switched to having the patient use leg stirrups. Now 90% of the smears I take are adequate and have endocervical cells. I find it interesting that in their discussion the authors do not review or quote the extensive literature on

the effectiveness of brush sampling techniques.

In their report, the authors do not discuss the significant confounding effects of patient age and fertility status on the adequacy of cervical smear sampling. Endocervical cell sampling is adversely affected by pregnancy and the menopause. Without knowing the distribution of these variables among the two study groups, their conclusions are open to criticism.

In the final paragraph of the paper the authors suggest that increasing the detection of abnormalities will reduce the need for major surgery. The reference for the cervix brush increasing detection rates comes from a journal that is not refereed. In fact, there is controversy about the relevance of increased detection to outcome.^{5,6} At least 30% of such lesions are reported to regress over time and better sampling might, in fact, lead to overtreatment.⁷

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Breast cancer screening

Sir,

In their discussion paper (*April Journal*, p.166), Drs Austoker and Sharp argue from contradictory premises. First they accept that 'the decision to mount the NHS Breast Screening Programme was largely political' and leave unanswered their rhetorical question, 'do the benefits of screening outweigh the adverse effects?' Then they exhort general practitioners to cooperate fully with the programme. General practitioners must choose