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Patient removals from GPs' lists

Sir,
O'Reilly *et al* (October *Journal*)¹ report a much-needed description of the epidemiology of patients who have been removed from a general practitioner's (GP's) list. The authors do not, however, consider ethnicity of patients as a possible variable. It could be hypothesized that patients of South Asian origin would be more likely to be removed — judging by evidence from a postal survey of GPs in a northern industrial town with a large Asian population, which suggested more unfavourable attitudes towards Asian patients compared with non-Asians.² Asians were thought to require longer consultations, to be less compliant, and make excessive and inappropriate use of health services. Clearly, if Asian patients were to be removed more frequently than non-Asians, it would have serious implications for equity.

We report here, a preliminary analysis of data on patient removals collected by Leicestershire Health Authority over the six-month period from 1 April 1998 to 30 September 1998, using the same definitions of removed patients as O'Reilly *et al*.¹ Ethnicity was defined on the basis of surname/forename analysis.³ One-third of Leicestershire's population of approximately 900 000 live in the city of Leicester, and 23.7% of the city's population can be classified as South Asian on the basis of the 1991 Census (22.3% Indian, 1% Pakistani, and 0.4% Bangladeshi).⁴

Over the period studied, there were 408 removal events, 403 removed patients, and 207 removal decisions made by GPs. Over one-fifth 106/500 (21%) of Leicestershire GPs made a removal decision. On average, those GPs who removed patients made two removal decisions (range 1–18). Of the removal decisions, 145/207 (70%) were individual removals, 60/207 (29%) were household removals (more than one individual at the same

address), and 2/207 (1%) were nursing home removals. The most frequent age group for removal was 20–39 years (140/396, 35%); 207/403 (51%) of removals were male and 196/403 (49%) female. The majority of patients removed (327/403, 81%) lived in Leicester. The proportion of patients removed in Leicester who were South Asians (90/327) did not differ significantly from the proportion in the population (28% versus 24%; $\chi^2 = 2.11$; 1 df; $P = 0.15$).

We conclude that our preliminary analysis does not suggest that Asian patients are more likely to be removed from GPs' lists than non-Asian patients in Leicester area. What is now required is to move beyond epidemiological description and produce a more detailed understanding of the processes that lead to removal for all patients.

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Accident and emergency medicine

Sir,
Dr Judith Fisher is a primary care consultant working in an accident and emergency department (AED), and therefore it is unsurprising that she wishes to encourage patients with general practice-type problems to attend AEDs.¹ However, your readers should be aware that most accident and emergency consultants do not share this opinion.

In particular, AEDs should not treat general practice-type patients for the following reasons:

- Such patients are more accurately treated by GPs,
- Such patients are more economically treated by GPs,
- Such patients delay the treatment of true accident and emergency cases, and
- AEDs must reduce their workload if the present chaos in so many of these departments is to be abolished.

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Reference

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Tonics and chronic fatigue

Sir,

When I started as a GP, we acknowledged our patients' perceptions of lowered vitality and gave them a tonic, usually of iron (sometimes laced with a smidgen of strychnine) or vitamins. Then we were told by our masters that there was no rationale for prescribing tonics and, as they cost the NHS money, we were to stop doing so. Since that time, there seems to have been a rise in chronic fatigue, as well as antagonism against doctors by the fatigued, who return yet again and again for relief.

By declining to prescribe tonics, we reject the notion of a store of vitality that needs replenishing, deny patients the benefit of placebo, and risk giving them more expensive and debilitating products rather than not prescribing at all.

Vitality may be difficult to pinpoint, but it is as real as pain. It can be affected for good or ill by disease, medication, and life experiences, and it can be measured on an analogue scale, just as pain can, yet we choose to ignore it.

Tonics appear to have been dismissed without proper thought or trial, and our patients appear to be the worse for their absence and the thinking and concern that underlie their use. Maybe it is time for the whole matter to be reassessed?

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Forty-seven minutes a year for the patient

Sir,

Sir Professor Pereira Gray's editorial (December *Journal*)¹ omits two important considerations in his commentary on GP consultation time.

First, process elements should not stand alone but should always be related to the

resources that are consumed and, wherever possible, to the outcomes that are incurred. Measuring outcomes in the environment of primary care is fraught with difficulty, but an annual GP input of 47 minutes per year at a cost of £34² would seem a bit of a bargain.

Secondly, Sir Professor Pereira Gray's analysis continues to reflect the anachronistic perspective of the Royal College of General Practitioners, which continues to view primary care as GP-centric. A more pertinent title for the commentary would not be 'Forty-seven minutes a year for the patient from the GP', but 'Eighty-five minutes a year from the primary health care team'.

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Methadone prescribing in general practice

Sir,

I read with interest the article by Martin, Canavan, and Butler (October *Journal*)¹ in which they documented their experience of prescribing for drug users in general practice. Their conclusion that it is feasible supports previous publications,² although it was clearly costly in light of the time and loss of income it entailed.

Although some interesting points are raised, I do have some concerns regarding the interpretation of their findings.

