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Hereditary haemochromatosis

The May issue of the *BJGP* made my mouth fall open with disbelief. What was the leading article about?¹ The latest NSF? The GPC resignation ballot? The Shipman inquiry? The recent spate of TB outbreaks? The RCGP's ideas about GP specialists and intermediate care? 24/48 hour access? NICE and the relevance of its guidance to Primary Care? What to do with your free copy of *Clinical Evidence*?

No. It was about hereditary haemochromatosis.

Is it any wonder so many ordinary GPs think their College is located in another galaxy, rather than London.

Get a grip.

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- Emery J, Rose P. Hereditary haemochromatosis: never seen a case? *Br J Gen Pract* 2001; **51**: 347-348.

Editor's response

As Editor, the only option is to take it on the chin. However, criticism of the College is, in this instance, misplaced. Since the College guarantees editorial freedom, failure to address such issues, many of which are being actively debated within the College, rests squarely with the *BJGP*.

General practitioner's awareness of colorectal cancer: has referral improved?

To assess the accuracy of general practitioner's (GPs') diagnosis of colorectal carcinomas we reviewed the records of 152 patients with proven carcinoma treated at Peterborough Hospitals NHS Trust from 1988-1993. These results were compared with those similarly treated in 1978-1988.

Of 102 patients with left-sided tumours, 44% were not diagnosed by the GP at the time of referral in 1988-1993. This is compared with 30% in 1978-1988. Of the 50 patients with right-sided tumours, 48% were not suspected of having colonic tumours in 1988-1993, compared with 13% in 1978-1988. The main reason for this increased proportion of patients not diagnosed was owing to the much greater number of all GP referral letters sent without any implied diagnosis: 24% in 1988-1993, compared with 4% in 1978-1988.

Of the 83 patients referred with a diagnosis of cancer, 62% were seen within two weeks and 89% within four weeks. Of those referred without a diagnosis of cancer, only 34% were seen within two weeks and 72% within four weeks.

Rectal examination at the specialist outpatients showed palpable tumours in 50 patients, 38 (76%) of which were palpated by the GP. Three easily palpable low-lying tumours were referred with no digital rectal examination.

This study demonstrates the difficulties for GPs in making a diagnosis of cancer: 24% of our cancer patients were referred without this diagnosis being implied in the letter. Despite the fact that most patients have had a rectal examination (a documented 94% compared with 78% 10 years ago) GPs

are now less likely to make a confident diagnosis, leading to delay in specialist assessment. This has now become more pertinent with the institution of the two-week target for patients strongly suspected of having colorectal cancer.

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NHS Direct

We would like to highlight our concern about the lack of quality research that has been undertaken around the introduction of NHS Direct (NHSD).¹ Apart from one quantitative study,² little work has been published on NHSD and on its effect on primary care. Many crucial questions remain unanswered, such as the opinions and attitude towards NHSD of primary care staff and their patients. We therefore carried out a small qualitative study involving staff and patients in a five-partner, inner-city general practice aiming to explore these perceptions.

Semi-structured interviews ($n = 20$), a structured questionnaire ($n = 171$), a discussion group, and opportunistic methods ($n = 87$) were all used for data collection. The study was carried out in early 2001, four months after NHSD went live in Teesside.

Our results highlighted several important issues. There was a major issue of publicity; only a small minority of patients had heard of NHS Direct when either questioned directly (8%) or asked via the questionnaire (25%). The few patients who had used the service were happy with the advice

they had been given. Interestingly, three-quarters of those who had never heard of NHSD said they would use the service in the future if they had more information.

The interviews brought about several key areas as to the attitudes of health professionals towards NHSD. The major recurring themes that arose from the general practitioners were the apparent lack of evidence supporting the service, the inadequate integration of NHSD with current primary care services, and concern over the cost-effectiveness of NHSD. Health professionals, administrative staff, and patients all made comments about the lack of information about NHSD.

NHSD appears to be a service that may be used by the majority of patients if more information were made available. However, the health professionals have grave concerns regarding the evidence base and the relative cost-effectiveness of such a service. Our study has highlighted areas of NHSD that are important to the health professional and the public. Further qualitative study must be carried out on a wider scale to aid and analyse the development of NHSD.

