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Editor's note 409

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 should be sent to the *BJGP* office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Asymptomatic peripheral arterial occlusive disease and erection problems

We would like to report the association between peripheral arterial occlusive disease (PAOD) and perceived erection problems found in the Limburg PAOD study.¹

Intermittent claudication (IC), the first symptomatic stage of PAOD, is a common atherosclerotic condition among mostly elderly subjects. However, the majority of PAOD cases are asymptomatic.¹ Symptomatic PAOD is associated with organic impotence, particularly when the occlusion involves the aortoiliac vascular bed.² Data on the prevalence of erectile impairment in asymptomatic PAOD subjects are non-existent.

Our study population consisted of 3649 male subjects (47%) with a mean age of 59 years (range = 40 to 78 years), who were selected out of a group of 26 620 subjects from 18 general practice centres by means of a stratified sampling procedure. Strata were formed on the basis of the number of positive answers on a short postal screening questionnaire, concerning complaints on walking and cardiovascular risk.¹ PAOD was defined as an ankle-brachial pressure index (ABPI) <0.95, measured twice in the same leg with a one-week interval. The ABPI was calculated as the ratio of ankle systolic blood pressure to the highest arm systolic blood pressure, using a Doppler device. Reproducibility and diagnostic accuracy of Doppler ABPI measurements have been shown to be adequate.^{3,4} IC was assessed according to a modified version of the Rose questionnaire.^{1,5} Asymptomatic PAOD was defined as an ABPI <0.95 without IC complaints. In addition, data were collected on experienced erection problems, smoking habits, hypertension, diabetes, and hypercholesterolaemia.¹

Among male asymptomatic PAOD subjects, 44% (66 out of 150) reported

erection problems compared with 25% (358 out of 1405) among male subjects without PAOD. For claudicants, this number was 47% (41 out of 87).

Logistic regression analysis showed that experienced erection problems were significantly associated with asymptomatic PAOD (odds ratio = 1.6, 95% confidence interval 1.1–2.4), as well as with symptomatic PAOD (odds ratio = 1.6, 95% confidence interval 1.2–2.9), adjusted for higher age, smoking, diabetes, hypercholesterolaemia, and hypertension.

Our findings are consistent with the notion that subclinical atherosclerosis of the aorta and distal arteries (aortoiliac, penile, and testicular arteries) may result in penile ischaemia. In case of a patient complaining of erection problems, the general practitioner could perform a vascular physical examination including ABPI measurements and assessment of atherosclerotic risk factors. Positive findings raise the possibility of organic impotence. Conversely, in male subjects with asymptomatic or symptomatic PAOD, attention could be paid to the possible presence of erection problems.

JD HOOI

HEJH STOFFERS

JA KNOTTNERUS

PELM RINKENS

JW VAN REE

Research Institute for Extramural and Transmural Health Care (ExTra), and Department of General Practice, Universiteit Maastricht, The Netherlands.

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Dihydrocodeine — drug of use or misuse?

An increase in drug misuse in the United Kingdom has resulted in an increase in substitute prescribing by GPs. While methadone appears to be the most frequently prescribed substitute for the management of heroin misuse in Scotland,¹ there is evidence of a growing preference for dihydrocodeine (DHC) by general practitioners (GPs).^{2,3} GPs, who regard DHC as a safe alternative to methadone, may prescribe DHC to patients whose drug dependence is considered to be less severe than those in receipt of methadone. Another factor affecting their choice is the perception that DHC is less addictive than methadone.⁴ In addition, the prescription policy associated with this Class B drug may seem more favourable in that several days supply can be dispensed at the one time without supervision. There is no need for patient follow-up care or the administrative measures that are associated with methadone programmes.

The deaths we investigated revealed that over the years 1998 to 1999, there was an increase in the number of drug-related deaths involving primarily illicitly obtained dihydrocodeine and this is in contrast to a decline in deaths involving methadone. Dihydrocodeine-positive cases have risen from 4% of all accidental drug overdose cases in 1997 to 15% between 1998 and 1999. There was an observed decline in methadone-related

deaths, from 29% to 21%, over the same time period. Polydrug use was prevalent, with the most frequently detected drug being diazepam (80%) which was followed by morphine (59%), a breakdown product of heroin. Of all morphine-positive cases, 83% were also found to contain at least one benzodiazepine, making for a potentially lethal combination leading to acute respiratory depression and respiratory failure.

