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Why aromatherapy works

In his editorial accompanying our systematic review of aromatherapy (June *Journal*),¹ Vickers² concludes that 'it is not of pressing scientific importance to know whether aromatherapy enhances the effects of massage, since the essential oils used in aromatherapy are not particularly toxic or expensive'. I believe that this statement is misleading, perhaps even unscientific. If massage therapy alone is effective, let's use it. If the addition of essential oils isn't, let's not use it. In many countries, e.g. continental Europe, massage therapy is entirely mainstream and covered by the health insurance systems. Aromatherapy, by contrast, is considered worldwide as a complementary or alternative therapy and has to be paid for privately; one session may cost around £40 and a course of treatment might include six to 10 sessions.

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In their recent systematic review of aromatherapy, Cooke and Ernst¹ acknowledge both the increase in its popularity and the need to establish evidence of effi-

cacy. Sadly, but unsurprisingly, they identified only small, poor quality studies and concluded that existing work is sufficiently flawed to prevent firm conclusions from being drawn. However, despite these reservations, five of the six studies included in this review reported positive effects of aromatherapy, albeit short-term, in reducing anxiety and increasing well-being. All of the included trials were undertaken in a hospital setting, often when patients were in a state of acute ill health; e.g. post-surgery² or in intensive care.³ Aromatherapy is often undertaken outside of such settings and should an effect be demonstrated for chronic diseases, then only a small benefit may be both clinically and financially important.

Surprisingly, the authors do not conclude that good quality research is required. However, this oversight is negligible compared with Vickers' editorial⁴ suggesting that we actually need less research. The systematic review is a research tool, aiming to summarise and appraise evidence in areas where the value of a technology or intervention is uncertain.⁵ Where such evaluations are unable to inform practice, the logical progression must surely be the development of research aiming to address this area of clinical uncertainty.

Vickers' statement that 'if massage is effective then aromatherapy — massage plus essential oils — is also effective' may appear logical, even if it has no evidence base. However, one of the goals of clinical research is to establish which elements of treatment regimens provide benefit. Many patients seek treatment from aromatherapists (both within the National Health Service [NHS] and privately) because aromatherapy is currently widely accepted as an alternative therapy. Therefore, the additional cost and effectiveness of aromatherapy is an important

issue to both patients and the NHS.

That large sample sizes would be needed to demonstrate a statistical effect is certainly no reason to avoid research in an area where evaluation is lacking and clinical activity increasing. That poor quality research benefits no-one is true. That underpowered research is of no value is more debatable. That aromatherapy probably reduces anxiety because it involves massage is also possibly true. To conclude from these points that we should not invest in a quality evaluation of an increasingly popular alternative therapy is a view that we must strongly disagree with.

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In response...

The letters of Ernst and Roberts *et al* merely re-emphasise the central arguments of my editorial.¹ Ernst characterises as 'unscientific' my assertion that research on aromatherapy is 'not of pressing scientific importance'. This is, of course, nonsense: it is one thing to set scientific priorities, quite another to be against further research in some abstract sense. Ernst also fails to distinguish between the overall costs of aromatherapy and its additional cost in comparison with massage. Roberts *et al* obviously take issue with my prioritisation of aromatherapy when they comment that its effectiveness is 'an important issue to both patients and the NHS'. This might be true. However, I seriously doubt that if you sat down a group of patients, doctors, nurses, researchers, and government officials and asked them what research we really need to help the NHS they would come up with: 'How much does the addition of essential oils enhance the effects of a massage?' Such a question might seem a pressing issue in the narrow world of complementary medicine; in the wider world of medical research, it barely registers.