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Bicycle parking

I was interested to read Herxheimer's comments on bicycle parking (April *BJGP*, page 315). He will be pleased to learn that, at our purpose-built premises (1998), we have two such 'inverted U' bicycle racks.

As yet, I have not seen the racks used for securing bicycles but they do provide an excellent restraint to tie the dog to while popping down to the doc-

tors during morning walkies. Perhaps, inadvertently, we are improving the health of our patients with this facility after all.

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Specialist outreach in the NHS

Three issues are of prime importance in considering specialist outreach. They are casemix, skill transfer, and equity. The paper by Bowling *et al* (April *BJGP*) is welcome and timely.¹ It gives answers to questions about satisfaction and access. However, it has little to say about casemix, skill transfer, and equity.

Casemix is likely to influence the site of specialist assessment and also the discharge rate and cost of new referrals. First, speed of access to a specialist (limited where specialist outreach is only monthly) is the chief issue in the diagnosis of malignancy or acute major illness. It is likely to require central booking and probably also assessment at the centre. It is therefore probable that the majority of malignant or acute major illness will be seen in hospital. If this is the case then it would hardly be surprising if discharge from hospital clinics was later overall than discharge from specialist outreach clinics. The influence of casemix will vary between specialties but there is no other characteristic of referral more likely to lead to differences between central and outreach referrals. Secondly, advice on long-term management is less likely to be urgent, and it is particularly appropriate to specialist outreach because of the potential benefit from 'local' communication between the specialist and the GP or practice nurse involved in the long-term care of the disease. Early discharge back to primary care would be more likely in such cases.

Skill and knowledge transfer between primary and secondary care is the main clinical 'added value' to be gained from specialist outreach. This is a key element of the concept of primary care specialists espoused in the new NHS Plan and of which 1000 are proposed by 2004.² Skill and knowl-

edge transfer implies an improvement in the capacity of primary care to meet patients' needs. It is the only credible theoretical basis for specialist outreach to improve patient outcomes. Equity is the least consideration, and the higher costs of specialist outreach identified by Bowling *et al* are not likely to be offset by increasing the scale of 'outreach' unless the new Primary Care Trusts establish local specialist clinics. Even then, such a move would simply be a translocation of the hospital base. Access for patients would not necessarily be better because 'cross-district' public transport and road networks are usually inferior to central routes. Without skill and knowledge transfer specialist outreach is a matter of providing the same service in a different place, at more convenience to the patient, at less convenience to the specialist, at a greater cost to the service as a whole, and to the disadvantage of patients seen in hospital.

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Personality-targeted strategies for explaining immunisation risk

The proportion of British children vaccinated with the MMR vaccine is falling, possibly putting herd immunity at risk; the most recent paper by A J Wakefield¹ on the question of MMR immunisation risk has re-ignited controversy. In consequence, the burden of advising parents is becoming increasingly difficult for GPs and nurses. Recognising that different individuals respond and react to the same risk information in radically different ways²⁻⁴ is helpful. Awareness that the general population can be broken into four

groups, each of which perceives risk issues consistently and distinctly,⁵ is more useful still.

Hierarchists believe in formal rules and procedures and are likely to follow clear medical advice from an accepted medical authority figure. They are less interested in a discussion of the risk balance of a vaccination decision than they are in a GP's certificates and diplomas. Here parental doubts about vaccination can often be resolved by appealing to a higher authority figure (a nurse can refer to the advice of a GP or medical council, for example).

Fatalists are passive personalities and will accept immunisation if it is the default decision. A good strategy here is for the professional to emphasise that vaccination is 'the done thing'. Like hierarchists, fatalists are reliant on family precedent. Noting, if possible, that other relatives have already been vaccinated encourages a pro-vaccination decision.

Egalitarians have no special respect for the GP but respond well to an empathetic, trusted professional. Egalitarians prefer a detailed appraisal of the relative risks of vaccination and non-vaccination. A successful strategy might be to tell the parent that, on the known evidence, 'I myself have chosen to have my child immunised.' Egalitarians are sensitive to issues of social responsibility, so an explanation of the importance of contributing to herd immunity can be effective.

