Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Topical chloramphenicol: have GPs cried halt?

Sir,

An editorial in the *British Medical Journal* (*BMJ*)[1] on the use of chloramphenicol eye drops suggested that the risks of topical chloramphenicol were sufficient to warrant practitioners to prescribe an alternative, such as Framycetin or Fucidic Acid.

We sent a postal questionnaire to 664 general practitioners (GPs) in the areas of Leeds, Guildford, and Cambridge to ascertain the influence this editorial, and ensuing correspondence, had on their prescribing habits eight months later. Three hundred GPs replied, of whom 235 (78.3%) had read the editorial. As a result, 62 (21.7%) of the respondents had initially stopped prescribing topical chloramphenicol. Twenty-one (7%) ultimately reverted to using chloramphenicol, 19 of whom indicated they had read the correspondence in the *BMJ* that supported the continuing use of topical chloramphenicol. At the time of the questionnaire however, 43 GPs (14.7%) had not reverted to using topical chloramphenicol, despite 13 admitting that they read the articles in support of it. Those GPs who had read the article but did not change their antibiotic practice totalled 164 (54.7%). Fifty-eight had not read the editorial.

A further study examining why GPs change their prescribing habits concluded that journal editorials cannot be expected to bring about major change.[2] Contrary to this, we found that a significant number of GPs were influenced to change their prescribing habits by the editorial in the *BMJ*. Although, some degree of bias may occur in a survey such as ours, in that those GPs who had read the editorial and changed their prescribing habits may have been more likely to respond to the questionnaire.

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Six months' experience of the new practice-based patients' complaints procedure

Sir,

The new practice-based patients' complaints procedure commenced on 1 April, 1996. It aims to be faster and more accessible to the patient than its predecessor,[1] and nationally agreed criteria have been accepted for the programme.[2] Six months after its introduction, the Portsmouth Medical Audit Advisory Group completed a review of the new process using a questionnaire survey of all local practices. The response rate was 75.3% (61/81).

All but one practice had a nominated person to administer the process; usually the practice manager. Every responding practice made written details of the complaints procedure available to patients either as a special leaflet (45), waiting room poster (42), or within their practice booklet (30). Eighteen practices used one of the methods offered, 25 practices used two, and 16 practices used all three. Most practices (51/61) indicated to the patients their right to complain directly to the health authority.

Responding practices had received 102 complaints between April and late September, 1996. Those practices that received no complaints totalled 21, and 40 had already used the practice-based procedure. Each practice manager provided her impression of the speed of complaint resolution. Thirty-one out of 40 practices stated that an acknowledgement had been made to every complaint within two working days. Of the 40 practices, 24 (60%) had been able to investigate and make a response to all complaints within 10 working days.

An analysis was made of the factors affecting the complaint rate. There was no apparent relationship between the size of the practice partnership and the average complaint per partner, location of the practice, or training status. Practices advertising their practice-based procedure widely were more likely to receive complaints. Those using two methods were over three times more likely to receive complaints than those using one method (OR = 3.25, 95% CI = 1.45–7.16). Those practices using all three methods were over four times as likely to receive complaints than those using just one method (OR = 4.22, 95% CI = 1.67–10.61).

The higher complaint rate in those practices that advertised their scheme widely was the most striking finding of the survey. Conscientious practices may therefore expect more complaints. Responding practices were generally achieving the nationally agreed criteria, although complaint rate resolution response times could have improved.

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Evidence-based general practice

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Sir,

I write as a GP tutor who has recently worked with the Clinical Guidelines group of our local Clinical Outcomes and Audit Group (formerly Medical Audit Advisory Group) to introduce the idea of the use of evidence-based guidelines to local GPs.

One of the topic areas in which we have asked GPs to review their practice has been the prophylactic treatment of patients with non-rheumatic atrial fibrillation. A key point has been that, for those patients in whom the most appropriate treatment is aspirin, it is important that this is given in the correct dosage of 300 mg daily. This we believed to be based on good evidence.[1,2]

Therefore, it was with disappointment that I read the article, Which prophylactic aspirin? in the January issue of *Drug and Therapeutics Bulletin*.[3] In the concluding paragraph — often read first by busy GPs — the journal talks of minimizing the dose of aspirin to reduce the risk of gastrointestinal bleeding in patients needing aspirin for thromboembolic prophylaxis. It goes on to state that 'a daily dose of 75 mg should be effective' but does not give a reference to support the efficacy of this particular dose.

I accept that our guidelines refer to a specific indication, but nevertheless feel that the conclusion of *Drug and Therapeutics Bulletin* could be seen to contradict the guideline advice. I believe many of my colleagues will take the words 'for thromboembolic prohylaxis' to include the use in chronic atrial fibrillation.

