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## Routine care of people with HIV infection and AIDS

The discussion paper by Singh *et al* in the May *BJGP* usefully outlines some ways in which general practitioners (GPs) could take on a greater role in the care of people living with HIV infection.<sup>1</sup>

The forthcoming Department of Health Strategy for Sexual Health and HIV is likely to promote greater access to sexual healthcare in the community. This occurs against a background of improved understanding and treatment of HIV infection and increasing prevalence, making the continued provision of HIV care in specialist units alone less viable.

Nevertheless, a recent consultation exercise that we have undertaken suggests that any move towards greater provision of HIV services in the primary sector needs to be managed carefully, taking into account the perspectives of patients and GPs.

A survey of 202 HIV outpatients attending our Directorate within a single week revealed that the vast majority are satisfied with their current outpatient care (97%).<sup>2</sup> Those proposing changes to HIV services should consider whether features thought to be essential by the majority of these patients — such as open access, anonymity and confidentiality, the latest treatments and specialist care — could be offered in the primary sector.

Singh *et al* argue that provision of routine HIV care is more suited to primary care. However, even standard care can involve complex and demanding treatment regimes and clinical support. Our survey of GPs

from four local Primary Care Groups (117 responded, 50% response rate), suggests that only a minority want to be involved in the delivery of HIV care. The draft Sexual Health Strategy acknowledges differences between generalist and specialist sexual health care. We found that almost all GPs currently offer generalist care (88%) and most wish to continue offering this level in the future, rather than developing more specialist services. This is borne out by the finding that most GPs feel they have about the right amount of involvement in HIV patient care (70%), while only a minority want to be involved in the development of HIV care guidelines (17%). However, opinions may differ in other areas of the United Kingdom.

We acknowledge that for HIV care in the community to succeed, patient confidence, GP interest and specialist support are required. At Chelsea & Westminster we are developing a shared care approach to sexual health services in partnership with interested local GPs that we hope will result in more responsive services in the future.

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## Prescribing for lower respiratory tract infection

I respond to the article on prescribing for lower respiratory tract infection (LRTI).<sup>1</sup> I regret my comments arrive late, but so does the local post.

As a doctor in a rural developing world situation, I am a little surprised to read the list of defining symptoms and signs used by Holmes *et al* for LRTI. We also have absolutely no access to CXRay, oximetry or other tests of lung function. Defining LRTI using cough as the cardinal feature seems to make a nonsense of the term at the outset:

The defining feature of LRTI is tachypnoea consequent upon hypoxia. Tachypnoea is not even mentioned in the case definition.

Although it may develop in LRTI, cough is principally a defining feature of upper respiratory tract infection (URTI) in which hypoxia, and hence tachypnoea, play a much less significant part. The bronchus is really part of the upper respiratory tract, having the passage of respiratory gas as its main function rather than the exchange of gas (as in the lower respiratory tract).

The importance of cough is only to introduce the range of URTI and LRTI infections. The subsequent history and examination define the difference.

WHO publish some very good guidelines on how to distinguish URTI from LRTI, using respiratory rate as the main deciding factor and backed up by observation of temperature, pulse rate, chest in-drawing, nasal flaring etc.

Using these guidelines our nurse auxiliaries are able to distinguish lower and upper respiratory tract infection and to use this distinction either to prescribe or not to prescribe antibiotics. Most upper respiratory infections need no antibiotic. Experience here has shown that, given adequate symptomatic relief, there is rarely a need to revise treatment later on to give antibiotics.

Genuine LRTIs with tachypnoea and fever do usually need antibiotics. The only afebrile cases that may be excluded by these criteria are those with septicæmia needing hospital admission.

The authors of this study conclude that 'physical signs at consultation appear unhelpful'. This is not true. The problem seem to be that the physical signs were ignored and antibiotics prescribed anyway.

It might be useful to recommend that the participants in this study purchase the interactive CD ROM from the Wellcome Foundation which covers respiratory infection. (Available from: CABI Publishing, Wallingford, Oxfordshire OX10 8DE.)