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Creating a district diabetes register: input from primary and secondary care is necessary for success

We report our experience in creating a district diabetes register. Sixty-four of 65 general practices and all hospital diabetes clinics participated. Demographic data of people with diabetes was obtained from a clinic management database at one hospital clinic, appointment systems at other hospital diabetes clinics, and laboratory HbA^{1c} records. These were then grouped by general practice. This identified the people with diabetes from each practice that were known to the hospital clinic or laboratory. These lists were compared

with existing general practice diabetes registers. In case of uncertainty, case records were examined manually. People with gestational diabetes, impaired glucose tolerance, and those who had transferred out of the area or had deceased were excluded.

Complete data were available for 61 practices (population = 307 064). Results are displayed in Figure 1. Practice registers yielded 5185 individuals, of which 635 had not been identified from hospital sources. Hospital and laboratory sources alone would have missed 11.2% of the total target population and practice registers alone would have missed 8.2%. Individual practice registers included 28% to 100% of the target population. The sensitivity of practice registers for identifying known diabetes was 0.92 and the sensitivity of combined hospital and laboratory sources was 0.89 with a positive predictive value of 0.83. The prevalence of diabetes recorded was 1.84%.

Diabetes registers are invaluable for the delivery of healthcare for people with diabetes. Our data show that a combination of selected data sources spanning the primary and secondary sectors can be effectively used to create a district diabetes register. Various authors have reported their experiences in compiling a district diabetes register by aggregating general practice registers.¹⁻⁴ We show that this is clearly going to miss a significant number of individuals. The DARTs study from Tayside⁵ used sophisticated electronic record linkage of five sources of data to compile a diabetes register. Our results show that similar results can be achieved using simpler methodology and a smaller number of selected sources. The only directly comparable report in the literature is from Vaughan *et al*⁶ but the authors of that report do not mention the number of people with diabetes identified and the receded prevalence of diabetes, making it difficult to validate conclusions or make comparisons. The principles underlying our work are applicable elsewhere and should help in the compilation of comprehensive district diabetes registers in other districts.

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Why do some practices respond to an educational intervention?

In 1995, we conducted a trial of the ability of a nurse facilitator to promote screening for carriers of haemoglobin disorders in primary care.¹ We recruited and randomised 36 out of the 93 general practices that regularly sent screening requests to our laboratory. In 1996, the facilitator made an average of three educational outreach visits to each intervention practice. The main outcome measure was the number of screening requests from study practices. Requests from control practices remained unchanged, while requests from intervention practice doubled. Most of this increase occurred in three single-handed practices and in one practice with four partners.

There is little information on the sustainability of the effect of education outreach visits once a project has finished.² However, the system set up to extract data on screening request from the laboratory computer enables us to monitor the effects of the intervention in 1997 and 1998. There was no change in these years in the number of requests from the control group or from non-participating practices. Table 1 shows that some of the intervention practices maintained increased screening activity.

Can we explain the variation between practices? There were no obvious differences between responders and non-responders in intensity of contact with the

Table 1. Number of screening requests from each intervention practice, 1995–1998.

Practice number	1995 baseline	1996 intervention	1997	1998
1	46	94	68	72
2	41	112	141	129
3	26	84	150	45
4	24	73	94	94
5	35	60	45	36
6	38	46	58	67
7	33	38	29	18
8	13	18	18	8
9	12	9	21	25
10	10	27	21	26
11	10	10	2	0
12	4	9	14	12
13	3	7	0	0
Total	295	587	661	532

facilitator or in practice staff's knowledge of genetics. The surgery premises of the initially responding practices were in wards with 30% to 45% ethnic minority residents and a likely annual list 'turnover' of about 15%. The relatively low total numbers screened make it unlikely that these practices relaxed because they had finished screening the relevant groups. The facilitator believed that a sustained positive response depended on the active involvement of practice nurses, who had some autonomy, but worked closely with supportive general practitioners. An 'opinion leader' is important; screening activity decreased dramatically in Practice 3 when the senior partner retired.