Evidence base to practice is a young and delicate plant, and will need all the support it can get if it is to survive in the harsh world of everyday practice. Statements in highly respected publications, such as *Drug and Therapeutics Bulletin*, that are perceived to contradict advice given in local guidelines, are likely to create uncertainty and lessen the credibility of the guidelines.

Perhaps I am looking for certainty where there is none; perhaps evidence is not as clear as it is sometimes presented; perhaps it is right that the validity of our local guideline be thrown into doubt. Nevertheless, I believe this article will, at least in this area, have damaged the validity of our local atrial fibrillation guideline, and probably, by association, other locally produced guidelines too. As a result of this, some Dorset patients in atrial fibrillation may not receive effective prophylaxis, some may suffer preventable stroke, and some may die as a result.

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3. Which prophylactic aspirin? *Drug and Therapeutics Bulletin* 1997; 35: 7-8.

Sir,

Dr Campion-Smith takes us to task for advising an aspirin dose of 75 mg daily for preventing stroke in patients with atrial fibrillation (above). The position we take is based on the results of the Antiplatelet Trialists' Collaborative study.[1] This meta-analysis, which used data from 174 trials (including those referred to by Dr Campion-Smith[2,3]), concluded that doses of aspirin of 75–325 mg/day were similarly effective in preventing stroke. This being the case, it is sensible to advise the use of the lowest effective dose, as this should minimize the risk of gastrointestinal bleeds. This is argued, with the appropriate references, in the *Drug and Therapeutics Bulletin* article to which Dr Campion-Smith refers.[4] If the *Bulletin* erred, it did so in 1994 when we were over-reliant on the results of these same two, relatively small trials,[2,3] and recommended a dose of 325 mg daily. Since that article we have decided to take the broader view, and so our advice has changed.

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4. Which prophylactic aspirin? *Drug and Therapeutics Bulletin* 1997; **35:** 7-8.

Hormone replacement therapy for osteoporosis prevention

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Sir,

I read with interest the paper by Roger and Miller (March *Journal*) looking at the adequacy of hormone replacement therapy for osteoporosis prevention assessed by serum oestradiol measurement and the degree of association with menopausal symptoms. They mentioned that, in their study, 37 women were using reservoir patches and only eight were using the matrix formulation. I understand that with these small numbers it is difficult to look at sub-groups. However, I would be interested to see the comparative serum oestradiol levels, as, in practice, reservoir patches cause more local skin reactions and may adhere poorly. This heterogenous cohort may account for the overall unexpectedly low serum oestradiol levels.

Data suggest that serum oestradiol levels in reservoir patch users fluctuate widely with peak and trough levels of 183 pmol/l and 95 pmol/l in one study.[1] In matrix patch users, plasma oestrodial levels tend to be smooth and more sustained, ranging from 150 pmol/l to 204 pmol/l.[2] These findings have been reproduced in other studies.[2,3]

A non-oral formulation not mentioned in the study by Roger and Miller was oestrodial gel. Studies suggest that percutaneous delivery of oestradiol results in smooth, predictable levels of oestrogen with serum oestradial levels reaching, on average, 250 pmol/l[4] using 1.5 mg dose daily (the normal recommended dose). Unlike the reservoir patches, not all of these newer products are licensed for prevention of post-menopausal osteoporosis. However, a recent study[5] has suggested that oestrogen gel is effective in prevention of post-menopausal bone loss.

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Mental health care training priorities

Sir,

The paper by Kerwick et al (April *Journal*) highlights the importance of training in mental health for primary care physicians. It was surprising, however, to note the low priority rating (25/26) given to bereavement issues by the respondents to this survey. Much work has been undertaken on the support needs of the bereaved,[1,2] which has shown that the bereaved frequently consult their GP for bereavement support. An ageing population and increasing social isolation leaves many bereaved individuals to rely on their GP for support.

A survey in Leicester of 130 GPs (response rate 53%)[3] found that 70% of respondents felt that they should be providing bereavement support, but only 14% perceived they had adequate training in this area. A subsequent study of GP registrars training in palliative care[4] found that only 30% had received any teaching on bereavement support during their vocational training, and this was perceived as adequate by only 9% of GP registrars.

Although bereavement has been given a low priority by the respondents in Kerwick *et al*'s paper, it appears appropriate that future continuing medical education sessions in mental health would offer some teaching on the needs of the bereaved for support and not focus exclusively on those topics given a high priority in this survey.

