

cards in the notes, or cards could be added opportunistically as patients are seen. Past hospital letters could be read to glean this information, but only 9% of letters about patients with cancer inform general practitioners unequivocally what patients have been told about their diagnosis.²

The cost and work involved in adding this new card is minimal, but the benefits are considerable. They inform the consulting doctor what the patient knows about the illness. This is particularly useful for a trainee or locum, or a partner who normally does not see the patient. The doctor can also use the information when referring to a hospital colleague or other member of the primary health care team.

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Practice guidelines and practical judgement

Sir,
I appreciated Bruce Charlton's wise editorial on guidelines and practical judgement (*July Journal*, p.290). Although considering myself a guidelines enthusiast, I too am concerned about the undervaluing of tacit knowledge as well as our current inability to incorporate the results of qualitative research into clinical guidelines. The challenge of applying the results of clinical trials to individual patients is dwarfed by the epistemological problems of putting into practice insights from qualitative studies. For example, a coronary heart disease management guideline which bases recommendations solely on randomized controlled trials would exclude knowledge about the experiences and needs of patients after a myocardial infarction.¹ Can this type of knowledge contribute to recommendations in guidelines? What relationship does it have to recommendations derived from randomized controlled trials about, for instance, the beneficial effects of low dose aspirin?

On another point, I would question the closing sentence of the editorial: 'Good

guidelines depend upon pre-existing good practice; guidelines are not the cause of good practice.' If one has a general concept of good practice as some form of absolute state, the statement is a tautology: doctors can only be good doctors if they are already good doctors. If, in fact, good practice can coexist with bad practice for the same clinician, which is certainly my personal experience, then there is no intrinsic reason why guidelines based on evidence-based good practice cannot make my clinical practice better. Indeed, there is evidence from a wide range of settings that guidelines with a dissemination/implementation strategy can do just that.² Initial results from research in east London confirm that this is also the case in inner city general practice (Feder G, *et al*. Association of University Departments of General Practice annual scientific meeting, 13-15 July 1994).

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Assessing inhaler fullness

Sir,
We were pleased to see the study by Rickenbach and Julious highlighting the problem of patients being unable to assess the contents of metered dose inhalers accurately (*July Journal*, p.317).

In our study into this problem, three of 51 subjects had been trained to float their metered dose inhalers in order to assess the contents.¹ However, when given a nearly empty inhaler to assess, they did not ask to float the canister, instead they shook it and listened to it in the same way as the remaining subjects. There is nothing on the canister to inform patients at what stage to try the floatation technique. If patients are advised to try this method when they judge their inhalers to be nearly empty, it is no longer an objective technique.

As patients are unable to assess the contents of their inhalers objectively, they

regularly run out of medication.¹ In our opinion this design flaw is associated with morbidity and mortality from asthma. It is essential that metered dose inhalers should have a dose counter fitted before they are considered to be a safe delivery system.

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Referral for x-ray

Sir,
Neal emphasizes the benefits of the therapeutic x-ray in reassuring patients (*September Journal*, p.427). His comments are well founded. A study of 530 general practitioner radiology referrals showed that 7% were done solely to reassure the patient.¹ Pressure from patients seems to be the third most common reason for general practitioner requests for sinus radiology.² Furthermore, a survey published in this *Journal* found that 88% of general practitioners requested radiographs to reassure patients: 'Faced with a vociferous, complaining patient a general practitioner may adopt a pragmatic approach.'³

However, many of the Royal College of Radiologists' guidelines⁴ are based on formal studies and would have medico-legal backing. Unnecessary x-rays statistically cause over 100 deaths each year from malignancies.⁵ Whether or not patients are referred for radiology, general practitioners should explain clearly when clinical examination and guidelines suggest that radiology is not indicated.

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