Why did several practices not respond? The pressure for more randomised trials can create problems in primary care because the unit of randomisation for evaluation of practice-based interventions is usually the practice. This makes it difficult to avoid pressuring ambivalent practices to collaborate to achieve the sample size needed. There is some evidence that this occurred in this instance. There might have been a more uniformly positive response if we had only recruited practices where the project was supported by the whole primary care team and tailored the basic educational programme to the needs of each practice rather than relied on a standard package.

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MSD foundation leadership courses

For a number of years from the mid-1980s, a series of residential development courses for doctors with 'leadership potential' were held at various locations in the UK and Ireland. The courses were conceived and developed by Marshall Marinker together with a tutors group in which David Metcalfe, David Pendleton, and others played key roles. The venture was carried out in partnership with regional advisers throughout the UK and funded by the MSD Foundation.

Now, a decade on, we would like to reflect on the success of the initiative. However, unfortunately, we no longer have records of who took part in the courses. This letter is an invitation to those who did take part to write to let us know of their current whereabouts and to give us a short resumé on how their careers have developed. Any information on where to find others who were also course members would also be appreciated.

We then hope to carry out a simple survey of how members have progressed in the years after the courses and present an

overview of the impact of the initiative on individual participants and on the development on general practice locally, nationally, and internationally.

Please write with any information that might help to David Metcalfe or myself at one of the addresses below. Clearly, the fuller the list of participants that we can construct, the more sensitively will the result of our study reflect the range of opinions and our outcomes.

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Refugees, asylum seekers, and general practice

There is a real need for central co-ordination and exchange of experiences among primary care professionals working with asylum seekers (*July Journal*),¹ especially since the new arrangements for dispersal were introduced in April. GPs and trusts from Glasgow to Plymouth have contacted us for advice and it is obvious from their enquiries that wheels are being re-invented right across the country. However, national policies must recognise that much of the literature concerning refugee care looks at relatively well-established, homogenous groups with support from community organisations. New arrivals have different problems to face and their needs change over time.

The authors rightly point out that overcoming language barriers is a priority for local providers to address. Unfortunately, the reality in most provincial towns is that trained interpreters do not exist for every language encountered. In south-east Kent there are no qualified interpreters for three of the four principal languages spoken by our patients. GPs have to become more creative in communicating with asylum seekers. We use a range of written material that covers many common situations. Asylum seekers with good English have helped us in its production.

The authors point out some of the purposes of a primary care service for asylum seekers but fail to mention others that are of vital importance. It is essential that

services recognise that asylum seekers arrive in England with little understanding of the National Health Service. Asylum seekers need to know at an early stage what they can and cannot expect from the health service. They also need help to negotiate the complex bureaucracy that plagues access to its services.

Finally, health professionals must avoid indiscriminately applying a medical model to all the complaints, symptoms, and distress presented by these patients. The majority of refugees, including those who have experienced torture, are resourceful survivors of oppressive societies and not victims in need of specialist care.² We have been impressed by the therapeutic value of just listening while individuals tell their stories, even if this has to be done in broken English. Other interventions that we have found improve well-being include facilitating access to English language courses, getting children into school, and encouraging people to celebrate their own religious and national festivals together.

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Problems prescribing inhaler devices

Recently, patients have been presenting to the asthma clinic I run in a medical practice in Surrey complaining that their inhaler devices have been changed. Some were confused about how and when they should be using the 'new' device and some had just stopped taking their medication, putting themselves at risk and allowing asthma control to deteriorate. I wondered if this was happening because branded repeat prescriptions were being changed to generic as they were presented and that confusion was arising when choosing from the 'picking list' on our surgery computers.

As I was studying this list, I realised

that many of our patients had been given an Easi-Breathe inhaler instead of a Clickhaler. As a small research study, I telephoned seven pharmacies in the area at random and asked the pharmacists what inhaler they would give the patient if presented with a prescription for a Beclomethasone breath-activated powder inhaler. All but one said that they would give an Easi-Breathe, which is an aerosol, not a powder inhaler. Further investigation showed that this generic form of breath-activated powder inhaler did not present on the picking list on the computers in some of the pharmacies.