Individualists, like egalitarians, are very interested in relative risks. But they sometimes derive satisfaction from holding contrarian opinions. Where herd immunity was high they would be tempted to free ride, if they understood this possibility. However, they can be responsive to appeals to their personal family responsibility. For example, 'How would you feel if your child contracted measles and developed encephalitis because of your decision to refuse vaccination?'

Of course, parents do not enter a surgery with a labelled risk personality, but awareness of the above categorisation can be an aid to a successful immunisation risk dialogue.

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Electrodiagnosis in carpal tunnel syndrome

In their recent review, Kanaan and Sawaya¹ state that electrophysiological testing should be performed where there is any clinical suspicion of carpal tunnel syndrome (CTS) and prior to any surgical intervention in the involved wrist. These recommendations are not supported by evidence from the literature.

A systematic review has assessed information on all studies in which patients were examined clinically and with electrodiagnostic studies.² Although the specificity of electrodiagnosis for confirming clinically characterised CTS was found to be high (95–100%), so that few people without clinical CTS would have abnormal electrodiagnostic results, the sensitivity was low and very variable (49–84%), so that a substantial proportion of patients with positive clinical symptoms who would benefit from treatment would have normal electrodiagnostic results. Thus electrodiagnosis would not seem worthwhile to confirm the diagnosis in the majority of cases of CTS where the symptoms are well defined.

We have examined the evidence that electrodiagnosis is predictive of surgical outcome in a systematic review³ and found that, in the four studies that allowed analysis, there were no statistically significant differences in outcome between those with positive and negative electrodiagnostic tests, providing no support for use of electrodiagnosis as a predictive indicator of the likely success of surgical treatment of CTS.

The evidence therefore suggests that in such circumstances, requiring electrodiagnosis will not be useful or cost-effective and may result in delays in patients receiving appropriate treatment.

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Adverse drug reactions

We welcome Dr Millar's important research into adverse drug reactions (ADRs) in general practice.¹ This is a much-neglected area and it is informative that he found a similar rate of consultations owing to adverse drug reactions as other researchers, as well as a high degree of under-reporting. It is,

however, disappointing that despite the high profile given to ADRs only one yellow card report was submitted during the six months of the study, especially as two of the top 10 drugs (venlafaxine and tramadol) had black triangle status at the time. A previous study has shown that only 9% of ADRs suspected to be caused by black triangle drugs are reported to the Yellow Card scheme by general practitioners.²

Another area of concern was that only labelled reactions were included in the study. Many reactions are only detected in clinical practice and one of the strengths of the Yellow Card scheme is that it is used to detect previously unknown reactions. A product licence is granted on the basis of trials involving an average of 1500 patients³ so, at the time of licensing, a serious reaction that affects as many as 1 in 500 patients could remain undetected.⁴ Spontaneous reporting of unlabelled reactions is important to develop a full adverse effect profile of new drugs.

This study has shown that doctors still seem to be unsure of what the Medicines Control Agency would wish to be reported. It is important to realise that only a suspicion that a drug has caused an ADR is required. The MCA's current guidelines (BNF41, page 10) state that any suspected reaction to a black triangle drug should be reported, even if the reaction is trivial.

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Diabetes in primary care: study raises questions

Khunti *et al*¹ examined diabetes care in

primary care and found that we are 'failing to provide effective care for a large proportion of people.' This is ascertained by finding that 42.9% of diabetics have a 'normal' glycosylated haemoglobin. By not further examining or categorising the other 57.1% of diabetics, from a GP's point of view, this is not helpful. Often we work hard to achieve 'good' or even 'moderate' glycaemic control in patients; if this merely is recorded as 'abnormal' then it is not reflective of a significant proportion of work in diabetes care.

Secondly, this study was of diabetics cared for exclusively in the practice setting. The reason for this was stated as 'the taxonomy of shared care is not clear'. This is puzzling as Khunti in an earlier study showed that just over 50% of diabetics are cared for solely by the GP, under a fifth are cared for exclusively in secondary care, and one-third are cared for in 'shared care'.²

Lastly, it seems a little disingenuous to qualify the study by saying that the questionnaires were completed by GPs of their own practices and so 'should be interpreted with caution'. Does this not undermine every study of, or involving, primary care? Is it GPs who can't be trusted or just audits in general?