First, the percentage of methadone users who became abstinent during the period under scrutiny is calculated as 34%. Other studies of detoxification also report high levels of initial success.³ Nevertheless, in Martin *et al*'s study, criteria for being labelled as 'drug free' mainly relied on the absence of any entries in the notes suggesting on-going drug use, even for patients who had moved away. Follow-up is notoriously difficult in this geographically mobile population,⁴ but a more rigorous method of assessment by the authors would have improved the accuracy of the figures

quoted.

Secondly, 41% of methadone users in this practice population were prescribed their medication in injectable form. As the authors themselves state, this is not generally recommended,⁵ and their finding that injecting patients are less likely to withdraw from drugs than those using oral preparations is in keeping with other studies.⁶ Another reason why prescribing intravenous methadone is not considered standard practice is the risk of diversion onto the street market. One justification given by the authors for continuing with their policy is that individuals using intravenous methadone are more likely to have a stable lifestyle (44% of injecting users compared with 5% of oral users). However, this leaves 56% of all the patients prescribed intravenous methadone that are not 'stable'. The risk of diversion therefore remains very real, particularly if the drug is not dispensed on a daily basis. This is an enormous worry for those involved in prescribing methadone, including GPs, and yet is not addressed at all by the authors. Perhaps Martin *et al*'s argument would be strengthened if evidence had been supplied that illicit use of intravenous methadone in Bedford had not risen in the decade under study.

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A decade of caring for drug users

Sir,

Martin *et al*'s report on treating drug dependent patients in general practice is heartening (*October Journal*).¹ It is a shame that the authorities do not reward such innovative and successful interventions with appropriate payment, encouragement, and replication elsewhere. Oral supervised methadone is well established as an effective management for heroin addiction.

Although it was obviously successful in numerous cases, the research evidence for injected methadone is still rudimentary. Like heroin prescription, it should probably be reserved for patients who have failed at standard treatments such as oral methadone or supported detoxification.

After 14 years of prescribing and dispensing methadone in our general practice in Sydney, we have found that oral methadone suits up to 90% of heroin injectors who present for treatment. There should be no arbitrary limits on daily doses (we use up to 350 mg daily; mean = 85 mg). It is normal practice in most jurisdictions for at least two doses per week (up to 7 in new or unstable patients) to be consumed under supervision. The use of non-supervised methadone may be effective in certain cases but this has not been demonstrated generally in the research literature. It omits a fundamental safeguard for compulsive drug users and also increases the possibility of drug diversion.

Oral methadone 'failures' should be candidates for studies of alternatives such as injected methadone, prescribed heroin, rapid detoxification, oral long-acting morphine, or other approaches. There is no reason for this to happen only in specialist units. A general practice with sufficient experience in dependency, as in this case, is perfectly capable of doing the same as, or even better than, existing dependency units.

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Relationship between new and return consultations and workload

Sir,

I read with interest John Bain's brief report, 'Relationship between new and return consultations and workload in general practice' (*December Journal*).¹

The author has shown a correlation between the ratio of new to return consultation with surgery hours, age of practitioners, and percentage of patients over the age of 65 years. However, the conclusions and reasons for such a correlation, which he discusses, are purely speculative, as is the assertion that GPs can simply reduce the number of return consultations by simply not asking people to come back.

His research does not control for casemix in that some GPs, particularly in large group practices, may be seeing more patients who have a clinical need to be asked to return; for example, because they are diabetic or have some other condition that requires medical input and monitoring on a regular basis. GPs may have particular expertise in this area, within practices; other doctors may more often deal with conditions that do not need to be reviewed. This may be because of the doctor's personal medical interests and specialism, or simply because of patient choice. Doctors who do not ask people to return may simply be unpopular doctors, which is why their consultations per week are lower. Patients may perceive that if they have a condition that requires ongoing support, they will see or return to another doctor in the practice.

There is no discussion of whether reviewing patients regularly is a necessary component of quality medical care, and there appears to be a bland assumption that all the doctors are seeing patients who have equal need.

While these findings are interesting, I do not think any useful conclusions about how to modulate demands for GP services can be drawn from them without significant further investigation.

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Simulated surgeries

Sir,

The letter from Allen and Evans (*October Journal*)¹ has been selective in the points answered from my original letter (*July Journal*).² No matter how they explain how the pass/fail decision is taken, this is still taken by the simulator and not a medically qualified person. I am surprised with their claim that a direct comparison with video is difficult. If both are measuring the same outcome, then such a comparison is essential, as any new method has to be compared with the benchmark.

The authors attempt to explain why sensitivity and specificity has not been looked at. If their method of simulated surgeries^{3,4} is to be used for summative assessment, then all candidates who are not competent must be detected by the method, and the number of false positives should be kept to a minimum.

Sensitivity and specificity are very important characteristics of an instrument used for summative assessment. Allen and Evans trivialized the importance of this, quoting our first publication;⁵ however, when the method became national, the methodology had a sensitivity of 99.7% in a cohort of 359,⁶ and it was the fully tested model that was accepted by the Joint Committee for Postgraduate Training in General Practice for summative assessment.