I contacted the pharmacist advisors attached to our primary care group (PCG) and further investigation by them showed that some pharmacy computers defaulted when the dry powder option was typed in, changing the prescription to Beclomethasone breath-activated and resulting in the patient incorrectly being given an Easi-Breathe. Steps have now been taken locally to highlight this problem and inform pharmacists in an attempt to ensure that this does not continue to happen. The computer companies concerned have also been contacted and are trying to rectify this mistake but this may take time.

When writing generic prescriptions for inhalers, confusion can arise between numbers of devices. Clickhalers, Autohalers, and Easi-Breathe are all devices that may be substituted in error. Some points highlighted by the PCG group are:

- If when writing a prescription the words 'Clickhaler' or 'Autohaler' appear, the prescription will be processed as a branded prescription but writing 'Asmabec' generically can cause the problems already discussed.
- To differentiate between Aerobec and Easi-Breathe: Aerobec needs to be prescribed by brand, as when written generically pharmacists will only be reimbursed for the cheaper product, the Easi-Breathe.
- Qvar should be prescribed by brand due to possible confusion around the dose adjustments required.
- The majority of these products can be prescribed generically but care is required when selecting the appropriate product.

Nurses running asthma/respiratory clinics take a great deal of time ensuring that the device chosen suits the patient and care is taken to ensure that patients can use their device correctly. The cost implications of patients being given incorrect

inhalers that are then used incorrectly or even discarded could be enormous. Patients' respiratory symptoms may also deteriorate, causing stress and discomfort and putting them at risk.

The number of inhaler devices on the market continues to increase and it gets ever more confusing for patients, pharmacists, and health professionals alike. The cost of good respiratory care continues to rise and those of us running clinics need to be aware of cost when prescribing. Every device has its pros and cons, and there is a place for them all, but using the cheapest inhaler device that suits the patient is good, sensible care. However, once the best device has been decided upon, and the patient taught how to use it, it is imperative that the correct device is prescribed and dispensed. Patient care must be our main priority.

Would it make sense if inhaler devices are exempt from the pressure of generic prescribing, at least until these problems are resolved? Until then, health professionals need to be aware of the problem and liaise with their local pharmacists to ensure that patients are receiving the correct device and the best care possible.

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Evidence-based medicine

The old adage that any publicity is good publicity means that I welcome David Kernick's paranoid attack on evidence-based medicine (EBM) (*August Journal*).¹ Central changes to health care provision seem to have come thick and fast over the past 16 years since I started in general practice. First, it was a swinging handbag approach, now the people making changes hide behind the initials of EBM, NICE, etc. as outlined by Kernick.

But the people working within these organisations are not the politicians making the changes. Certainly (as in any organisation) there may be a few who see their CBEs glowing in the faint distance and will toe the party line while massaging the data. But the ones I have met are all health care workers who believe that knowledge empowers the patient and the health professional, enabling better informed choices to be made. The art is

the sharing of that knowledge and the decision-making. The aim of EBM, Cochrane, Bandolier, etc. is the translation of research into usable, accessible knowledge. This work is (despite Kernick's implication) seriously underfunded and relies mainly on the enthusiasm of unpaid professionals working in what is laughingly called their spare time. They frequently question government guidelines (where is the evidence for influenza vaccination of everyone over 65 years of age? — we are told by the government that several studies have shown benefits but which, what did they show, etc.) and clash with authority.

Kernick has only uncovered the York–Oxford axis but I am afraid his paranoia has only led him a limited way into the labyrinth. This axis is only part of an international network of mostly unsupported individuals working to make knowledge explicit. This work often has the effect of limiting the knowledge to specific areas covered by the research. For example, rather than just accepting that drug X cures condition Y (drug company promotional material), the evidence-based knowledge may show that the research only demonstrated a marginal improvement in one endpoint (not necessarily of much importance to the patient sitting in front of me). At other times, the evidence-based knowledge may demonstrate that the cheap medicines are ineffective in comparison with the expensive.