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Sir,

London GPs who missed Professor Sir David Goldberg and Shaun Kerwick's comments about them, which were first published in the King's Fund document, London's mental health,[1] now have another opportunity in the *British Journal of General Practice's* (*BJGP's*) editorial (June *Journal*)[2] by the same authors.

Despite smaller list sizes, GPs in inner deprived areas in London are underperforming compared with colleagues in similarly deprived areas outside London.

I have no idea whether this statement is true, but inasmuch as the authors attempt to justify it, it appears somewhat sweeping. It would be fun to spend paragraphs challenging some of the King's Fund report's more speculative associations, the alleged relationship between out-of-date cervical smear uptake data being an obvious one, but to do so would be to miss the point. The point is that in order to work in collaboration, a basic starting point is mutual respect.

In their recent paper on training priorities in general practice (April *Journal*),[3] Kerwick *et al* also display a curious attitude to their local GP colleagues in reporting the results of their needs assessment questionnaire. In their final paragraph, the authors register their 'main concern' that GPs do not have the requisite mental health skills, which 'is reinforced by GPs'recognition that further training is a priority'. This begs the question of how concerned they would have been had the GP respondents commented to the contrary? The paper's authors seem particularly churlish when one considers that, even in an area where primary care is apparently so dreadful, not only did GPs collaborate in designing the quaestionnaire, but 237 filled it in, and 74% exhibited interest in further education.

Apparently unbeknown to Goldberg and Kerwick, education has moved towards addressing the needs of the learner rather than those of the teacher. For this reason, most of the initiatives aimed at developing ongoing education for GPs have been increasing the autonomy of primary care and diminishing the influence of consultant specialists as a key to increased effectiveness. Hectoring supposed colleagues about their deficiencies seems a somewhat unpromising start to developing an education programme. It infers that education is a linear process, where expertise is the unique province of psychiatrists — the learners having nothing to contribute. The fallacy of this approach can be seen when one considers the topics chosen by the responding GPs: counselling skills and 'heartsink' patients. Many GPs would consider that the most useful introduction to these subject areas came from vocational training, through study of the consultation. GP trainers or professionals from outside psychiatry are just as likely influences and resources for this important and relevant work.

For three years we have been collaborating with community-based psychiatrists locally, running multidisciplinary mental health educational meetings. All clinicians working in the area of mental health in primary and secondary care have been invited. The philosophy of mutual learning has been promoted, leading to improved understanding and respect. A wide spectrum of professional groups have been represented including nurses, psychologists, counsellors, social workers, and doctors. The content of the meetings has varied from different models in the management of depression to the working of the care programme approach.

Evaluation has shown that this multidisciplinary approach, developing integrated working and cross-fertilization of techniques and skills has been popular and rewarding. Participants have reported the value of meeting colleagues whose backgrounds are different, and also of hearing cases presented by and discussed with clinicians from other disciplines.

The articles in the *BJGP* and the King's Fund report conclude with support for initiatives to promote education for those woking in primary care. However, the implication is of an agenda imposed from the top down, principally addressing the agenda of the organizers rather than the potential participants. If education is to meet the needs of its participants, a collaborative approach, acknowledging strengths as well as weaknesses, and incorporating a wider perspective than that

of psychiatrists and GPs alone, could be more popular and effective.

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OTC prescribing

Sir,

Drs Baines and Whynes hypothesize that higher rates of prescribing for over-the-counter (OTC) preparations in dispensing practices, compared with non-dispensers, are due to financial incentives (April *Journal*).[1] There is no denial that such preparations add to the income from dispensing, and it is doctors working in dispensing practices have been among those who call for changes to remove this bias.[2] To concentrate on this finding, however, obscures the key point that such prescriptions are an important service to our patients.[3]

The regulations prohibit us from encouraging OTC sales, and also from dispensing a private prescription that may cost less than £5.65, thus saving a paying patient money.[4] Therefore, the only way in which a dispensing doctor can provide medication is by prescription. Consequently, the costs to the NHS are higher, but the patients in rural practices, who are more often elderly,[5] receive access to treatments that are taken for granted as freely available OTC in urban practices. Thus, the drug budget costs of maintaining equity of service in rural areas are higher, although no account is taken of the added costs for urban prescribing, which is of course a different budget.

These costs should not be seen as a criticism of dispensing doctors, but rather as an incentive to rationally review the regulations that bind us.

