Table 1. Parents' reported use of paracetamol in specific conditions in their children.

Symptom	% of respondents indicating paracetamol		
	Would be given	Would be given only on a GP's advice	Would never be given
Earache (n = 66)	80	15	5
Headache (n = 66)	82	12	6
Sore throat (n = 59)	71	19	10
Fever (n = 66)	91	8	2
Vomiting (n = 53)	11	30	58
Diarrhoea (n = 54)	7	30	63
Screaming/crying (n = 53)	26	19	55
Stomach ache (n = 55)	45	25	29
Cough/cold (n = 59)	78	12	10

n = number of respondents to question on specific condition.

on a doctor's advice. Most parents did not see a role for paracetamol in the treatment of diarrhoea or vomiting and there is no evidence that this view should be changed unless the symptoms are associated with fever when the child probably ought to be assessed before further treatment. Holme found that the majority of parents did not seek a consultation when their infant had diarrhoea or vomiting. Screaming, especially in infants, can be a worrying symptom particularly if it is persistent and the infant is inconsolable. Most parents said they would not give paracetamol for this condition.

Van de Kar and colleagues showed that when patients felt able to treat a complaint at home without the help of a general practitioner, they were less likely to consult.[3] Specific parental management of childhood illness was beyond the remit of the present survey. Holme did not look at the method of treatment of non-specific symptoms by parents but the results of the present survey showed that the majority of parents would use paracetamol appropriately in common childhood complaints. This may result in fewer medical consultations, including home visits, by the general practitioner.

Health care workers including health visitors, practice nurses and general practitioners, must continue to give advice and information to parents about how to manage childhood illness including the use of paracetamol. Emphasis on correct dosage and secure storage will reduce potential hazards. Use of the drug in the absence of specific symptoms of illness should be discouraged.

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Outcome measure for parkinsons disease

Sir,

In her excellent editorial, Leone Ridsdale highlights the lack of systematic evidence for many current interventions for patients with parkinsons disease (May *Journal*, p.226). She also draws attention to the lack of appropriate outcome measures. From content analysis of indepth interviews with patients with parkinsons disease, we have developed a simple, self-completion questionnaire. It contains 39 questions assessing eight dimensions of function and well-being: mobility, activities of daily living, emotional well-being, stigma, social support, cognitions, communications, and bodily discomfort.

The instrument has been shown to have good internal and test–retest reliability and validity.[1,2] In a series of 131 patients with parkinsons disease presenting at a hospital neurological outpatient clinic, the agreement between scale scores for the 39-item parkinsons disease questionnaire and a standard assessment of disease severity performed by the neurologist (the Columbia scale[3]) was significant for seven of the eight scales (correlation coefficients varying from 0.54 for mobility to 0.19 for bodily discomfort, $P<0.05$).[2]

A further survey has been conducted using the 39-item parkinsons disease questionnaire to examine health-related quality of life in a defined general practice sample. Patients with parkinsons disease were identified by general practitioners and by Northampton District Health Authority hospital records. All patients were examined by a geriatrician to confirm the clinical diagnosis and to assess symptoms. A total of 185 out of 255 patients (72.5% response rate) completed the questionnaire. The most common experiences reported by this group (reported as often or always being a problem) were problems with handwriting (66.5%), difficulties undertaking leisure activities (63.2%), difficulties looking after the home (63.2%) and problems walking half a mile (61.1%). The issue of stigma in parkinsons disease has recently been highlighted[4] and this was also a central finding of our survey in which 23.8% of patients with parkinsons disease reported that they often or always felt the need to conceal their condition in public.

Instruments such as the 39-item parkinsons disease questionnaire should be used as outcome measures to evaluate the impact of current management strategies upon the diverse aspects of parkinsons disease.