But what about the guidelines Kernick mentions? With 27 kg of paper guidelines (2.2 kg from the cardiovascular NSF alone) I am not surprised that we are not following them. We have a massive implementation of expensive computer programmes to help with this. But these have been produced in total ignorance of an area Kernick did not attack. All of us in EBM, HIMPs, etc. have fallen into the same trap of believing that we know how knowledge should be provided. Yet we know almost nothing about how health professionals need or use knowledge during consultations. How many times did you need medical knowledge during your last surgery? What type of knowledge was used? What were you uncertain about? Until we answer the question of what knowledge we need and use during consultations, I believe that primary care will continue to largely ignore all the pieces of paper and computer information delivered (unasked for) to our desk.

I know what I want — answers to questions. A woman who comes to me on Thursday evening for the first time complaining of a breast lump wants to know what the chances are of it being cancer. I

tell her about fast access referral, etc. but she continues to ask how likely it is that the lump is a cancer. A common enough question but an answer was not found in the latest cancer guideline. It has taken a long time and much effort to track down that answer. What is the probability of a woman with UTI symptoms having a UTI? How does this probability change if a dipstick is negative? The list of questions generated each day is large. Some are important, some occur frequently. These are the ones I want answers to.

I don't want to wade through textbooks; I don't want to search through complicated systematic reviews; I certainly don't want Medline. What I want is simple, one-line answers with the strength of the evidence displayed so that I can then use this knowledge in the context of the patient in front of me. But that's my personal system. We are applying for funds to find out what you would want and need. Perhaps then Kernick will start to believe that what we are trying to do is help ourselves and others have access to the knowledge in a way that they/we would find useful — not to further our academic careers.

But meanwhile, I agree with Kernick, these are dangerous times. Trust no one; appraise the evidence for yourself; question the guidelines; and in the lowland swamps of primary care keep using the insect repellent of sceptical caution to subdue the irritating bites of political change.

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Slapped cheek is fifth disease: but what of the others?

In 1923, an epidemic of 'fourth disease' (Dukes–Filatov disease) was reported.¹ Thus, the commonly diagnosed fifth disease (erythema infectiosum, nicknamed 'slapped cheek') was not a randomly chosen starting point for the numeration of childhood exanthema (acute infections with associated rashes).

A literature search reveals that third dis-

ease (rubella) was the starting point for this categorisation, with sixth disease being roseola infantum and the suggestion for a seventh disease being Kawasaki's disease.^{2,3} As for the first and second disease, it is not known which came first, measles or scarlet fever. It would also be interesting to know if an eighth disease has been described.

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The continuing legacy of medicine of the Third Reich

I would like to draw the attention of your readers to some important issues that I was made aware of when attending the Sixth European Conference of the World Organisation of General Practice (WONCA) in Vienna in July this year.

The opening session, which was attended by international television and radio, dealt with 'The Continuing Legacy of Medicine of the Third Reich' and 'Lessons of the Holocaust'. Other issues, such as apartheid, euthanasia, doctors' involvement in the medicalisation of the death penalty in the USA, and rehabilitation of torture victims were also discussed. At the subsequent panel discussion, it was unanimously agreed that a working group should be set up to study the ethical issues of involving doctors in these horrors.

Of perhaps even greater concern to your readers will be the following facts. There is still continued use of the Pernkopf Atlas by Austrian medical students. The illustrations of this atlas are thought to be based on concentration camp victims with the original artists using SS symbols in their signatures.

There is also the unresolved case of Dr Heinrich Gross, an Austrian doctor accused of killing children in a Nazi euthanasia centre. Many of the brains removed from these children are still

standing in an Austrian anatomical museum and cannot be buried until the case of Dr Gross is finally concluded. He recently claimed inability to plead at a court case and subsequently walked free from this. He then gave a perfectly coherent interview to the media, delighting in the cases' outcome.