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Assessing for audit

Sir,

The discrepancy noted by Lough and Murray (May *Journal*)[1] between the assessment of trainee audit projects by 114 trainers and by five 'expert' assessors is truly remarkable, but they are perhaps too quick to conclude that the fault lies entirely with the trainers for the following reasons:

- If the criteria were as clear-cut as Lough and Murray presuppose, there should have been 100% agreement between the 'expert' assessors. The fact that the expert assessors did not agree shows that the criteria are less than absolute.
- The selection of those five projects in which there was least disagreement between the experts as the ones to send out to test the discriminatory powers of the trainers ('the five projects were chosen to maximize the unanimity of the assessors') introduces a bias in the study. This is an elementary methodological error; the unanimity is a deliberate artefact. There is no justification for the implication that the projects used to test the trainers were the ones that were most certainly inadequate.
- The repeated statements that the 114 trainers had participated in the 'crafting' of the criteria they subsequently failed to apply raises questions about how the conflicting views of such a varied group were discussed and effectively reconciled.
- The possibility that trainers may have applied their judgement to the projects (the characteristic approach of general practice), rather than apply rigid criteria to them to find the 'correct' answer (an alien concept in general practice, and rightly so), is not entertained in the discussion.

Lough and Murray take the fact that almost all the trainers passed the projects that they (the experts) had failed, not as a criticism of the whole silly system, but of the trainers who (surprise, surprise) need to learn more lessons. I suggest that a more correct interpretation of this study is that 'expert' assessors are blighting junior colleagues' careers by failing their projects on criteria that are not agreed by experienced doctors actively involved in front-line general practice.

The real lesson still to be learned by the trainers of the West of Scotland, and elsewhere, is that they should have stood together and simply said, 'no'. Meanwhile, sadly, Lough and Murray are failed and are out on their ears. But general practice is the better for it...

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1. Lough JMR, Murray TS. Assessing for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.

Sir,

The data presented by Lough and Murray (May *Journal*)[1] show a clear difference in the marking of audits by 144 trainers on the one hand and an 'expert' group of five assessors on the other. I am not sure that the conclusion drawn by the authors, that the trainers are failing to recognize basic audit methodology, is justified by this data.

An alternative explanation of their findings relates to the difficulties with criterion referencing described by Rhodes and Wolf.[2] Lough and Murray's five assessors chose the five audits for their study from a cohort of 104, of which 10% were thought by them to be below the minimum level of competence. The trainers were sent five audits that were all thought to be below this level of competence. Perhaps the reason for the trainers' comparative leniency lies in a natural tendency to mark by peer referencing, and so pass the audits that seemed to be the least bad of the sample they saw. Perhaps criterion referencing is a facade.

An additional problem lies with the West of Scotland marking scheme. The five criteria have to be marked as either present or absent, and the schedule sup-

ports each criterion with a short statement, which may be seen as a standard. Perhaps there is a difficulty in translating a subjective judgement of a piece of written work into a binary mark.

If the authors had included this sort of evaluation in the paper, they would be less likely to be seen to be claiming 'everyone's out of step but us', possibly.

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Management of hypertension

Sir,

Barton and colleagues state (March *Journal*), in response to our paper (November *Journal*), that using blood pressure measurement alone and ignoring other risk factors in the management of hypertension 'will not optimally identify the group that will benefit from treatment, but has the advantage of simplicity.' We ask, in reply, if it is simple but less accurate, then why continue to manage hypertensive patients in this way without considering a more accurate alternative? We repeat our original conclusion that prospective studies are required for an answer to this question.

Barton *et al* also seem to misunderstand the underlying epidemiological studies on which our paper was based. Framingham data do not give equal weight to major and minor risk factors.[1,2] They, and the subsequent hypertension guidelines on which our study was based, clearly differentiate between major risk factors, which individually increase absolute risk of a cardiovascular event to $\geqslant$20% in a 10-year period, and minor risk factors, which only do so in combination.[1-3] They are correct in stating that the 20% cut off is an arbitrary point on which to select treatment. However, as absolute risk and blood pressure measurement are both continuous variables, any cut-off point will be arbitrary whatever index is used. The advantage of calculating absolute risk is that individuals at a higher risk of a cardiovascular event will be selected more accurately and treated in preference to lower risk patients.[4,5] Even in the elderly, absolute risk of a cardiovasculr event can vary substantially; for example, for those aged between 60 to 79 years in our study, the 10-year absolute risk varied from 5.3% to 87.8%.

As regards the exclusion of blood pressure itself from our regression model, it is, of course, part of the outcome variable; namely, the absolute risk of a cardiovascular event. Its inclusion as an explanatory variable is therefore debatable. In the event, adding blood pressure into the model did not change the conclusions for the risk factors associated with adequate control. Indeed, if anything, the independent associations between these risk factors and poor control by absolute measurement became even stronger.