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## TB and prisons

Continuity in the management of infectious disease between prisons and the community requires two innovations. We need both a system of record transfer and a secure database that is accessible to GPs, to enable the occasional tracing of some infectious people entering prison. The latter might carry less risk of stigmatisation than notification to GPs by the courts.

Mukerjee and Butler raise the ethical

problems in transferring information from medical records between prisons and general practice.<sup>1</sup> Confidentiality within prisons is likely to be a major concern of prisoners; however, do we know whether some record transfer is acceptable to them? What safeguards would be needed, given the variations in medical services between institutions? Could GPs later exclude stigmatising information from the records of former prisoners?

The mass incarceration of the past 20 years (55% population increase)<sup>2</sup> has contributed to the neglect and uncoordinated management of several chronic and infectious diseases, including hepatitis C, the 'prison disease'.

Ethical considerations should not obscure the clear need for co-operation between the Departments of Health and the Home Office. They could consider piloting opt-out and opt-in systems of transfer. If these were effective, doctors at the interface could focus their efforts and resources.

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## Risk information in general practice

Dougal Jeffries, in his letter in the June *BJGP*, feels compelled to pressurise patients into taking treatment, seemingly unconvinced by the quality of advice meted out by the various 'reputable' bodies. Probably, like me, he can remember those days when polypharmacy was defined as any person taking more than three prescribed drugs! Yet I think society has changed in the past couple of decades.

How many of our patients, despite

saying that they don't like taking medication, will reel off a list of vitamins, supplements, and fancy-sounding plant extracts that they take to maintain their health? Despite the fact that the lifetime risk of having a serious accident in which a seatbelt would save life or serious injury is probably less than 1%, how many of us would be happy to tell our children or spouse not to wear their seat belt, because it was a waste of time? I suspect that, for many patients, taking a tablet to reduce your blood pressure and therefore your risk of cardiovascular disease by at least 1% over 10 years must seem just as intrusive (or not) and beneficial as wearing a seat belt.

For me, the advent of the Joint Society's guidelines and charts has enabled me for the first time in my career to give a personalised estimation of risk to patients — most of whom seem to find it acceptable. I wonder how much we are afraid to discuss risk openly is because of vestiges of paternalistic medicine, maybe self-preservation owing to a rising tide of workload, and genuine concerns that all the information is not there. Although we have evidence that aspirin, beta blockers, etc. are useful for secondary prevention, do we really have evidence that a combination of them all is better than one singly? Having prevented further episodes of ischaemic heart disease, or treated blood pressures successfully, do we know how people will then die? If we are really supposed to be giving risk advice then maybe we should be discussing the real endpoint — death, and how we want to die.

So, I'm not running scared, but my enthusiasm is tainted by that nagging feeling that it is all not quite so simple as it sounds!

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## Topical antibiotics for acute bacterial conjunctivitis

This otherwise excellent paper has a weakness in common with many meta-analyses, which is the question of heterogeneity.<sup>1</sup> On the one hand, the

authors acknowledge clinical heterogeneity between selected studies for a number of characteristics. On the other hand, the authors accept the findings of statistical analysis of the results that seem to exclude significant heterogeneity.

There is a potential problem with this process. Statistical tests for heterogeneity are not particularly sensitive and therefore may not find heterogeneity when indeed it does exist.<sup>2</sup> This then is compounded by the selection of a fixed effect model, where possibly a random effect model may have been more appropriate.

Combining results, such as in meta-analysis, leads to more narrow confidence limits thereby giving a more statistically significant result. However, if the combination of these studies in the first instance was not appropriate then the results may mislead us into a type 1 error.

This meta-analysis has combined very different characteristics. Patients may be children or adults, in a hospital or general practice setting, have different diagnostic criteria, different treatment, and different outcomes. The use of statistics to support such a process may be fundamentally flawed, bringing spurious precision to a meta-analysis of studies with major differences.

