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Reference

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Management of opiate dependence

Sir,
I was most interested in Martyn Judson's letter (December *Journal,* p. 688). Having been retired for some years, I do locum duties for various local general practices and in the three H.M. prisons in this area.

Drug addiction is an increasing local problem; one of the difficulties is that drug addicts ten to 'move on' for various reasons and it is not possible to get any 'feedback' information on how much our efforts to help them have been successful.

My own 'follow-up' efforts have given depressing results, including one young addict (with whom I had spent much time trying to help) dying from an overdose of drugs and alcohol.

Dr Judson's results are most encouraging, but I would make the following points from his letter:

(1) His results of 95% abstinence are remarkably good; however, it is not clear how dependent his patients are on methadone, which is an opioid agonist: Are they on a continual reducing dose? How long does it take to wean them off addictive drugs? How many are successful?

(2) Dr Judson claims that some physicians treat drug addicts with contempt, distaste and disdain when, in fact, these patients have a disease. If this is true, then it is partly because most patients wish their physician to help them to recover from their disease; many drug addicts consult their doctor simply to obtain more drugs. They are most demanding of time, and are abusive and noisy if not given what they want, upsetting the doctor, his staff and patients in the wanting room.

Finally, I must congratulate Dr Judson on the success of his special unit and I would agree with him that it would seem to be the best way of helping this very sad group within our communities. However, unlike Ontario, I doubt if British physicians in the National Health Service would have the 'luxury of devoting as much time as they need to interviews with drug-dependent patients'.

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Problem drug users

Sir,
I read with interest the editorial on problem drug users by Wilson *et al* (September *Journal,* p. 454).

I agree with the general theme of the authors, but would take exception to two related assertions.

While adding psycho-social supports certainly improves treatment outcomes, the provision of methadone alone with virtually no additional support has also been shown to yield significant benefits to patients. Even doctors with little experience in the area, given some guidelines based on simple pharmacology and therapeutics, would be doing much good and little harm in prescribing to addicts who are otherwise denied appropriate treatment.

Though respecting Scottish GPs' claims for increased funding for the treatment of addictions, it is my belief that most drug and alcohol treatment lies directly within the scope of general medical services.

Over the past 10 years in New South Wales, the number of GP methadone prescribers has risen from a handful to over 200. Most treat their patients using their nursing, pathology and pharmacy staff, as they would for patients with other conditions. Most GPs have found it a very rewarding experience and there have been no 'horror stories' reported. One of the accompaniments has been a drug-user HIV incidence below 1%, compared with up to 50% in some foreign studies.

I was shocked to read that some British GPs are so busy that others must write their prescriptions. In addition, may I suggest that there *is* evidence for the benefit of other prescribed drugs in chemical dependence. Naltrexone, buprenorphine, disulfiram and even heroin itself have all shown some promise.

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Patient choice of general practice

Sir,
The excellent paper by Thomas and colleagues (November *Journal,* p.581) is not the first paper to demonstrate that patients in general prefer small practices, nor will it be the last, as evidenced by Baker and Streatfield's paper exploring the practice characteristics that influence patient satisfaction (December *Journal,* p.654).

There is evidence that the healthy and the sick look for a different health service.[1] There is no doubt that those who steer the health service are healthy and predominantly upper class and that most are men. My anxiety is that general practice is being moulded by the opinions of the healthy rather than by the needs of the sick.

Most jewels have flaws. The paper by Thomas and colleagues is no exception. They state without validation, 'single-handed general practitioners gaining patients do not generally conform to the characterization of the good practice (greater access and wider services) being encouraged in government policy'. For access the contrary is true; small practices provide greater access.[2] As regards wider services, I have seen no evidence to suggest that single-handed general practitioners provide fewer services to individual patients than do their group practice colleagues.

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2. Baker D, Legh-Smith J. *Access to primary health care.* Bath: Centre for the analysis of social policy, University of Bath, 1992.

Computer medical records

Sir,
In August 1995, we carried out an analysis similar to Pringle and colleagues' assessment of the completeness and accuracy of computer medical records in four practices committed to recording data on computer (October *Journal,* p.537).

In a six-principal practice which has been computerized for 10 years, we compared the computer-held records of 1000 randomly selected patients aged between 30 and 64 years with the paper medical records of the same patients. Eighty-four per cent of 153 patients with a record of chronic obstructive airways disease or asthma in their paper medical records, 96% of 46 patients with diabetes, and 80% of 65 patients with coronary heart disease were correctly identified in the

computer records.