Finally, they state that a simple message of basing control on blood pressure alone may be more effective. Alternatively, it may not be. We are conducting a randomized controled trial to assess whether a computer-based Clinical Decision Support System, which calculates absolute risk, is acceptable to GPs, and if it improves control of hypertension in their patients.

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General practice: additional services

Sir,

At the beginning of November 1995, a joint health/social care funding initiative between Iechyd Morgannwg Health and Neath/Port Talbot County Borough Council allowed Port Talbot Citizens' Advice Bureau to provide two advice sessions per week at the Upper Afan Practice. At the end of the first 13 months, the project secured £185 163 for its clients; £131 901 of this sum was for benefits where the client was unaware of his or her entitlement. The total annual cost of the project was less than £10 000.

The Upper Afan Practice is based on the former mining villages of Blaengwynfi and Glyncorrwg in south Wales. It has a list size of 3540 patients. The area suffers from high levels of unemployment and morbidity with a low level of access to private car ownership. The nearest towns are 6 to 12 miles away and are served by a poor public transport system. In the years leading up to the establishment of the project, the local Citizens' Advice Bureau (CAB) was forced, for financial reasons, to withdraw its peripheral offices in the Upper Afan Valley and concentrate its efforts at its central office.

During the 13 month period, 206 practice patients made an appointment to see the CAB worker (SG). Fifty-six per cent of clients were seen within one week of referral and the average time spent with the client was 50 minutes. The areas in which advice was provided can be seen in the Table.

One fifth of the clients said they would probably have brought their problem to the CAB even if the services had not been based at the practice. One half felt they might have used the CAB if the services had not been based at the practice, while the rest said they would not have done so. All the clients said they would use the service again.

In recent years, practices have been providing additional services to meet the physical and psychological needs of their patients. This small project illustrates a practical way in which primary care could respond to their patients' social needs as well.

BRIAN GIBBONS
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Table 1. Numbers of patients receiving advice in different topics provided by the CAB worker during the 13 month period.

Welfare benefits	255	Housing	9
Relationships	12	Other	23
Legal	12		

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Ethnicity and paediatric referral in Amsterdam

Sir,

Minority ethnic communities make up 6.1% of the population in the Netherlands.[1] In the underprivileged neighbourhoods of western Amsterdam, 70% of the children under the age of 15 years belong to an ethnic minority, mostly of Moroccan (26%) or Turkish (17%) descent.[2] Although these children are more often admitted to hospital than the white majority of children,[3] little is known of the use of ambulatory paediatric care.

The present study was undertaken to assess a possible relationship between ethnicity and referral to the paediatrician. From June 1, 1994, to February 1, 1996, data on age, sex, ethnicity, and reason for referral were collected on children younger than 15 years who were newly referred to the paediatric outpatient clinic of St Lucas Hospital, a general district hospital in western Amsterdam. Patients were divided into ethnic groups according to their mothers' country of birth. Group differences were analysed with ANOVA (one way) and the student-Newman-Keuls test. Nine hundred and four children, 494 (58%) boys, were referred from the same neighbourhood. Migrant children totalled 622 (69%), 255 (28%) Moroccan, and 179 (20%) of Turkish descent. Respiratory (27%), gastrointestinal (16%), and urinary complaints (7%) were the most frequent reasons for referral, and asthma (16%) was the most common diagnosis. Only the prevalence of asthma differed when the various ethnic groups were compared ($P<0.01$). Asthma was more often diagnosed in migrant children than in Dutch children ($P<0.05$). Analysis of subgroups revealed that asthma was most prevalent in Moroccan children. No differences were found in the sex or mean age of children with asthma in the various ethnic groups.

A recent population-based study of the Health Services department in Amsterdam[4] showed asthma to be less frequently found in migrant children than in Dutch children. We therefore assume that the higher prevalence of asthmatic Moroccan children in our outpatient population is due to increased referral.

Communication difficulties are increased in the underprivileged neighbourhoods of Amsterdam,[5] and GPs who have a high workload might have little time to instruct laborious dose-aerosol treatment to migrant children. Moroccan migrants, in particular, often still live in traditional and closed communities, and assimilate less than other ethnic minorities in the Netherlands.[6] However, since this study was not designed to evaluate reasons as to why children with asthma are referred to the paediatrician, our preliminary results need to be interpreted with caution. More detailed studies are needed.

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CORRECTION: In the June issue, the third paragraph of Tim Stoke's letter (p402) was printed as follows: '…and there are those who would argue that quantitative research is phenomenological.' The correct text should read: '…and there are those who would argue that qualitative research is philosophically as well as methodologically distinct from quantitative research.[2,3] The underlying philosophical position of qualitative research is phenomenological.'