Finally, it is extremely sad that Professor Neugebauer, an Austrian who is looking into many of these unresolved 'medical issues', has recently had a case of defamation of character brought against him by Dr Jorg Haider, supported by the Austrian Minister of Justice.

I feel that your readers, as both doctors and European citizens, should be aware of some of these issues, about which I would be happy to supply further details.

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Travel agents' misleading health advice

Lawlor *et al*'s excellent paper on advice provided by travel agents (*July Journal*)¹ reinforces my view that their only aim is to sell as many holidays as possible. Last year, one of my patients was going to the Maldives on a direct flight package, arranged by one of the largest travel companies. The printed advice sent with the confirmation stated that protection was required for hepatitis A, polio, typhoid, and tetanus.

However, the company then covered every option by advising:

- Malaria tablets for a malaria-free area via a direct package flight. (If the package went via the Indian sub-continent malaria cover would be required.)
- Yellow fever — only necessary if arriving from a yellow fever zone.
- Meningitis — not required.
- Hepatitis B — only if in an at-risk group, mixing too intimately with the locals or travelling in the wilds.
- Hepatitis C — no such vaccine is available yet.
- Cholera — not available in the UK and not recommended anywhere by the World Health Organisation.

They could have included, totally unnecessarily, the Royal Flush of Rabies, Japanese Encephalitis, and anthrax. There was no mention of HIV prevention. No

wonder my patient was more worried about the vaccinations than the long air flight.

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Unresolved grief in young offenders in prison

The paper by Finlay and Jones (*July Journal*)¹ deals with an aspect of bereavement that is rarely examined. I have experience in this field, so offer these comments.

First, gaining access to bereaved offenders is not easy, even when the prison staff want to be helpful. This, I believe, is also the experience of Cruse and the Samaritans. Under the auspices of the Prison Chaplaincy Service, I have regularly visited a young offenders' institute since 1996. During that time, I have been asked to help 150 teenagers with severe bereavement problems, which may indicate the numbers needing help nationwide. Also, I have spoken to 100 consecutive new admissions during their induction period. Of these, 53 mentioned significant bereavements, mostly of friends who had died suddenly from RTAs, drugs, suicide, and murder. Fourteen deaths were from natural causes and among these were six parents: recollecting the deaths of their mothers appeared to be particularly disturbing.

Prisoners continue to experience bereavement while serving their sentence, probably more frequently than is the norm outside. Particularly hard to bear is a death associated with parenthood. Many teenage prisoners have children and are devastated if their child dies, or is stillborn, or if the girlfriend has the pregnancy aborted. These events are not uncommon, nor is the arrival of a 'Dear John' letter, itself a form of bereavement. Prison officers usually react sympathetically to these losses but there is little they can do to help and if the inmate is allowed to attend the funeral it is under escort and in handcuffs.

Initially, I was not prepared for the high incidence of bereavement that occurs in

prison nor the suddenness of the deaths. Some lads have to cope with multiple bereavements — the record was 12 verified deaths during an 18-month sentence — and cannot grieve normally in this restrictive environment. Crying tends to be debarred by a macho culture, an overt display of anger may end in the punishment block, and suicidal gestures are frequent.

Often the root cause of teenage imprisonment is loss by death or family breakdown. We are not handling these situations well and need to develop a better understanding of the ways bereavement affects the young. Little research has been done in this field. Could the primary care teams help?

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My GP doesn't know that I smoke

I read with interest the article by Wilson *et al* (*June Journal*)¹ comparing smoking data from a postal survey and GP records. They usefully draw attention to the difficulties in obtaining accurate data about smoking. However, I am not convinced by their arguments that GP data give an overestimate of smoking prevalence. Both their sources of data derive from patients' self-report, either to a questionnaire or to the GP, and both are likely to give underestimates because of smoking deception.

