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.

ROGER PEPPIATT

15 Wyvern Close
Dartford
Kent DA1 2NA

References

1. Peppiatt R. The role of the general practitioner in the care of malignant disease. In: Gray DJP (ed). *The medical annual 1984.* Bristol: Wright and Sons, 1984.
2. Beck NE, Wilton J. Hospital discharge communications: information given to patients with cancer. *J R Coll Gen Pract* 1988; **38:** 471-472.

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).

GENE FEDER

Department of General Practice
St Bartholomew's Medical College
Charterhouse Square
London EC1M 6BQ

References

1. Johnson JL. Learning to live again: the process of adjustment following a heart attack. In: Morse JM, Johnson JL (eds). *The illness experience: dimensions of suffering.* London: Sage, 1991.
2. Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993; **342:** 1317-1322.

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.

DERYK J P WILLIAMS
ANNA C WILLIAMS

Heathcot Practice
York House Medical Centre
Woking GU22 7XL

DONALD G KRUCHEK

Queen Elizabeth II Hospital
Howland
Welwyn Garden City
Hertfordshire AL7 4HQ

Reference

1. Williams DJ, Williams AC, Kruchek DG. Problems in assessing contents of metered dose inhalers. *BMJ* 1993; **307:** 771-772.

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' guidelines[4] 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.

PIPPA OAKESHOTT
SALLY KERRY
JOHN WILLIAMS

Division of General Practice and Primary Care
St Georges Hospital Medical School
London SW17 0RE

References

1. Barton E, Gallagher S, Flower C, *et al.* Influence on patient management of general practitioner direct access to radiological services. *Br J Radiol* 1987; **60:** 893-896.
2. Houghton D, Aitchison F, Wilkinson L, Wilson J. Use of sinus x-ray films by general practitioners. *BMJ* 1994; **308:** 1608-1609.
3. Owen J, Rutt G, Keir M, *et al.* Survey of general practitioners' opinions on the use of radiology in patients with low back pain. *Br J Gen Pract* 1990; **40:** 98-101.
4. Royal College of Radiologists. *Making the best use of a department of radiology: guidelines for doctors.* London: Royal College of Radiologists, 1990.
5. Godlee F. Environmental radiation: a cause for concern? *BMJ* 1992; **304:** 299-304.

Alternative contracts in the NHS

Sir,

Denis Pereira Gray (letters, October *Journal,* p.479) states that I misrepresented the sense of the three papers written jointly by him, Marshall Marinker and Alan Maynard,[1-3] when I wrote that they first proposed a managed National Health Service market in which general practitioners would compete both as purchasers and providers.[4]

I accept that this proposal was introduced earlier by Enthoven in 1985[5] from the United States of America, and earlier still by Marinker;[6] but the good practice allowance, which Gray, Marinker and Maynard presented as their preferred option, was just one of several ways of introducing market competition into the NHS, reviewed in their papers.

Gray, Marinker and Maynard's papers assumed that progress depends on the development of general practitioners as competing independent contractors rather than as cooperating public servants. They dismissed selective resourcing of public service in 36 unreferenced lines, ignoring practical experience of salaried general practice in Canada, Finland, Norway, Portugal and Spain. When paradigms collide, some mutual incomprehension is probably inevitable.

JULIAN TUDOR HART

Gelli Deg
Penmaen
Swansea SA3 2HH

References

1. Gray DP, Marinker M, Maynard A. The doctor, the patient, and their contract. I The general practitioner's contract: why change it? *BMJ* 1986; **292:** 1313-1315.
2. Marinker M, Gray DP, Maynard A. The doctor, the patient, and their contract. II. A good practice allowance: is it feasible? *BMJ* 1986; **292:** 1374-1376.
3. Maynard A, Marinker M, Gray DP. The doctor, the patient, and their contract. III. Alternative contracts: are they viable? *BMJ* 1986; **292:** 1438-1440.
4. Hart JT. Burnout or into battle? [letter]. *Br J Gen Pract* 1994; **44:** 96.
5. Enthoven A. *Reflections on the management of the National Health Service.* London: Nuffield Provincial Hospitals Trust, 1985.
6. Marinker M. Developments in primary care. In: *A new NHS act for 1996?* London: Office of Health Economics, 1984.

History of general practice

Sir,

A number of historians are now working on the history of general practice. Dr Michael Bevan at the Wellcome Unit for the History of Medicine in Oxford is researching the period 1935–55.

There is some concern among historians that general practitioners have been destroying papers about their general practices for this period, not realizing that they might be of considerable interest and relevance to historians.

The Royal College of General Practitioners obviously wishes the history of general practice to be as accurate as possible and this means supplying historians with the raw material for their work.

The Director of the Wellcome Unit at Oxford and Dr Bevan are willing to arrange for the preservation of as many general practice records as possible and particularly wish to receive those from the pre- and early post-National Health Service introduction periods. These would be offered to the Contemporary Medical Archives Centre at the Wellcome Institute in London.

Dr Bevan will be writing to all founder members of the RCGP in the hope that this group in particular will be able to help with the research. Any readers who may hold documents of any kind relating to general practice in this period should let me know, at the address below, or contact Dr Bevan at the Wellcome Unit for the History of Medicine, 45-47 Banbury Road, Oxford OX2 6PE.

DENIS PEREIRA GRAY

9 Marlborough Road
Exeter
Devon EX2 4TJ

Ehlers–Danlos syndrome

Sir,

I would like to draw readers' attention to an inheritable disorder of connective tissue called Ehlers–Danlos syndrome. This syndrome may be more prevalent than generally quoted in medical texts. The figure often given is in the order of 1: 700 000 but it has been reported to be as high as 1: 156 000[1] and Steinmann even goes so far as to say: 'With increased medical awareness, however, the presumed rarity seems likely to disappear. The aggregate frequency of EDS [Ehlers–Danlos syndrome] may be about 1: 5000 births with no racial or ethnic predisposition. The syndrome has been encountered all over the world.'[2]

Ehlers–Danlos syndrome affects collagen synthesis and is classified into 10 separate types depending on severity, parts of the body affected and type of inheritance. Most sufferers fall into types one to three with variable degrees of joint hypermobility and skin hyperextensibility and fragility. Type four affects only a small percentage of sufferers and can lead to arterial rupture and death of the mother and/or fetus during pregnancy. Types five to 10 are rare, making up 6% of cases of Ehlers–Danlos syndrome. Other problems associated with the syndrome include scoliosis, flat foot, mitral valve prolapse, stomach migraine (severe stomach pain perhaps caused by internal bruising), varices and spontaneous bruising (which can lead to allegations of self-abuse or child abuse). Nearly all sufferers have joint pain and some degree of muscle weakness.

The Ehlers–Danlos support group (which is advised by a medical panel and so can give up to date, factual information) provides detailed fact sheets on all aspects of the condition, as well as a booklet and a short videotape covering basic information for anyone wishing to find out more. Through heightened awareness of this syndrome its true incidence should emerge and Ehlers–Danlos syndrome will then receive the attention it has so far been denied.

VALERIE ARMSTRONG

12 Bridgefield
Farnham
Surrey GU9 8AN

Useful address

Ehlers–Danlos syndrome support group, 1 Chandler Close, Richmond, North Yorkshire DL10 5QQ.

References

1. Beighton P. *The Ehlers–Danlos syndrome.* London: Williams Heinmann, 1970.
2. Steinmann B. The Ehlers–Danlos syndrome. In: Royce PM, Steinmann B. *Connective tissue and its heritable disorders.* New York, NY: Wiley-Liss, 1993.