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*Authors' response*

We agree that, when deciding the appropriateness of performing meta-analysis, it is important to consider the possibility of clinical and/or statistical heterogeneity in relation to studies to be included in the analysis. We considered both these questions and decided that, on balance, meta-analysis was justified.<sup>1</sup>

Although the populations studied in the trials in our review were clinically

heterogeneous in terms of age group and place of recruitment, in each of the trials, topical antibiotic treatment was compared with placebo, and the outcome measures of interest were similar, namely clinical and/or microbiological remission. While age and recruitment differences can lead to differences in absolute measures of effect, this is less likely for the measures of relative effect we presented, since relative effect measures are on the whole remarkably stable across populations. In addition, statistical tests for heterogeneity were of borderline significance. Although such tests are of low power, there was no clear evidence of heterogeneity. Using a random effects model in fact gave similar point estimates of effect to those obtained using a fixed effects model but, predictably, decreased the precision of the estimate (early clinical remission: RR = 1.53, 95% CI = 0.70 to 3.33; early microbiological remission: RR = 1.77, 95% CI = 1.23 to 2.54).<sup>2</sup> Lack of a substantial difference between the combined effect calculated by fixed and random effects models suggests the studies were not markedly heterogeneous.<sup>3</sup> Any heterogeneity present is therefore unlikely to be of sufficient magnitude to recommend alteration in practice, or to make relying on the strongest evidence available (from meta-analysis of all high quality trials) unsafe.

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**Local research ethics committees**

The introduction of multi-centre research ethics committees (MREC) in autumn 1997 was intended to streamline the obtaining of ethical approval from large numbers of local research ethics committees (LRECs). However, the difficulty in implementing the new system prompted the NHS Executive to issue further guidance in September 1998, explicitly stating the remit of LRECs in handling MREC approved applications.<sup>1</sup> Our experiences in obtaining LREC approval suggest that not all LRECs adhere to these guidelines.

MREC approval was obtained for two follow-up studies of historical cohorts. LREC approval was sought from 225 and 137 committees respectively. Each LREC application averaged 47 pages — consuming 109 000 sheets of paper! It was apparent that many LRECs did not have sub-committees and requested an average of seven copies of the application. If each LREC had a sub-committee with the recommended three members, 59 000 sheets of paper would have been saved.

Although approval was eventually forthcoming from all LRECs approached, approximately 10% made comments and requests for changes beyond the remit of LREC review. These included changes to approved documentation and requests for protocol amendments, in direct conflict with MREC conditions of approval. In two cases, the same committee was inconsistent in their interpretation of data protection issues.

Despite frustrations of other researchers in obtaining local approval,<sup>2-5</sup> LRECs continue to apply their discretion in following established guidelines. Having endured five frustrating months in an expensive and tedious process, we welcomed the new operational guidelines developed by the Central Office for Research Ethics Committees (COREC). In this recent ini-

tiative from the Department of Health (<http://www.doh.gov.uk/research>) it has been decided that, for non-therapeutic studies involving no local researcher, MREC approval is sufficient, the need for local review being redundant. For studies with subject contact by a health professional unrelated to the research team (e.g. GPs) LRECs are to be informed, but only where the competence of the person is questioned may the LRECs become involved.

These changes represent a clear improvement to the ethical review process. However, they do not address the difficulties encountered with some LRECs not adhering to the guidelines. It is imperative that each LREC only requests a reasonable number of copies of all documents for a sub-committee and that they review the study for local issues only within the suggested three weeks. Furthermore, latest guidelines on the use of personal information in medical research (<http://www.mrc.ac.uk/>) need to be widely disseminated to LRECs.

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## Carpal tunnel syndrome

In their extensive review of modern diagnostic and management techniques applicable to carpal tunnel syndrome, (CTS) Kanaan and Sawaya twice refer to the cervical spine.<sup>1</sup> The first reference reads, '... and the dis-

ease may be mistaken for cervical radiculopathy...'. Later, in discussing the diagnostic value of electromyography, they write, '... these include nerve entrapment in the forearm, plexus lesions or cervical root disease.' They make no mention of the local clinical signs to be found in the lower neck and at the cervico-thoracic junction in pain of vertebral origin (PVO),<sup>2</sup> nor of the paired phenomena of referred pain and referred tenderness.<sup>3</sup> While CTS may indeed be mistaken for cervical radiculopathy, it is conversely by no means uncommon for PVO to mimic CTS, and also other brachial or thoracic lesions, including shoulder pain, tennis elbow, golfer's elbow, and coronary ischaemia.<sup>2</sup>