The issue of smoking deception needs much more attention. There is now a large literature on this, though, unfortunately, it is scattered through journals of epidemiology, health psychology, chest medicine, and so on. Many studies have been done comparing biochemical measures with self-report of smoking. There are always subjects who say they don't smoke but who test positive on the biochemical measure. Studies have shown, for instance, that self-reported ex-smokers have higher rates of deception than self-reported non-smokers² and that subjects undergoing a cessation intervention are more likely to misreport their smoking status than others under no pressure to quit.³

From another angle, Hatzianreou *et al*⁴ compared total self-reported cigarette consumption from national surveys in the USA with consumption data from cigarette excise taxes. The ratio of self-reported consumption to the excise tax estimate was 0.72. This under-reporting is partly explained by smokers under-reporting the number of cigarettes they consume and partly by smokers misrepresenting themselves as non-smokers.

We should recognise that self-report of smoking is a subject's own account of an addictive behaviour; we do not expect high reliability from addicts. For example, on an anecdotal level, one of the smoking cessation advisors in my district recently told us that his clients often ask about confidentiality because, as they say: "My GP doesn't know that I smoke."

Smoking deception introduces error into all kinds of studies. Its relevance for the practising GP, who is constantly urged to advise patients to stop smoking,⁵ is this: smokers who deny smoking cannot be reached by GP advice. Furthermore, I suspect that GPs' ambivalence about discussing smoking⁶ stems partly from the conscious or subconscious awareness that smokers may not be telling the truth.

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Dermatology-trained practice nurses

In their study, Kernick *et al* (July *Journal*)¹ concluded that their study was underpowered to detect a change of 50% in the dermatology life quality index (DLQI) by the intervention of a nurse-run clinic. They found a significant improvement in a patient-generated measure but were unable to show an improvement on a generic quality of life scale (the EuroQOL).

Guyatt *et al*² suggest that if a study shows no difference in health-related quality of life (HRQOL) when patients receive a treatment compared with a control intervention, clinicians should look for evidence that the instruments used have been able to detect small or medium sized effects in previous investigations. The DLQI was developed using responses from patients attending a hospital dermatology outpatient clinic who might be expected to be individuals more severely affected than in a community setting.³ It uses a scale that has a maximum of four gradations, which may not allow the 'minimal important difference'⁴ to be detected.

The patient-generated clinical measure appears to have been more sensitive in detecting these changes, strengthening the argument for incorporating individual patients' values into HRQOL tools.⁵ The psychological morbidity caused by skin disease (and psoriasis in particular) is often underestimated by health professionals.^{6,7} There were no psychological symptoms in the list of eight aspects of their skin condition from which patients chose three for the purposes of the study. In the qualitative responses, participants expressed embarrassment, fear about the future, and the effects of the treatments, suggesting that these are important components of their condition to them. The differences between the control group and those receiving the intervention might have been more statistically demonstrable if the psychological impact of the illness had been incorporated into the patient-generated clinical measure.

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Outpatient appointments

I welcome the recent introduction of a maximum two-week wait for an outpatient appointment for patients with suspected cancer and the accompanying referral guidelines.¹ However, I was surprised that the guidelines are expected to cover 90% of patients with cancer.

I have undertaken an audit of the electronic and paper notes of all patients with a diagnosis of colorectal cancer (CRC) registered with my practice from 1990 up to 1 April 2000. Thirty-six patients had this diagnosis. Nineteen patients were dead or had moved away and could not be included. Of the remaining 17 patients, nine (53%) fulfilled the current guidelines for urgent referral; in one case, the notes were unclear. All 17 patients were referred immediately on presentation.

There were seven patients who did not fulfil urgent referral criteria at the time of presentation. Two subsequently fulfilled the criteria at the time of referral but one was three months and the other 12 months after the initial presentation. Two of these seven patients were referred immediately and two within three months of presentation. Two of the seven patients not fulfilling current guidelines presented with rectal bleeding and one with altered bowel habit but as these patients were less than 60 years old they fell outside current guidelines.

