LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Background music in consultations

Sir,

A study was carried out in 1991 which aimed to evaluate the effects of background music on general practice consultations. Recent years have seen developments in consultation models and techniques.[1-4] Encouraged by the government,[5] patients are becoming consumer conscious and expecting more from their general practitioners, a fact which will affect the consultation process. It is therefore important to assess and update consultation style in order to ensure maximum benefit for both doctors and patients.

Music has been used in various areas of medicine, for example in hospital waiting areas,[6] to aid the development of handicapped children,[7] and to relieve stress[8] and pain.[9] This study involved playing continuous music (Mozart's piano concertos, numbers seven and 21) during 102 consecutive consultations with a general practitioner trainee at a level which did not interfere with normal speech but could be clearly heard at other times (the doctor could turn off the music, although this was never necessary). Patients were asked by the doctor to complete a written questionnaire on their reaction to this at the end of the consultation and this involved patients having to agree or disagree with certain statements. There was a 100% response rate to the questionnaire, but 16 patients did not hear the music so were excluded from the analysis. Only one patient reported that the music interfered with the consultation, 82.6% found the music relaxing, 82.6% felt that more doctors should play music in the surgery, and 67.4% considered the music to have helped with their consultation.

Although the sample size was small, so that the results cannot be extrapolated to the population as a whole, this survey shows that, in general, patients had no objection to music being played during the consultation, and in fact found it helpful and relaxing. The survey did not investigate the reaction of doctors to the idea. A study involving a greater number of general practitioners and their patients would be necessary to give more weight to the notion of music in the consultation. This study has achieved its purpose in introducing a new and simple concept which may help both general practitioner and patient to get more out of the consultation — the result appears to be a more enjoyable surgery with lower levels of stress for patients.

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Personal medical attendant reports

Sir,

Insurance forms present ethical and practical problems for general practitioners — ethical in forwarding confidential information about patients and practical in extracting information from records. The term 'double-agent' describes the difficulty well.[1] All 243 personal medical attendant reports received in one week in February 1991 by the Medical Sickness Group were studied in order to see how real these problems are.

One form had been completed by a consultant physician for a diabetic patient while the other 242 forms had been completed by general practitioners. In one the patient's name was omitted, and in 10 the handwriting was illegible for more than one answer. The remainder were legible. Fifty nine of the 243 patients had been registered with their general practitioner for less than one year.

There are five main questions on a personal medical attendant report, with some subheadings. The first question asks how long the patient has been registered, how far the records go back, and about the latest consultation. The second asks about smoking and drinking habits; the third requests details of any illnesses or accidents, treatment, time off work, sequelae and current treatment; the fourth asks about investigations (including urinalysis) and recording of blood pressure and the fifth requests any additional information.

The contents of the 243 forms were examined (Table 1). Only 95 forms (39.1%) supplied information on both smoking habits and alcohol intake together with a blood pressure recording in the last five years.

Ethical problems with personal medical attendant reports have always existed,[2-4] but have intensified with the advent of the acquired immune deficiency syndrome (AIDS). The essence of the problem is whether a general practitioner can pass on confidential information. The patient gives consent for this, although one study showed that this was only remembered by 52% of patients, and 57% would have expected the general practitioner to withhold information on items of a sensitive nature.[5] The problem has been eased by the access to medical reports act 1988, which allows the patient to see, alter, or withhold the report. Furthermore, most insurance companies no longer have a question relating directly to the lifestyle of the proposer, which some general practitioners refused to answer in the past.[2]

The results of this study show that the ethical issue seems to have been largely resolved, in that only one general practitioner refused to give information on smoking habit or alcohol intake. No alter-

Table 1. Analysis of information included on the 243 personal medical attendant reports.