Seeking local physical signs in the neck takes a very short time. On eliciting such signs, and in the absence of contraindication to its use, cervical manipulation offers an unpredictable chance of rapid relief of these pains. Its failure is an indication for resort to the relatively complex, costly range of diagnostic and therapeutic procedures described. Its success saves both patient and doctor a great deal of time, at nil cost.<sup>4</sup>

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## Role models and the clinical influences

In his letter in the March *BJGP*, Peile addresses the problem of effective medical education, having just concluded the qualitative phase of a research project which he undertook to examine the effect that trainers have on their registrars in general practice.<sup>1</sup>

As part of a research study that I car-

ried out in North Thames at the time that vocational training for general practice became mandatory, the trainer-registrar relationship was studied. One aspect of this was the extent that trainers acted as role models for their registrars and their clinical behaviour influenced the neophyte doctors. One such example that emerged from my data was in the handling of emotional anxiety.

Peile, in his study, looked at qualitative features of the trainer-registrar relationship and adopted a behavioural approach to determining the extent that a GP trainer's clinical style impacts on the registrar's future clinical role in general practice. Aspects of the training relationship can provide a role model for the registrar's future practice and Peile discussed the case of 'reflective' practice. However, in a short letter it is not possible to outline all examples of conflict and consensus and professional socialisation in the trainer-registrar relationship. Role modelling does take place and this involves both positive and negative aspects of the role model which may influence registrars' new professional role as a GP.

One sphere in which registrars might be influenced by their trainer and which hospital medicine does not provide a satisfactory model is in the handling of emotional anxiety. Here, many of the registrars in my study spoke of how they were affected by their trainer's handling of it.

In the words of one registrar: 'I think I picked him because I liked his style. I sat in on a surgery before I started and saw the way my trainer handled emotional anxiety ... I liked his approach.'

A second registrar put it this way: '...taught me that as a GP you have to sit back and listen, not say too much — he influenced me in terms of the fundamental point of the consultation ... agitated patients, he let them talk to see what the main problem is ... I think I've picked up this technique from him'.

General practice provides a more egalitarian milieu for the practice of medicine than hospital medicine, which is more hierarchical. It is here in general practice that intraprofessional relationships differ from those in the hospital. Registrars have to 'unlearn' the lessons of hospital medicine and relearn the 'vocabulary' of general practice and its

style of working in the new 'democracy' of it. In particular, those registrars who had a more fluid model of the medical relevance of symptoms and illness were more able to respond to the more egalitarian intraprofessional relationships and more patient-centred consultation in general practice.

Peile's point was concerned as to whether there are training behaviours on the part of trainers that affect the registrar's style of doctoring. In my study, the data suggest that the role model that trainers provide are of value in influencing and bringing about change in the registrar's mode of clinical behaviour and style of doctoring, such as the handling of emotional anxiety in the consultation.

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### Patients' views on anxiety and depression

Kadam and his colleagues draw an uninspired conclusion from an otherwise inspiring piece of research.<sup>1</sup> They establish convincingly that anxious and depressed patients do not like drugs and do not want to take them. Perversely, they conclude that GPs should try harder to make them change their minds. They also suggest that counsellors should play a part in this persuasion — a suggestion that most counsellors find odd.

When patients say they do not like drugs and do not want to take them, we could choose to listen to them instead of lamenting their ignorance. Who knows, we might even end up changing our own beliefs instead of theirs.

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### PUNs and PUEs, DENs and SANs

In assessing the quality of service that they provide to their patients, I believe that it is important that doctors take into account, not only patients' unmet needs (PUNs) but also patients' unmet expectations (PUEs). Similarly, in addition to doctors seeking to identify and remedy their educational needs (DENs) it is also important that they seek to identify system adjustments needed (SANs).

The following case with which I am currently involved provides a practical illustration.