It is difficult to draw conclusions from a small and retrospective audit such as this. The patients who died from CRC are more likely to have a more advanced stage of tumour² and, therefore, more likely to fulfil referral criteria. However, even if all the patients with incomplete data fulfilled

the current criteria, this would only comprise 81% (29/36) of the total. These guidelines present a paradox: early stage CRC tumours have the best prognosis,² yet to maintain reasonable sensitivity and specificity these guidelines are less likely to include early tumours. I hope that careful data collection is currently being undertaken of all patients referred to hospital with suspected CRC, both within and outside the two-week referral system. This will enable the refinement of these guidelines to ensure that more early-stage tumours are treated, leading to a reduction in mortality.

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Nursing home patients

Groom *et al* (June *Journal*)¹ present hypothesised costings for the workload generated by the care of nursing home residents. Using itemised costs published in 1997, they conclude that each patient creates work valued at £18.21 per month or £218.52 annually. They suggest that such figures may have a place in negotiating for greater reimbursement for the care of institutional patients. They also point out that unit costs are highly sensitive to the number of patients seen at each visit, which raises a question as to the comparative cost-effectiveness of a regular, proactive visiting service.

The East Cheshire Nursing Home Project (ECNHP) has been providing a salaried, supplementary service to the occupants of 417 beds in nine nursing homes since May 1998. Two GPs are employed to visit weekly and provide, proactively, all aspects of general medical services for four three-hour sessions each week (7.1% of time). Cover for the remaining 156 hours of the week is provided by the patients' registered GPs.

We examined the number of visits by the registered GPs of the residents of these nursing homes before and after the introduction of the ECNHP compared with

control homes in the same health authority matched for patient dependence. During a two-week period in January 1998, there were 78 visits to the subject homes, which fell to eight during the equivalent fortnight in 1999. During the same periods in the control homes, there was a smaller reduction in visits (286 versus 215). A chi-squared test confirmed that the reduction in visits was the result of the introduction of the ECNHP ($P<0.0005$). We conclude that this dedicated, supplementary service reduced the nursing home visit workload of registered GPs by 89.7%.

Visits were the largest component of expense in Groom *et al*'s study; we have no data on telephone calls, the other relevant component. Using the per capita costs calculated by Groom *et al*, the annual cost of visits alone to 417 patients would be £81665.28; a reduction of 89.7% equates to £73253.75.

The annual cost of the ECNHP, including the salaries of the GPs (paid at the BMA-negotiated employed non-principal rate) and all clerical costs, was £62000 in 1999. If figures such as those produced by Groom *et al* are to be the basis of negotiation for greater remuneration, a different model of care, such as a dedicated salaried service, may prove more cost-effective.

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Study did not show inequitable use of mental health care

Raine *et al* (August *Journal*)¹ found that GPs' decisions about mental health interventions can be influenced by non-clinical patient factors and concluded that the current practice may not be equitable. However, their analysis and interpretation of their results may not be correct.

In their analysis, the authors correctly stated that to develop a multivariate model with optimal predictive power less stringent criteria ($P<0.1$) are recommended for

adding variables to it. However, the normal criteria ($P<0.05$) rather than these less stringent criteria should be applied to conclude inequity of access. Hence, the P -value of 0.087 for ethnic group in the logistic regression models on GP intervention should be interpreted as statistically non-significant. Furthermore, as the authors carried out testing of 12 potential predictors, appropriate adjustments for multiple testing should have been made. Hence, the criteria for a result to be considered statistically significant would become even more stringent.

The authors found that GPs were more likely to intervene in the presence of a history of mental problems or life events in the last 12 months. This is quite understandable as patients with a history of mental problems or life events within the past year are at greater risk of developing further mental problems. Interventions (e.g. return appointment) targeted on these high-risk groups may well be appropriate preventative measures and do not necessarily represent inequitable use of mental health care. Mental health needs do not depend solely on the current GHQ scores. Past history and socioeconomic considerations can be equally important.

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