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Authors' response

David Carvell makes an important point regarding our study of diabetes care in general practice.¹ We found that 42.9% of people with diabetes had normal glycosylated haemoglobin; however, we did not categorise the other 57.1% of people with diabetes who may have had good or moderate glycaemic control. We collected routinely

available data from three Primary Care Audit Groups and not all of them had categorised the data in good, moderate or poor control. However, all audit groups had collected data on the proportion of patients who had normal glycosylated haemoglobin. Carvell is also correct in stating that we have previously reported the proportion of patients cared for in general practice, hospital care and shared care.² However, in the present analysis we did not use the proportion of patients receiving shared care as there are no clear definitions of what constitutes a 'true' shared care scheme and their effectiveness and cost-effectiveness are still uncertain. The Audit Commission Report *Testing Times* also acknowledged that the definition of shared care is unclear and can be interpreted in a variety of ways.³ They found considerable variation across the country in where patients are seen for their annual review, and by whom, and the role of the hospital.

On Carvell's third point, postal questionnaires are frequently used in general practice to determine self-reported activity. The majority of questions in our study comprised 'yes/no' closed questions. However, there were some questions — for example, a question on attendance at diabetes courses — which required the responders to choose from several options. These questions need to be interpreted with caution as there is evidence that there is a variable relationship between what general practitioners report in such self-reported questionnaires and what they actually do.⁴

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Medical school selection procedures

Medical school selection procedures are the subject of debate within the profession and will soon come under intense political pressure, with the NHS requirements for more doctors.

General practitioners, like all doctors, have a responsibility to join in this debate and help selection procedures for prospective medical students. Most job selection procedures are blunt instruments and it is easy to view selection procedures for prospective doctors from the standpoint of only general practice, and forget the galaxy of worthwhile careers that a modern medical graduate can choose from. As a profession, however, we do have a broad responsibility to choose the right people for their sake and the patients' sake. More graduate entry and exit procedures from medical courses into alternative university courses, without the lasting feeling of failure, are the best options to secure the health of patients and doctors. Intellectual rigour, communication skills, and teamwork are the defining qualities for a doctor, and calls to reduce the most important component of intellectual rigour, to solve a short-term planning failure, would be a long-term disaster for healthcare.

Medical schools require prospective medical students to state their case on the UCAS form and often at interview. All advise evidence of relevant work experience and GPs are often asked to help with this process, as described by Thistlethwaite.¹ She raises the difficulties and confidentiality and questions the relevance of work experience in general practice. School children from rural areas find GP placements impossible because of confidentiality and school children from the state sector schools may be at a disadvantage in comparison with the private sector, where professional networks and coaching for university admission may be easier.

The RCGP North of Scotland Faculty

recognised these difficulties four years ago and set up the Highlands Schools Medical Mentor Scheme. School children are put in touch with a GP, via the Faculty office and school guidance system, in their final year when they are considering a career in medicine.

It is made clear from the outset that work experience is not on offer because of confidentiality, but career mentoring and help with the application process is available.

The GP mentors use their educational and consulting skills in reflective questioning and discussion about communication skills, teamwork, and the different styles of undergraduate course on offer. Work experience on a supermarket checkout, with a Saturday job or voluntary work in an old people's home, can give just as much insight into the personal attributes for a medical career as standing around feeling embarrassed in a hospital. The TV is saturated with medical programmes of every description, so there is no lack of information about the doctor's role in the process of health care.

In conclusion, GPs have an important role to play in helping prospective entrants to medical schools to decide whether a career in medicine is a good idea or not. The focus of that role should be to utilise the educational and consulting skills of GPs to best advantage, rather than work observation with all the difficult issues of confidentiality, time, and resources. RCGP Faculties can have a role in formalising these arrangements to the benefit of everyone.

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Deprivation payments

The comprehensive paper by Norman Beale¹ on deprivation and UK general practice, drew attention to the questionable basis upon which deprivation payments were instituted. The Jarman

Index was based on the subjective views of general practitioners about what sort of patients caused most workload.² These stereotypes, for which there was no objective validation, were then used at the last minute by the then Minister of Health, to counterbalance the effects of the new contract in deprived areas, where practices would have had difficulty in qualifying for the new target payments.