It can be speculated that an increase in DHC prescribing over the study period has resulted in increased availability on the streets. This, in turn, makes DHC a low cost analgesic which presently can be purchased on the streets of Glasgow for between 50 pence and £1.00 (personal communication, Strathclyde Police, 2000). Its use during periods of heroin deficit has been highlighted⁵ and confirmed during the spate of contaminated heroin deaths in Glasgow during the year 2000 (personal communication, Glasgow Drug Problem Service, 2000).

While in some aspects, DHC may appear to be a good alternative to that of methadone, its abuse potential should not be overlooked. The incidence of DHC detected in cases is a matter of concern and requires monitoring to establish if this is a 'real trend' or 'fashionable phase'.

ALISON SEYMOUR
MARJORIE BLACK
JOHN S OLIVER

Department of Forensic Medicine and Science, University of Glasgow, Glasgow G12 8QQ.

JANE JAY

Glasgow Drug Problem Service,
Glasgow G20 7LR.

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A comparison between patient consultation satisfaction scores from a trainer and registrar in a Nottinghamshire practice

Patients' agendas are often not fully addressed during the consultation.¹ This may lead to low levels of patient satisfaction with consultations, poor compliance, and poor outcome.² With experience, general practitioners (GPs) may be expected to become more adept at addressing these patient agendas and general practice registrars may be expected to demonstrate a lower level of patient satisfaction than their trainers.

We measured patient satisfaction with their consultations with a general practice registrar and trainer in a rural Nottinghamshire practice in 1996, using the Consultation Satisfaction Questionnaire (CSQ, Eli Lilly National Clinical Audit Centre).³ The practice had six-and-one-half partners and a list size of 12 000. A personal list system was not used, although patients were encouraged to see the same doctor for a single episode. The registrar was in the third training month and the trainer was a principal with over 10 years' experience.

The criteria were defined with reference to a large study of CSQ results in 126 GPs.⁴ The CSQ has four sub-scales and the audit standards were defined as an 80% general satisfaction with the quality of consultations, 82% with professional care, 73% with depth of relationship, and 72% with perceived time.

Consecutive adult patients and younger patients accompanied by adults were asked to complete the CSQ immediately after their consultation until 75 questionnaires were available for each doctor, and to give freetext comments.

The trainer and trainee differed significantly only in respect of general satisfac-

tion (Table 1). However, the range of satisfaction scores was greater for the trainee. These findings suggest that patients may not discriminate between doctors on the basis of clinical skill. Instead, they may value characteristics such as empathy, the ability to listen, and an appreciation of their point of view. The free text comments suggested that longer consultations and shorter waiting times were important to patients.

ANDREW MARTYN THORNETT

Department of Psychiatry, University of Southampton, Royal South Hants Hospital, Southampton SO40 8XP. E-mail: eanador@soton.ac.uk

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Natural history of lower respiratory tract illness

Holmes *et al*¹ present pertinent observational data on the prolonged natural history of lower respiratory tract illness (LRTi) in the community, with or without antibiotic treatment, an important message for all general practitioners (GPs). The paper and the accompanying editorial² assume that antibiotics are inappropriate for many patients presenting in this way, although both recognise the dif-

Table 1. CSQ satisfaction scores for the GP trainer and GP registrar compared with the audit standard (standard deviation in brackets).

	Mean score for GP registrar (%)	Mean score for GP trainer (%)	Student's t-test/ANOVA P-value (trainer/trainee comparison)
General satisfaction	75.6 (16.9)	82.2 (13.5)	0.022
Professional care	79.6 (13.6)	79.3 (10.5)	0.910
Depth of relationship	63.6 (15.5)	68.7 (13.9)	0.072
Perceived time	66.5 (20.2)	71.1 (17.0)	0.180

faculty in detecting those who will benefit from treatment.

Antibiotic prescription rates of 70% in general practice are still typically observed for LRTi,³ in spite of educational initiatives directed towards reducing GP prescribing,⁴ and GPs usage of antibiotics in LRTi is sometimes portrayed as being irrational and retrogressive.⁵ Interestingly, even Macfarlane and Holmes' Community Respiratory Infection Interest Group, as well informed as any GPs, believed antibiotics to be definitely indicated in 64% of the patients given them. There seems to be a discrepancy between the frequently aired specialist directives to GPs on antibiotic usage in LRTi⁴ and the daily practice of most GPs.

