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.

MRCGP

Sir,

I was saddened to read St John Livesey's letter (December *Journal*). In any examination like the MRCGP, where we are looking for excellence rather than just a minimum level of competence, the examiners need to stretch the candidates to find out just how good they can be. If every candidate has the same level of questioning, then the more able candidates will not have an opportunity to shine. As a result, in the oral examinations some of our candidates may feel surprised at the depth of questioning that they experience. However, they are only being questioned at this depth because they are doing well. It is likely that this is what happened in the case outlined in St John Livesey's letter.

The changes that we are bringing into the examination are certainly not being introduced for reasons of fashion, or because we want to appear clever. When developing the changes we were at all times very careful to take particular note of the needs of candidates. Indeed, we talked to a large number of candidates about their hopes and expectations about the exam. To date, our changes have been greeted with near unanimous support — only an absurd optimist would expect total unanimity. Nevertheless, I do take Dr St John Livesey's comments very seriously and have shared these with the examination board. We genuinely value feedback, however negative it might be.

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Evidence-based health care

Sir,

Rarely if ever, in discussions about evidence-based health care, is the hypothesis even considered that the doctor, and not the intervention he or she prescribes, is more likely to materially affect the outcome of a consultation. Psychotherapy research is beginning to produce evidence that it is often the 'effect' of the therapist and not the 'effect' of the therapy that it is likely to produce favourable outcomes. I believe this to be true also of the profession of medicine as a whole.

The psychological components of many patient illnesses is thought to contribute up to 50% of the symptoms presented, and careful categorization often fails to 'label' more than 50% of illness presented to GPs by patients.

My own observations over nearly 40 years of doctor-watching have certainly convinced me that some doctors are naturally therapeutic and some are certainly not so. Until this matter is addressed and researched, I can see that using evidence-based medicine to inform practice will have mixed outcomes. It could be that a doctor, naturally therapeutic, following no protocols or guidelines, could nevertheless manage to influence consultation outcome more favourably than a poorly-communicating or psychologically-impaired doctor who slavishly applies the medical intervention decreed by the most advanced evidence base. I suspect that this is likely to be so. Surely we need to attend to those factors that influence 'therapeutic' power, other than evidence base that informs practice, if we are really to learn how to practice 'effective' health care.

I believe we need to be sure that all the evidence available to inform our practice is used, including those psychological components that seem to be absent from much of the literature presently generated by the evidence-based health care lobby.

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Teenagers' views on seeking contraceptive advice

Sir,

The paper by Donovan *et al*[1] highlights the difficulty that teenagers feel in seeking contraception advice from their general practice surgery, with only 159 of the 1074 responders indicating that their GP was their preferred source. I agree that it is important that consideration be given to enable teenagers to more readily attend the GP surgery for information and supply of contraception, including condoms. GPs are able to offer both sexual health and contraceptive information and advice, but are only able to prescribe oral or depot contraception or contraceptive devices in spite of repeated calls for a procedure to make condoms available.[2,3]

A number of unpublished reports and one published[4] report on GP distribution of condoms agree that, given staff training and support, GP surgeries are an appropriate setting for distributing condoms. However, cost–benefit analysis has suggested that they should only be available to those at high risk in sexual health terms.[5] It would seem appropriate that high risk should also include the newly and potentially sexually active patients.

In a pilot project in one health authority, 16 practices were supplied condoms, funded from an HIV/AIDS budget. Staff collected data about the consultation with 766 patients, to whom they distributed a total of 12 665 condoms. Half (52%) of the patients were aged under 25 years and 378 patients (49%) were being supplied with condoms for the first time, with nearly a quarter not using any form of contraception at the time.

Nearly half the men (47%) who received condoms in a GP consultation did so in a travel clinic, compared with only 8% of the women; nearly half the women (47%) received condoms in family planning consultations, compared with 22% of the men. Sixty-five per cent of the 20 patients under 16 years of age received condoms in a family planning consultation, compared with 44% among the patient group as a whole.

There is an indication that staff embarrassment must be overcome. Apart from during family planning consultations, staff found it easiest to raise the subject of condoms during travel clinics. However, anecdotal evidence from the nurses at the practices indicates that some found it difficult to initiate discussions about condoms unless the patient had done so. Further, in spite of being trained to do so, health professionals reported giving only 12% of patients a condom application demonstration.

Most evaluations of condom distribution through general practice have recommended that the projects should continue. There seems little reason for restricting the availability of the full range of contraceptive methods from general practice (still less if the availability of the condom as protection against sexually transmitted diseases is also considered). Taking into account the economic considerations, it may be necessary to limit the numbers distributed and to target potentially or newly sexually active and high-risk patients.