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Clinician involvement in commissioning

Sir,

Sir Roy Griffiths' introduction of general management into the National Health Service 10 years ago appeared to relegate consensus decision making to the methodological dustbin, the lid being firmly closed by the introduction of the internal market. Not so, according to the minister of state for health. He urged delegates attending a conference on 28 November

1994 on the involvement of clinicians in commissioning and purchasing care (organized jointly by the Institute of Health Services Management and the Conference of Medical Colleges and their Faculties in the UK) to 'base contracts on consensus' involving clinicians and patients as well as managers. He was referring to the conclusions of an NHS Executive task force set up in response to professional concerns that purchasers were not seeking clinical advice. It seems that while successive NHS Executive letters were advocating clinical involvement in purchasing decisions,[1] the dominant market ethos in many localities kept clinicians out of the process. Provider as well as purchaser managers often perceive clinicians as having conflicts of interest which may affect clinicians' negotiating stance over contracting. Current health service guidance (which is still being discussed) makes clear the requirement of health authorities to ensure that the professions are involved in the full range of health authority work and discusses ways of achieving it.[2]

The secretary of state's announcement of the expansion of fundholding together with the publication of a document on primary care led purchasing[3] means, however, that the commissioning agenda has already moved on. The focus is now on the purchasing decisions of fundholding general practitioners. The debate is not how 'non-professional' commissioners can make valid decisions but is around the legitimacy of general practitioners' responsibility for purchasing as well as providing care. How will general practitioners resolve the ethical dilemma this raises in the balance between personal and public health priorities? How will they make their decisions on purchasing services and from where will they get their information?[4]

Identifying and overcoming the difficulties of obtaining sound, unbiased, local professional advice is necessary to ensure uniform quality of care across the NHS. Research undertaken in South Thames (West) Region has confirmed that both managers and clinicians are happy to rely on local advisory mechanisms for day-to-day contracting problems but that external guidance is considered necessary for major investment and strategy decisions.[5] The two groups differed on the relative importance of local advice versus published national effectiveness data: commissioners considered local professionals as only one of the sources of professional advice to be used in coming to a decision, while clinicians thought their own views should take priority. General practitioner fundholders preferred to rely on their own experiences and contacts with local clinicians rather than try to assimilate all the national effectiveness literature. In practice this may be a legitimate stance but puts the onus back onto providers to offer only effective care.[6]

Public health physicians were considered by managers and clinicians to have a central role in these negotiations on service changes, having an appreciation of clinical as well as managerial issues, understanding the process of critical appraisal and being able to take a non-partisan population perspective. Despite this, many new commissioning agencies are now being established on the basis of a primary care led service with the public health role being questioned.[7] A primary care led health service is a new health policy that still has to prove itself. New health commissions should bear this in mind.

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Facilitation projects

Sir,

We are pleased to see a report from the Royal College of General Practitioners focusing on the special and challenging needs of inner-city primary care.[1] We welcome its emphasis on seeking solutions rather than on identifying problems. The information is a valuable review of the literature and confirms the key issues in and obstacles to delivering primary care. We are concerned, however, at the lack of references to the role and contribution of facilitation projects in recent years in enabling solutions to long-standing problems in primary care.[2-4]

In the original work of the Camberwell primary care development project, a number of key principles emerged which underpinned our activities: support would be offered to all practices; areas of work would start from issues of importance for local practices; regular contact with practices (both in person and in writing) would be critical to reduce isolation and increase involvement; support would empower the primary health care teams to serve the needs of their local populations, as well as local people themselves; and that one of the most important enablers of change was education.

Meetings between members of the Camberwell project and the Liverpool primary health care facilitation project[4] highlighted shared common principles and experiences and we believe these shared principles and experiences to be important in our achievements. We wanted to see if other long-term facilitation projects elsewhere in the country had similar experiences and were delighted when the King's Fund centre for health service development offered to organize and run a workshop. The aim was to share experiences and knowledge, and to identify common processes and methods of working which were key factors in achieving sustained change in primary care. Representatives of projects from London, Sheffield, Norwich, Cardiff and the Welsh valleys, Birmingham, Leeds, and Newcastle attended the workshop. We are surprised that only three of these appear to be mentioned in the inner city task force report.[1] The day produced considerable consensus, and a report of the workshop and a summary of the projects' activities are to be published.[5]

The inner city task force report makes little mention of the role of eduction as a key enabler of change, and gives little specific advice and few references to projects that have improved teamwork. We note the comments in advice given to the Culyer report[6] that there is a lack of peer review journals covering development work, and that education was highlighted in the evidence given to the task force as an excellent way of disseminating research-based changes in practice.