The percentage of adult patients who withheld consent for video-recording was 14.1% (76/538). Analysis of our data suggests that there are significant differences in the clinical problems presented and the demographic characteristics of patients who agree to video-recording, compared with those who don't. We have presented a preliminary analysis of our data to a national conference[5] but cannot divulge further details here as we intend to publish these fully in a peer-reviewed journal.

Cromarty is justifiably cautious when discussing the extent to which he believes his findings can be applied. We hope that our conclusions, when published, will enable a greater understanding of how video-recorded consultations compromise the representativeness of patients recruited to research projects.

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Treatment of dementia

Sir,

I was very interested to read the letter from Dr Rahul Rao (September *Journal* p. 554) reporting his findings of patients with dementia not receiving analgesia for chronic pain. As he states in his letter, it is particularly difficult to assess the presence and degree of physical symptoms in patients who are cognitively impaired, and there is a lack of literature that comments upon the detection and management of physical symptoms in these patients.

I recently looked at the prevalence of pain and other symptoms in patients with end-stage dementia who died on long-stay psychogeriatric wards.[2] Seventeen case notes were retrospectively reviewed. Dyspnoea and pain were the most common symptoms in the last two weeks of life, and these symptoms were not adequately palliated: all patients appeared to be in some distress in the last 48–72 hours of life. Analgesics were prescribed on an 'as required' basis, but were rarely administered as the patients were unable to articulate their distress. The majority of patients died from bronchopneumonia, and uncontrolled pyrexias and troublesome dyspnoea were also very common. Patients were treated with antibiotics that have been shown not to influence morbidity or mortality in this population group. Steps to alleviate the distress of dyspnoea and excess secretions, however, were not taken.[3]

This study suggested that symptoms in the late stage of the disease were both underdetected and undertreated. As long-stay psychogeriatric wards are being closed, a very large number of patients with end-stage dementia will be cared for in the community, either at home or in nursing homes for the elderly mentally ill under the care of their own general practitioner.

The principles of palliative care are being increasingly implemented for patients with end-stage diseases that are not malignant. Patients with advanced dementia should also be treated according to the principles of palliative care and analgesia, including the use of opiates, which should be prescribed regularly.

As a result of this study, guidelines have been devised that look at the most common symptoms in end stage dementia, and that give a step-wise approach to palliation.

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Evidence-based learning in general practice

Sir,

Leone Ridsdale makes a number of pints concerning access to computerized information sources (September *Journal,* p.503). I would agree that database searching skills are not difficult to acquire. The real problem is being aware of the need to use additional tools such as Medical Subject Headings (MeSH) in order to maximize the relevance and efficiency of any search. Searching for evidence-based material requires the accurate use of some very complex search filters[1] in order to get a comprehensive result. We should not forget that, for all the empowered end-users who are in a position to do their own searching, there are others who would prefer to assign this task to a librarian. Librarians are playing more of a role in supporting the information needs of primary care. We should always ask the question, 'Who would do this search most efficiently?', when searching for evidence.

I have been testing out various 'free' MEDLINE services on the Internet. It takes about 20 minutes to train someone to use one of these systems. The problem is that the search results are to a large part uncontrollable, unpredictable and inaccurate depending on the search engine fronting the database. These systems are geared to end-users and yet would be highly unsuitable for performing accurate evidence-based search strategies. In all cases, access to MeSH would be an absolute necessity and yet this is not always obvious. The BMA free Medline service for members allows accurate searching and offers MeSH searching as a basic facility. I would recommend those who can to take advantage of this facility.

Access to the BIDS system is not as straightforward as Dr Ridsdale suggests. BIDS is only available to the academic community, which means that it is not available to general practitioners who are unconnected with education. The databases that BIDS offers (such as Excerpta Medica) can also be accessed by CD-ROM or by a premium dial-up service.

The clear message that I am receiving from GPs is that there is still a real need for mediated search services. My concern is that some practitioners may be so put off by the perceived complexities of new user-oriented services that they give up altogether. I believe that we should make library services more accessible to general practice, as an essential component of evidence-based learning.

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