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References

1. Donovan C, Mellanby AR, Jacobson LD, *et al.* Teenagers' views on the general practice consultation and provision of contraception. *Br J Gen Pract* 1997; **47:** 715-718.
2. Kirby D. A little something for the HIV epidemic? General practitioners should be able to prescribe condoms on FP10s. *BMJ* 1991; **302:** 801-802.
3. Hall M, Barnett L, Melhuish C. Family planning services. *Br J Gen Pract* 1993; 43: 352.
4. Pengilley L, Kay R. Condom use and distribution from general practice - a study from Oxfordshire. *Br J Fam Planning* 1995; **20:** 108-111.
5. Hughes D, Morris S. The cost-effectiveness of condoms in the prevention of HIV infection in England and Wales: should condoms be available on prescription? *Journal of Health Service Research and Policy* 1996; **1:** 205-211.

Management of hypertension

Sir,

In the article by Fahey and Peters on interpractice variation in control of hypertension,[1] they mention that unknown confounding factors may be responsible for the correlation they observed, indicating that practices who controlled blood pressure well did so whatever guideline was used as a standard.

We agree with Smith and Clayton,[2] and suggest that an important factor may be the number of blood pressure recordings taken before hypertension is diagnosed and, consequently, whether true hypertension exists. All five guidelines quoted by Fahey and Peters recommend that more than two readings should be taken before diagnosis.

Table 1. Proportion of people diagnosed hypertensive after one or two readings (%).

Practices	1	2	3	4	5
1995	12/18 (66)	8/12 (66)	13/41 (32)	2/9 (22)	9/25 (32)
1996	6/11 (55)	8/13 (62)	7/22 (32)	7/12 (58)	12/30 (40)

In an audit of hypertension management in five inner-city practices, a significant proportion of those recorded as having hypertension and receiving medication had been diagnosed after only one or two blood pressure readings had been taken. Of 105 patients diagnosed with hypertension in 1995, 44 (42%) were diagnosed after only one or two readings. These findings were repeated for the audit period of 1996, with 40/88 (45%) having two or fewer recorded blood pressure readings. This mean figure disguises significant inter-practice variation (Table 1).

Consequently, blood pressure control may be excellent, but there may be some patients who do not necessarily have hypertension in the first instance.

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References

1. Fahey T, Peters TJ. Clinical guidelines and the management of hypertension: a between-practice and guideline comparison. *Br J Gen Pract* 1997; **47:** 729-730.
2. Smith TDW, Clayton D. Individual variation between general practitioners in labelling of hypertension. *BMJ* 1990; **300:** 74-75.

Primary care services for problem drug users

Sir,

Ann Deehan *et al* (November *Journal*) suggest that GPs are only minimally involved in the care of problem drug users, and that extra training would not even encourage them to increase this involvement.[1]

This conclusion seems to be supported by their data, derived from a questionnaire survey to which 52% of the 157 GPs in one London area responded. Geographically, service provision for problem drug users varies considerably throughout the UK. The same is true in London. In many areas, the level of GP involvement is considerably higher than Deehan *et al*'s data suggest.[2]

A recent London survey of over 200 female drug injectors, of whom 82% were recruited in the community rather than in treatment settings, showed three interesting things (Hunter GM, Judd A. Women injecting drug users in London: the extent and nature of their contact with drug and health services. Submitted to *Drug and Alcohol Review,* 1997). First, the majority of participants were in contact with services in relation to their drug use; secondly, among those who were not, lack of perceived need for services rather than a perception of service inaccessibility was cited as the principal reason; and thirdly, the main service used was general practice.

Outside London, the evidence suggests that GPs are the principal service providers in contact with problem drug users either through 'shared care' arrangements with specialist services or exclusively in primary care where these services don't exist.[3,4] A survey of 341 GPs in Manchester achieved a 79% response.[5] It showed a much higher level of contact between GPs and drug users than in Deehan *et al*'s study. Sixty-five per cent of GPs who responded stated a desire for extra training in this area.

Several things are clear. The first is that being prepared to work with problem drug users varies among GPs for a variety of reasons. Despite this, general practice is currently the mainstay of the service response to problem drug use throughout the UK and, because of the numbers involved, is likely to remain so. Apart from a perceived lack of specialist knowledge, a barrier to further GP involvement is probably scepticism as to the effectiveness of the interventions involved. Such evidence that exists derives almost exclusively from non-UK, non-primary care settings.[6] Clearly, this is a deficiency and points to an area where further work is needed.

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