I would suggest that there are understandable and rational reasons why we do prescribe for many patients and that these pragmatic reasons are related to areas of academic uncertainty. In general, GPs are keen not to under-treat or miss serious respiratory tract infections, such as community-acquired pneumonia (CAP), and also want to help their patients to recover quickly, even from minor and self-limiting illness. These two wishes reflect areas where real academic uncertainty exists and where unequivocal evidence to inform decision making does not; first in the clinical diagnosis of CAP, and secondly the effect of treatment on the speed of resolution of self-limiting LRTi.

The recently reported audit of deaths from CAP in previously healthy young adults⁶ revealed that the primary care management of these patients at the severest end of the LRTi spectrum was deficient in many cases — three quarters of patients had seen their GP for the illness without a correct diagnosis having been made and few had received antibiotics prior to admission. Macfarlane *et al* have shown that CAP may be difficult to diagnose on clinical grounds alone⁷ and that GPs are understandably reluctant to under-treat a condition with appreciable morbidity and mortality.

General practitioners are under pressure from patients who feel ill to help them recover quickly, even in self-limiting conditions. The evidence for whether or not antibiotics will help them do this in LRTi is currently inadequate,⁸ with different systematic reviews of the randomised controlled trials comparing antibiotics with placebo reaching contradictory conclusions.^{9,10} The Cochrane analysis does however conclude that 'antibiotics have

some beneficial effects in acute bronchitis'⁹ and recommends further studies. Worries about emerging antimicrobial resistance in common pathogens⁴ encourage the responsible use of antibiotics but the balance of risk and benefit to the individual symptomatic patient, and to the wider community, is as yet unclear. We need to quantify what, if any, are the clinically relevant improvements produced by antibiotics and to understand better the currently hazy area of the emergence and spread on antimicrobial resistance in the community.

The uncertainties facing GPs in LRTi are complex and multi-faceted, but are underpinned by an inadequate evidence base. Quality observational studies, such as this, certainly help to bring clarity into this confused area but, as indicated by Verheij,² adequately powered prospective randomised controlled trials conducted in real-world primary care settings are indeed needed to clarify everyday clinical decision making.

MIKE THOMAS

Clinical Research Fellow, Department of General Practice, University of Aberdeen.
E-mail: MikeThomas@doctors.org.uk

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Holmes *et al* confirm once again that coughs are benign and general practitioners (GPs) often prescribe antibiotics for no logical reason.¹ However, I refute their assertion that familiarity with the natural history of lower respiratory infection (LRTi) would overcome their lack of confidence.

The problem lies with the fact that these presenting symptoms and signs are the same as those with community-acquired pneumonia (CAP) and mycoplasma, etc. So one can only be confident of the natural history of LRTi if that is definitely the diagnosis.

Following a complaint about a missed diagnosis of CAP, I recently searched the literature to ascertain the natural history of this condition. I found that the presence of physical signs early on is rare. Furthermore, the presenting symptoms were often just cough, pyrexia, and poor appetite.

So, future research into managing LRTi, to inspire the confidence of GPs and their patients, should answer the following questions:

- How can one distinguish which apparent LRTi will progress to CAP?
- When should you consider further investigation, such as chest X-ray, for persistent cough?
- When should antibiotics be considered to prevent the progress to CAP or possibly just used to treat symptomatic mycoplasma infections?

I look forward to reading the relevant evidence.

RICHARD GALLOW

The Surgery, Parkwood Drive, Hemel Hempstead, Herts HP1 2LD.

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Diabetes care in Flanders

We read, with much interest, the paper by Mary Pierce, *et al* in the July 2000 *Journal*, entitled 'A survey of diabetes

care in general practice in England and Wales'.¹ The article described both the involvement of general practitioners (GPs) and the prevalence of some key features of diabetes care, such as protected time for diabetes care, disease registers, practice nurses with some knowledge of diabetes, and written management protocols agreed with local diabetologists. The results are very interesting: registers of patients were almost universal; in three-quarters of practices the register was fully computerised, indicating the potential for recording continuous, population-based data. The study also showed that clinics are the most common method of providing diabetes care in general practice, where most of the literature on 'best practice' assumes a clinic-based model.

