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Watchful waiting in glue ear

Sir,
The brief report entitled 'Do GPs have the techniques for "watchful waiting" in glue ear?' by Dr Mark Huggard and his team at the MRC Institute of Hearing Research (March *Journal*), highlights a serious shortcoming in British general practice: a postal survey of 900 practices (711 respondents) revealed that an audiometer was used in only 43.3%.

Deafness is the second most common handicap (after mobility problems) and afflicts millions of our patients. We cannot begin to help them if we have no instrument to measure hearing loss, any more than we can manage blood pressure without a sphygmomanometer.

In January 1990, the council of the Royal College of General Practitioners approved a paper calling for the audiometer to be looked upon as a standard piece of equipment in every GPs' practice. The reasons why more than half of our practices still lack one probably includes cost, a deficiency of training, procrastination consequent on the hurly-burly of the day's work, and perhaps a degree of misplaced humility over the contribution general practice can make towards the problem of deafness. Suitable audiometers, however, cost in the region of one-third of the price of electrocardiograph (ECG) machines. Learning to record audiograms is no more challenging than learning to record ECGs, and the recordings take no more time. As well as being needed in the management of glue ear, audiograms are required to identify the growing problem of presbyacusis (more than one-third of patients over the age of 70 years are deaf enough to need a hearing aid), and in the counselling of patients with tinnitus.

Dr Haggard *et al* have provided us with a timely audit, let us hope we will come out better if and when the audit is repeated.

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Counselling

Sir,
I was interested to read the two papers on counselling in the *Journal* this month (March *Journal*).

Counselling is usually offered to patients in emotional states or with relationship problems that often resolve with time. Therefore, any assessment of treatment effect needs to be in the form of a comparative randomized controlled trial. Unfortunately, Baker *et al*[1] were merely recording the natural resolution of these emotional states, and it is impossible to relate this to any treatment effect of the counselling service they provided.

Harvey *et al*[2] present the results of a randomized controlled trial, which appears to show that GPs are as good as trained counsellors in their communication skills. Outcome was measured at baseline and after four months. This appears a relatively long time for the majority of minor emotional crises that present to GPs. By four months they have often been resolved.

Counselling may be more effective than 'placebo', but the difference is likely to be greater soon after the emotional crisis. With time, the differences would expect to diminish. Could not the outcome in future trials be measured at intervals over time rather than a single long-term outcome?

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Evidence-based consultation

Sir,
Toby Lipman's article on evidence-based consultation (February *Journal*: Back Pages) illustrates that using scientific evidence in medical care is a prerequisite to, and not a substitute for, the art of medical care. I have a few quibbles however. First, the New Zealand risk tables for heart disease are to be found at www.nzgg.org. and not at the address given in the article. Secondly, it is not accurate to say that '80% of children with earache settle without antibiotics in 2 to 7 days'. It is correct to say that, by 2 to 7 days after presentation, 80% will have no pain. This is not the same however, since many patients recover much more quickly: by 24 hours after presentation 60% of children will have no pain.

For those who are interested, an evidence-based patient information leaflet on throat infection is available on the Internet at www.nhantphd.demon.co.uk/tonsil.htm and I am developing a similar leaflet for acute otitis media.

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