A persistent concern of the simulated surgery model is the fact that two consultations are ignored in the overall decision, and this does concern me from a safety point of view. Major errors can occur in both consultations and the candidate could still pass.

I admire the work that has been published about simulated surgeries; however, as the authors acknowledged in their paper,⁴ further work needs to be carried out. For its use as a summative tool, further work on sensitivity and specificity is essential, and a direct comparison with the current system mandatory.

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Follow-up of depression

Sir,

We read with interest the paper by van Weel-Baumgarten *et al* (October *Journal*),¹ which reported on the 'Ten year follow-up of depression after diagnosis in general practice'.

The authors have done a valuable work studying this relevant and frequently neglected problem. However, methodological issues always affect the studies in this field, and we would like to highlight some of the main problems that can arise from this fact.

From a practice list of about 12 000 patients in the Nijmegen region, a population of 386 depressive patients represents 3%. This figure is coherent with those found in previous studies reviewing medical records with diagnosis of mental disorders according to ICHPPC-2 criteria.² Furthermore, in the WHO *Psychological problems in general health care*, it has been shown that psychological problems (depression, anxiety-related) comprised only 5% of the presenting complaints.³ The prevalence of depression found in primary care when we study the sample with diagnostic instruments (structured interviews, questionnaires) is around 10%, and half this figure when the physician is asked for a diagnosis. For example, in the same WHO study,⁴ ICD-10 depression had a prevalence of 10.4% and only 39% of these were recognized as depressed by the primary care physician, and the patients with a diagnosis of depression in the medical records vary in great degree. Approximate figures could be about 10%, 5%, and 3% respectively among attenders.

As van Weel-Baumgarten *et al* noted, the false positive diagnoses are not a relevant problem. The main issue is the false negative diagnoses, since these could affect the generalization of the results. This is a very important methodological

problem, since some authors have suggested that undetected major depressive patients in primary care present poor outcomes.⁵

We agree with van Weel-Baumgarten *et al* in the conclusion, that necessity of treatments based largely on studies performed with referred patients should not be generalized to patients who have not been referred. We must add that it is also true that conclusions based on the outcome of depressive patients derived from medical registers should not be generalized to all depressive patients presenting in primary care.

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Implementing evidence-based medicine

Sir,

We were interested to read the recent paper on the implementation of evidence-based medicine in general practice by Salisbury *et al* (December *Journal*).¹

Since April 1998 we have been running a project to implement evidence-based medicine in 13 disease areas with 102 GPs in 26 practices in East Kent. We have

agreed and set standards in a number of disease areas including hypertension (a standard of 85% of hypertensives with blood pressure of 160/90 or better), the use of aspirin and warfarin in atrial fibrillation, and secondary prevention of myocardial infarction.

This is specifically an implementation project rather than a research project, and our aim is to improve standards of care. We are now nearly three-quarters of the way into the first year of the project, and signs are that practices are succeeding in meeting most, if not all, of the standards we have set, and that the project is providing a vehicle for the implementation of evidence-based medicine in general practice.

We are now working to extend the project to more practices in East Kent and hope to have about 60% participating by April 1999.

If any readers would like further details on our project, or progress so far, they should contact Derek Mitchell or Tony Snell, our medical adviser.

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Lipotrim diet in general practice

Sir,

I was interested to read Dr Molokhia's experiences with the Lipotrim diet (May *Journal*).¹ The same diet was introduced into our practice in 1994. Initial enthusiasm with impressive weight loss in some of the most obese patients was later tempered by caution following gradual return of weight over the following two years. All patients were offered full dietary advice on returning for the refeeding programme. Because of the amount of doctor and nurse time taken up with implementing the diet, after 1996, new patients were only taken on in exceptional circumstances.

At the first audit in 1996, 42 patients who had stayed on the diet for at least one

month were weighed. The average body mass index (BMI) reduction was 5.02. Average weight loss totalled 14 kgs. This compares with Dr Molokhia's results of 6.1 and 15 kg respectively after 12 months. Twenty-one (50%) of our patients had returned for the refeeding programme. Sixty per cent of these had put back on less than 6 kg in weight.

The second follow-up has just been completed. A computer search identified patients who had started on the Lipotrim diet in 1994–1995, and invitations were sent for re-weighing and further diet advice from the practice nurse.

The total number of patients starting the diet was 72, of which 58 (80.5%) completed the diet and 39 attended follow-up. The weights of these 39 patients were compared with their weight before starting the Lipotrim diet. Sixteen of the 39 patients had a similar weight from when they started, three had gained more than 6 kg, seven had lost 6 to 12 kg, and 13 had lost more than 12 kg.

It seems likely that the 19 patients who did not attend for follow-up did not sustain any significant weight loss. Given this bias, an average weight loss or BMI reduction in the attenders would be mis-

leading. Overall, 13 of the 58 patients completing the diet (25%) maintained a very significant weight loss. One patient was able to have a successful knee replacement after his BMI came down from 42 to 34.

Very low calorie diets such as Lipotrim can be useful for well-selected patients. They require a high degree of commitment and motivation from the patients and time-consuming support from nurses and GPs.

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