In 1992, we carried out an audit of preventive activities in 16 practices in inner London using a validated measure of patient population, the 'active patient' denominator (September *Journal*, p.463). We found that last recordings of blood pressure and smoking in the medical notes were only recorded in the computer records of 53 and 54% of 1346 patients, respectively. Recording on computer was greater for practices with longer established computer systems, and levels of recording have improved in a subsequent audit. High levels of recording are feasible, but considerable variation will remain as long as paper medical records are maintained. Quality assurance is an outstanding issue and needs to be addressed in both fully computerized practices and those still maintaining paper records.

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Health promotion

Sir,

In their paper on health promotion (December *Journal*, p.665), Langham *et al* state that, in the 1990 'New Contact',[1] 'a fee was introduced for each clinic provided'. This implies that additional money was invested in health promotion. They do not consider the fact that this contract entailed the loss of a considerable proportion of other income; for example, through the removal of supplementary practice allowance and supplementary capitation fees, and the reduction of seniority increments. Opportunities had to be taken to try to recoup these sums, and it is well known that there was a high degree of creativity in the development of so-called health promotion clinics. While perhaps representing a therapeutic means of addressing the anger evident within the profession, it is not surprising that no clear evidence within the profession, it is not surprising that no clear evidence of beneficial outcome exists.

The concept of winners and losers is ameliorated through the pool system of remuneration because earnings above target net income are clawed back later anyway! The real losers are the tax-payers who have funded the management of this ill-planned saga.

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Anecdotes and empiricism

Sir,

I appreciate what Jane Macnaughton was trying to say in her editorial on anecdotes and empiricism (November *Journal*, p.571), but I found the editorial to be both misleading and untimely.

It was misleading in that the anecdote seemed to be set up as a form of knowledge distinct from empirical observation. Science then becomes an ingredient in some wider intuitive, and no doubt ancient, wisdom which is arrived at largely by non-scientific means. So Macnaughton writes, 'Learning the scientific basis for understanding people is only one part of the holistic approach to which students must aspire.' This would be a false dichotomy. For example, the anecdote about the man aged 80 years who was active despite smoking 30 cigarettes a day is actually part of the empirical knowledge that we need to take on board when trying to evaluate the dangers of smoking.

Every experienced teacher knows the importance of bringing lessons to life with interesting examples. If teachers understand the significance of anecdotal evidence, they will realize their responsibility for choosing examples that are typical of the point being made. Thus, breathlessness when carrying shopping upstairs is a good example of exertional dyspnoea but it should not be used to contend that the air is thinner at the top of the stairs. Teachers who lapse into specious argument will know that a good anecdote is the best way to persuade an audience into thinking that this particular story proves a dubious point.

The editorial was untimely because the biggest danger to medical practice today is not pre-occupation with audit or evidence-based medicine, but the all-pervading relativism that dominates public perceptions of truth. 'It works for me, see if it works for you' has become the sales pitch of every alternative therapist. The majority of patients believe such testimony to be incontrovertible and the Advertising Standards Authority offers no protection against it. Outrageous claims are being justified on the basis of anecdotes.[1]

General practitioners seem to be par-ticularly vulnerable to this current anti-science shift. They are being held to ridicule by rationalists — and rightly so. Health commissions are being asked to fund therapies without any basis in science and with only anecdotal evidence to support them. If the patient seems happy and the treatment costs less than evidence-based treatments, general practitioners are being heard to say, 'Who cares if it actually works?'

It seems to me that we should care. The scientific soul of medicine is at stake. It is not the importance of the anecdote that is being neglected today but its significance in the wider picture. Medical science must certainly engage with human faces and individual histories — that is what general practice is all about — but in the current climate, those human faces could lure us all back to superstition and medievalism.

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Reference

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Anecdotes and empiricism

Sir,

I think Dr May (letter, March *Journal*, p. 201) might have misunderstood my use of the word 'empiricism'. In my editorial, I was contrasting knowledge obtained from anecdotes with empirical knowledge. The difference between them is that empirical (or scientific) knowledge is testable and repeatable, while that obtained from anecdotes is not. Therefore, anecdotal information is not part of empirical knowledge, but is one of the different ways in which doctors gain an understanding of patients. Both modes of knowledge, the scientific and the anecdotal, are equally valuable and available to GPs.

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