Together with a fully voluntary continued medical education project for GPs on diabetes care, local discussion groups in Flanders produced a diabetes care audit (article in preparation). A total of 206 GPs (49.73%) responded to a postal questionnaire. All of the responders are working without practice nurses or any other official help. Only one-third of these GPs are fully computerised and only one quarter use any method of 'flagging' for quickly recognising diabetes patients in the practice files. One GP in two has not taken the opportunity to record lists of treatments, biomedical values (such as HbA_{1c} or body mass index), nor have they produced screening results to prevent early or delayed complications. Therefore it is perhaps understandable that there is no potential for recording continuous, population-based data and the consecutive recall of patients for review, nor is there any programme of quality assurance that could use this valuable regional data. There are also remarkable differences in the education of diabetes patients: two thirds of all GPs never, or rarely, use specific materials, such as posters or leaflets, for their educational tasks and only 2.9% work together systematically with a nurse for educational tasks. Owing to a lack of management protocols, as well as the absence of organisation of care, Belgian GPs and other care providers experience many barriers in their cooperation.² Other research about primary care for type II diabetes patients in Flanders confirms the findings that the process and outcome are not of guideline level.^{4,5}

Belgium has a very liberal health care system in which the patient freely

decides his or her care provider and can switch without any constraints from one echelon to another. Despite the apparent lack in organisation of care, Belgian patients claim to be satisfied. Despite the high standard of care outlined in the British National Health Service report described in Pierce *et al*'s study, we are aware of the problems of daunting waiting lists and the general discontent experienced among British patients. The advantages of both systems, a structured care with smooth access to second- and third-line care without extensive waiting lists, could make advanced diabetes care possible.

J WENS

P VAN ROYEN

J DENEKENS

Centre for Family Practice,
University of Antwerp, Belgium.

F NOBELS

Department of Endocrinology,
OLV Hospital, Aalst, Belgium.

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Is menstruation obsolete?

*Is Menstruation Obsolete?*¹ aims to challenge the pervasive belief that recurrent menstruation is physiologically necessary to the health of women. In her review, Ann McPherson states that it 'really polarises the issue' between the two extremes — 'naturalists', who feel there should be no unnecessary tampering with women's normal functioning, and those who believe medicine should, where possible, eliminate any adverse effects.² The question is whether the problem lies with the intentionally

provocative case put forward in the book, or with one (or both) of the 'extreme' positions.

The authors acknowledge that menstruation retains profound cultural significance, but observe that this is based on traditional but flawed understandings, by both lay women and clinicians, that recurrent periods are 'natural'. The book aims to achieve the first stage in a paradigm shift, by providing for women themselves, as well as for health professionals, both an evolutionary overview and up-to-date scientific information.

Even if it is accepted that periods are inessential to health, it does not necessarily follow that medicine should strive to eliminate them. However, neither need it any longer strive to preserve them. For example, 40 years ago the new oral contraceptive regimen specified a pill-free week (and withdrawal bleed) to mimic the 'natural' cycle, and this has remained the standard regimen. Very few of the 100 million women worldwide who use oral contraception realise that they could take it continuously and avoid periods altogether. For those with fragile blood-iron status this would provide health advantages. For all these women there could be financial, environmental, and lifestyle advantages. Why does this remain 'one of the best kept medical secrets'?³

Among women of reproductive age in the United Kingdom, menstrual problems are a frequent reason for consultation with the general practitioner (GP)⁴ and provide one of the most commonly encountered reasons for referral to hospital clinic. The most effective treatments for menstrual complaint eliminate periods medically or surgically and, in the majority of cases, these are offered in the absence of any diagnosis of pathology. Yet this does not polarise medical opinion. Is context the key: clinical management decisions rather than women's informed choices about menstruating unnecessarily?

If a GP prescribes oral contraception and the woman asks whether it is alright to take the pills continuously, what should the reply be? If you have no ready answer to hand, this book provides a good start,¹ wherein thought-provoking arguments are marshalled in support of the authors' thesis. Alternatively, Kaunitz addresses similar issues in a biomedical paper.⁵

PAMELA WARNER

Public Health Sciences, University of Edinburgh Medical School, Teviot Place, Edinburgh EH8 9AG.

