

felt that they could be used to record anything that was relevant to their health.

The recording time limits the amount of information that can be stored on the DRDs. One minute is enough to record summary information or details of medication, but if longer explanations are required or a patient is on multiple medications it is not sufficient.

The DRDs can be re-used but their re-use is dependent on patients returning with them at their next appointment. There could be a danger in giving patients multiple devices as messages could get out of date or mixed up. Some form of labelling on the outside of the device could overcome this.

The DRDs used in this pilot were reliable, used frequently and found to be acceptable. It is possible to see that a small investment in DRDs could have an impact on attendance rates and compliance with prescribed medication that, in turn, could contribute to reducing any waste of NHS resources. The cost of the DRDs needs to be considered against the above patient benefits.

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Competing interests

The authors have stated that there are none.

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Ensuring confidentiality

Sokol and Car¹ suggest that identification of patients over the telephone is impossible because others may impersonate patients to request test results, breaching confidentiality. A suggestion is that patients be seen face-to-face and no information be given over the telephone. Besides increasing the amount of work in surgery and inconvenience to patients, I do not believe that this would achieve the objective. It cannot be guaranteed that the person who comes into the consulting room

is who they say they are. In fact, worryingly often they are not, either due to mistake (such as deafness), or, quite possibly, by impersonation, and I cannot identify all our practice patients by sight, and never will be able to.

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Written on the body

John Salinsky might like to know that I once completed a dermatology quiz at our local postgraduate centre simply by describing each of the displayed slides in what little remained of my schoolboy Latin. That, so far as I was concerned, was the diagnosis. I came top!

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Competing interests

Failed O-level Latin; but it didn't matter as by then Leeds did not require Latin for admission to the Medical School.

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Sex inequalities

Hippisley-Cox *et al* have reported evidence of sex inequalities in access to care for diabetes in primary care in the UK.¹ We are undertaking a national study of the factors that influence the care of patients with diabetes in Tunisian primary care health centres, including a retrospective medical review of over 2000 patients from 48 centres. Our results suggest that sex

inequalities in the care of patients with diabetes are international.

In our study,² women with diabetes attending health centres are significantly younger than men, less likely to have type 1 diabetes, less educated, less likely to be working, less likely to be smokers and to drink alcohol and more likely to have cardiovascular disease. Women also have significantly higher levels of systolic and diastolic blood pressure, total cholesterol and body mass index but lower mean creatinine levels than men. These findings were all to be expected. However, Table 1 shows a selection of other data related to access of care suggesting significant differences between the care of men and women. Women are more likely to attend their appointment on time, but the time until their next given appointment is significantly longer. Women are also less likely to have their care recorded in the new disease-specific medical records. This is important, as we have shown that use of these records is associated with improved quality of care.³

Sex inequalities in the care of patients with diabetes in primary care are not limited to the UK. We sincerely agree that further work is required to confirm, and if possible, explain these findings, and to seek ways of correcting these inequalities.

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Table 1. Differences between the care of men and women.

Factor	Men (n = 841)	Women (n = 1319)	P-value ^a
Mean age (years)	58.01	60.88	<0.001
Number of visits in preceding 12 months	3.65	3.75	0.07
Mean time until next appointment (days)	81.62	84.58	0.033
Consultations >2 weeks late (%)	27.7	23.3	0.082
New records used (%)	89.3	84.8	0.08
Completion of new records (score of 12 variables)	7.11±4.22	6.68±4.27	0.014

^aP-value using logistic regression with sex as the dependent variable and the factor in question plus age and health centre entered as the explanatory variables.