Question	% of forms indicating an answer			
	Full answer	No answer	Not known	Answer refused
Patient general practice details	98.8	1.2	—	—
Smoking habit	72.0	—	27.6	0.4
Alcohol intake	60.5	—	39.0	0.4
Illnesses/accidents	100	—	—	—
Treatment	89.3	10.7	—	—
Time off work	24.7	75.3	—	—
Sequelae	93.4	6.6	—	—
Current treatment	93.0	7.0	—	—
Investigations	94.7	5.3	—	—
Blood pressure recording	71.2	28.8	—	—
Additional information	6.6	93.4	—	—

ations by proposers have been identified on personal medical attendant reports since the access to medical reports act came into force on 1 January 1989 and only one person has refused to allow the form to be submitted, from the approximately 50 000 reports received. Fewer than 10% of proposers require to see the form (Flanagan MJ, Medial Sickness Group, personal communication). This suggests that the ethical dilemma may be more of a problem for general practitioners than their patients, although some proposers may be worried by the delay of up to 21 days that a request for access may cause.

The insurance company asks general practitioners for information about smoking habits, alcohol intake and blood pressure measurement, although the first two are also requested on the proposal form. Completion in this regard was significantly higher (chi square test, $P<0.01$) in those who had been registered with their general practitioner for less than one year. This may well be a result of the registration check, brought in as part of the new contract for general practitioners, in which all new patients are offered simple screening procedures, which include urinalysis and blood pressure measurement.

Legibility was acceptable, given that Mansfield found 14% of general practitioner records contained illegible entries.[6]

Completing insurance forms appears to be more a problem of data retrieval than an ethical problem.

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Minocycline induced skin pigmentation

Sir,

Skin pigmentation as a complication of minocycline therapy is familiar to dermatologists but is less well recognized in general practice where the treatment is widely prescribed. Although the *British national formulary* states that high doses of minocycline are associated with hyperpigmentation of acne lesions,[1] this specific side effect is not included in the minocycline data sheet or the *Monthly index of medical specialities (MIMS).*[2] In a six month period two patients have been referred to our department of dermatology for assessment of facial pigmentation. Both patients told their general practitioners that they felt the minocycline had caused the pigmentation but this was refuted.

In case A, a 58 year old woman developed perioral pigmentation after four years' treatment with minocycline 50 mg twice daily for a perimenopausal acneiform eruption. The patient had been taking conjugated oestrogens 0.625 mg and norgestrel 0.15 mg as hormone replacement therapy for a similar period of time. On examination there was perioral grey pigmentation and grey pigmentation of the conjunctiva and nails. These appearances have remained unchanged despite discontinuing therapy 12 months ago.

In case B, a 15 year old Asian patient was prescribed minocycline 50 mg twice daily for acne vulgaris. After six months' therapy she noted pigmentation of the face. Examination showed grey pigmentation which was confined to acne scars of the forehead, pigmentation of the tongue and grey discolouration of the nails. Six months after discontinuing therapy these changes are resolving.

Three types of minocycline pigmentation are known to occur.[3] The most common type is well-demarcated blue–black macules at sites of previous inflammation and the patient in case B showed this pattern of pigmentation. Circumscribed macules distant from the site being treated (usually the legs) may also occur. The staining characteristics of the pigment in these two types are those of iron and the pigmentation tends to resolve within about 12 months of stopping treatment. The third type of pigmentation is known as the 'muddy skin' syndrome and describes a diffuse brown–grey discolouration, worse in sun exposed areas. Here the pigment stains as melanin. In these patients the pigmentation is often irreversible and case A fits this pattern.

Minocycline pigmentation is not uncommon; in a prospective study of 300 patients, the incidence was shown to be 3.7%[4] and there was no statistically significant difference between dosages of 100 mg and 200 mg daily. The average time to onset was five months. Previous reports have suggested that concurrent therapy with ethinyloestradiol and cyproterone acetate or phenothiazines may potentiate minocycline pigmentation[5,6] and the role of hormone replacement therapy in case A should be considered.

Minocycline is a convenient, effective treatment for acne vulgaris and with the introduction of the new once daily preparation its use as first line therapy is likely to increase. Included in the list of side effects of minocycline therapy in the *Data sheet compendium* is pigmentation of the thyroid gland and it is stated that dermatological reactions are rare, but no specific mention of skin pigmentation is made.[7] It is particularly important that general practitioners recognize this adverse effect early as in a small number of cases the change is irreversible.

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