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MMR vaccination uptake in a rural setting

We read with interest the article in December's *Journal* from the University of Birmingham.¹ We have also undertaken a study of MMR uptake, but in the rural setting of Herefordshire. Our coverage rates for the first MMR vaccine by 24 months were 86.5%, compared with a regional average of 88.9% (1998-1999 figures), and similarly we are concerned about the potential for a resurgence of measles.

Our study was also a questionnaire survey but was aimed at a one-year cohort of parents who had not had their child immunised against measles, mumps, and rubella. A total of 164 questionnaires were sent (with a stamped, addressed envelope), followed by a second mailing and telephone follow up for non-responders. A total of 71 (43%) parents responded and a further seven replied but were not prepared to complete the questionnaire. A high proportion of telephone numbers were unavailable — either with no telephone or ex-directory.

Parental perception of the severity of these illnesses was an important factor influencing their decision: 21% felt that the diseases were not serious. However, concerns over vaccine safety (particularly the reports on an association with Crohn's disease and autism), were the major factors which dissuaded parents from having their child immunised (68%). A figure of 69% cited the media — television, newspapers, and the internet — as sources of information on vaccination. Most parents also consulted a health

professional, either a general practitioner (GP) or health visitor, providing an opportunity for balanced information to be given.

Another important factor was the feeling among parents that information from the government and health professionals was unreliable and biased. Distrust in official literature arose from previous health scares, such as the BSE crisis, and the knowledge that GPs receive target payments for attaining certain coverage rates.

Interestingly, given our rural location, transport and access to the surgery were not cited as important factors by those who responded (4% and 10% respectively).

Given these findings, health education could potentially improve knowledge about disease severity, but the majority of parents fail to vaccinate due to safety concerns. There was a widely held perception that separate vaccinations were safer, with 28% suggesting that the availability of these would have influenced the decision to vaccinate.

The relatively low response rate to the questionnaire, with the associated potential for the introduction of bias, means that the findings are of limited value. However, they reinforce the magnitude of the task facing all health professionals in the promotion of the MMR vaccine.

A JOHNSON
E V JOYNES

Department of Public Health,
Herefordshire Health Authority, Hereford.

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Alcohol abuse — common or garden?

Webster-Harrison *et al's* study in the March 2001 *Journal*¹ reveals that a knowledge and skills gap exists in the delivery of effective advice on alcohol-related issues. I believe the situation is complicated still further by an increasing body of research that demonstrates many health care professionals, who are well placed to set an example for safer intake of alcohol, suffer from high levels of drinking dependence.^{2,4} Taken together,

this has the potential of compromising health promotion messages relayed to patients in order to lead to improvements in health gain.

I conducted a survey among health care professionals and 'health care professionals in the making' in inner-London teaching practices to elicit information on their alcohol consumption and its effects on their ability in the workplace. A questionnaire was completed by a total of 204 responders, comprising 40 student nurses, 62 medical students, 43 qualified nurses, and 59 junior and qualified doctors. While a higher proportion of responders (82%) reported they were aware of recommended safe drinking for men and women than in Webster-Harrison *et al's* study, 34% of men and 9% of women, nevertheless, stated they regularly drank in excess of their respective safe alcohol levels. Excessive drinking was not confined to medical and nursing students alone. A significant minority ($n = 9$) of qualified nurses and doctors reported drinking in excess of 35 units of alcohol per week.

Responders were asked to rate the effect of their alcohol consumption on their professional capabilities in the workplace. Overall, 42% ($P < 0.05$) of health care professionals, nursing, and medical students reported they had turned up to work, on at least one occasion, hung over from the previous night's drinking. While no responders admitted that they were responsible for major errors associated with their alcohol consumption, a different, although more subjective, picture emerged when they were asked to rate their colleagues' professional performance. Responders reported that they observed a total of 81 instances where alcohol had moderately or dangerously affected qualified nurses' or junior and qualified doctors' performance.

Historically, doctors were once heavy smokers but evidence confirmed a causal link between tobacco consumption and mortality. Their action has now been successful in influencing their patients' smoking behaviour.⁵ Although many health care professionals are aware that they are doing harm to themselves, and possibly others, by drinking too much, it is evident that a number are still no wiser than the rest of the population. In the meantime, *The Health of the Nation* targets⁶ will remain elusive.