The result of this piece of political expediency has been to create a deprivation industry which is both academic in terms of amending indices and bureaucratic in terms of administering payments. This industry is based on two questionable assumptions. The first is that general practitioners' workload is proportional to the deprivation of their patients and the second, by implication, is that paying GPs more will make any difference to deprivation.

Concerning workload, one study from Manchester showed that GPs with surgeries in wards with the worst deprivation scores spent less time on average with their patients than those in the best wards, and also had higher doctor-patient ratios.³ Another study in Sheffield correlated the workload of 100 GPs with the proportion of patients on their lists who lived in wards qualifying for deprivation payments. There was a consistent negative correlation between the proportion of patients attracting deprivation payments and measures of workload, in terms of patients seen per week and hours spent providing general medical services per week.⁴

The issue of deprivation in this country, whether urban or rural, is too important to be sidetracked into sterile debates about how GPs should be paid. A good start to the urgent task of revising the Red Book and clarifying GPs' remuneration would be to scrap deprivation payments altogether and redistribute the money with the administrative savings to all GPs in a more equitable way.

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Sexually transmitted infections in primary care: a need for education

We read this paper with interest.¹ If improved sexual health of the UK population is a goal then we are in complete agreement that it is essential for genitourinary medicine and primary care to develop effective working partnerships. The preliminary data from the Portsmouth and Wirral chlamydia screening projects (Dr M Catchpole, personal communication) suggest such a high prevalence of chlamydia that neither service in isolation will be able to manage the problem. We agree with Matthews and Fletcher that specific training in sexual health issues is an essential prerequisite for all those involved in service delivery. As such, the Medical Society for the Study of Venereal Diseases (MSSVD) feels it has a role and sense of responsibility for both specialist and non-specialist training of medical and nursing staff. The Society is currently working with other stakeholders to develop a two-day multidisciplinary foundation course in sexually transmitted infections (STIF). The course will concentrate on developing skills and attitudes using a variety of educational methods, such as case scenarios and role-play in small groups. The pilot took place in June of this year and it is hoped to run at least one course in each region by the end of the year. Within three years we hope to attract at least one member from each primary health care team in the country to the course. These courses will be run locally by GUM and primary care in collaboration with a curriculum and written materials produced, validated, and regularly updated by the MSSVD.

We hope that this initiative will be an alternative and appropriate method of addressing the training needs of health care professionals currently working in the field of sexual health. Ultimately, we feel that the training should begin

at medical or nursing school.

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GPs prescribing specialist medicines

Horne *et al* propose a number of quality indicators for the prescribing, by GPs, of specialist initiated medicines.¹ Many of these indicators, or themes, have previously been clearly identified as important and necessary when considering prescribing arrangements.

EL(91)127 states that a transfer from hospital of drug therapies with which GPs would not normally be familiar should not take place without full local agreement and the dissemination of sufficient information to individual GPs.² Reference is also made to the importance of ensuring continuity of supply of the drug.

The themes of respective responsibilities, monitoring, and effective communication have also been well stressed.^{3,4}

To these themes, first identified nearly a decade ago, should be added two additional GP concerns. First, the increased workload inherent in monitoring some of these drugs. Secondly, the impact on any potential practice prescribing incentive scheme that some of these specialist drugs may have.

We accept that the recent opportunity arising from primary and secondary care unified budgets should overcome the absurdities of the purchaser-provider years.⁵ We also acknowledge that over the years much time and effort has gone into the development of shared care guidelines and interface prescribing policies. Despite this, we would argue that

some of the difficulties that existed in the early 1990s are still with us today, even though here in Cornwall the cost of specialist drugs issued by primary care has risen from 2.3% of all GP prescribing costs to 3.6%, over a seven-year period.

We would suggest two additional quality indicators to add to the helpful list proposed by Horne *et al*:

- Has the additional workload on the primary care team been recognised?
- Are financial arrangements in place to prevent practice prescribing schemes being jeopardised by the shared care arrangements?

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