JONATHAN KOFFMAN

Department of Palliative Care and Policy, Guy's, King's and St Thomas's Schools of Medicine, New Medical School, Bessemer Road, London SE5 9PJ.

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The executive partner in general practice

A high premium is being placed on leadership in NHS organisations, yet leadership and management arrangements in general practice partnerships have rarely been studied. In 1987 Atkinson emphasised the importance of clear management structures in general practice and suggested the idea of an 'executive partner' who would lead the practice by managing change and facilitating team development.¹ We have recently carried out a postal survey of practice managers in all 73 practices in our health authority district, in the urban North-East of England, to determine whether practices had an executive partner.

Forty-six managers (63%) responded, of whom 24 (58%) had an executive partner. Fifteen of the executive partners were also senior partners but only six of these were judged by the practice manager to be the partner with the best management skills. Only half the executive partners were felt to have clearly defined responsibilities and less than half (44%) had any protected time to carry these out. In the 22 non-executive partner practices, business meetings were the most favoured method for making decisions. Different partners often took responsibility for specific areas, such as finance, computing, education, and personnel. Overall, 32 (69%) managers thought their practice's systems worked very well or

exceptionally well. Managers who felt their practices were functioning sub-optimally raised a series of issues in free text comments, such as the lack of regular partners' meetings or any autonomy in making decisions.

This small study provides some evidence that general partnerships have effective management structures, as judged by their practice managers. There is some conflict between the non-hierarchical structure that underpins most GP partnerships and the need for visionary leadership in organisations as they become more complex. Our findings reflect this, showing that many practices recognise the value of leadership but do not provide protected time for the executive partner to carry out the role, nor do they necessarily give this responsibility to the partner most skilled in this area. Leadership development is a priority in the NHS Plan and effective leadership has been identified as one of the key component processes of clinical governance in primary care.² There is an urgent need for further research to identify which models of leadership are likely to be effective, both within practices and in the new and larger groupings, such as primary care trusts.

DI JELLEY

TIM VAN ZWANENBERG

Collingwood Surgery, Hawkey's Lane, North Shields, Tyne and Wear NE29 0SF.

References

1. Atkinson CJ. The Executive Partner. *Br J Gen Pract* 1987; **37**: 183-194.
2. Harrison J. Developing Leaders. In: Van Zwanenberg T, Harrison J (eds). *Clinical governance in primary care*. Oxford: Radcliffe Medical Press, 1999.

Editor's note

We have received several letters in relation to the editorial¹ and articles^{2,3} on identifying patients with alcohol problems published in the March *Journal*. One found an error in the calculation for the units in a bottle of wine, but this was because the volume was shown as 70cl, not the correct one of 75cl. Others took us to task for not publishing the questionnaire found to be most reliable. Of course we should have included it, and thanks to the correspondents for pointing it out. For interpretation of patients' scores, readers are referred to the paper by Bush *et al.*⁴. Here is the questionnaire:

AUDIT-C questionnaire (maximum score = 12)

1. How often do you have a drink containing alcohol?
 - (0) Never
 - (1) Monthly or less
 - (2) Two to four times a month
 - (3) Two to three times a week
 - (4) Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
 - (0) 1 or 2
 - (1) 3 or 4
 - (2) 5 or 6
 - (3) 7 to 9
 - (4) 10 or more
3. How often do you have six or more drinks on one occasion?
 - (0) Never
 - (1) Less than monthly
 - (2) Monthly
 - (3) Weekly
 - (4) Daily or almost daily

References

1. Wallace P. Patients with alcohol problems — simple questioning is the key to effective identification and management. *Br J Gen Pract* 2001; **51**: 172-173.
2. Aertgeerts B, Buntinx F, Ansoms S, Fevery J. Screening properties of questionnaires and laboratory tests for the detection of alcohol abuse or dependence in a general practice population. *Br J Gen Pract* 2001; **51**: 206-217.
3. Webster-Harrison PJ, Barton AG, Barton SM, Anderson SD. General practitioners' and practice nurses' knowledge of how much patients should and do drink. *Br J Gen Pract* 2001; **51**: 218-220.
4. Bush K, Kivlahan DR, McDonell MB, *et al.* The AUDIT alcohol consumption questions (AUDIT-C). An effective brief screening test for problem drinking. *Arch Intern Med* 1998; **158**: 1789-1795.