A 59-year-old English man had a myocardial infarct while on holiday in Australia and was treated in an Australian Public (NHS) Hospital. After his discharge he consulted a private cardiologist who recommended that he should have cardiac catheterisation. This could be done immediately in the private sector. In the public sector it could not be performed for several months. However, the patient's insurance policy excluded private treatment in countries such as Australia, which have reciprocal arrangements with the United Kingdom for public sector treatment of visitors.

I spoke to the cardiologist who agreed that the patient was fit to return to the UK and that there was no necessity for cardiac catheterisation to be performed before the patient returned home. On the basis of this discussion I advised the patient's insurers that arrangements should be made for him to return to the UK without further delay. I also spoke to the patient and assured him that, in the cardiologist's opinion, he was fit to fly and that further investigations were not immediately necessary. The patient returned home safely and without incident but he has nevertheless written a letter alleging the mishandling of his case.

If we define a patient's needs as 'treatments or services essential for health' then quite clearly this patient

did not have a PUN, but he did have a PUE. For my part, I do not know what more that I as a doctor could have done. Having established the medical facts my notes show that I spent rather more than an hour in numerous telephone calls to the patient and his relatives explaining the situation. I can see no DEN here, but I do see where SAN is needed. In my final report to the insurers I intend to make a recommendation that proposal forms for medical insurance should spell out in greater detail, in simple language and perhaps in bold print, the various limitations of the insurers' liability.

I believe that this extension of the framework of the analysis to include PUEs and SANs is important. It is important not only because an exclusively PUNs and DENs based assessment will in many cases be inadequate but also because the inadequacy of the analysis could distort the perception of the quality of service that the doctor, as opposed to the system, is providing. The broader based analysis could, I believe, be genuinely useful in helping to provide a better service for patients. The danger of the more limited analysis is that it could all too easily provide a cloak for politicians and bureaucrats to conceal the systemic failing of the NHS at the expense of an already widely demoralised profession.

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### Patient consultation satisfaction scores

Thornett (*May BJGP*) reported the differences in satisfaction scores between a registrar and trainer. Coincidentally, we have also been looking at consultation satisfaction using the same methods but instead comparing a pre-registration house officer (PRHO) GP with his supervising partners.

PRHO GPs are a relatively new phenomenon in primary care. There has therefore not been a huge amount of research into how successful a job they can perform. Patient satisfaction has been identified by many as an important health outcome, especially within the context of primary care.<sup>1</sup>

During the spring of 2001, we measured patient consultation satisfaction with four partners in a five-partner practice and a PRHO on the four-month general practice section of his house officer rotation, using the Consultation Satisfaction Questionnaire. The partners had 10-minute consultations and did not keep personal lists. The PRHO had a split between 20-minute and 30-minute consultations depending on which surgery site he worked in. The CSQ creates reproducible and comparable results. As reported by Thornett,<sup>2</sup> the CSQ's audit standards have been defined as 80% general satisfaction, 82% with professional care, 73% with depth of relationship, and 72% with perceived time. Seventy and 76 questionnaires were completed for the PRHO and partners respectively. (See table below.)

As can be seen, the general satisfaction and professional care as viewed by the patient was the same between the two groups. This differs from what Thornett found for registrars. As expected, perceived time was greater for the PRHO bearing in mind the longer consultations. The depth of relationship was greater for the partners, which could be explained by the special nature of being a family practitioner with its continuity of care. However, this discrepancy doesn't seem to alter the patient's overall satisfaction.

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## Out-of-hours palliative care advice line

Primary care provides the majority of palliative care for patients in the last year of life.<sup>1</sup> Difficulties with accessing appropriate advice and support from out-of-hours care can lead to patients being admitted to hospital when their decision had been to die at home, causing dissatisfaction by patients and professionals.<sup>2,3</sup> Specialist palliative care is predominantly available from 9.00 am to 5.00 pm with little out-of-hours cover. A palliative care advice line that was widely advertised to all health care professionals was established to offer information and advice for primary care medical and nursing staff caring for patients out of hours. Senior nursing or medical staff answered calls and data was documented on the profession of caller, diagnosis of patient, information requested, and advice given.

Ninety-eight calls were received during the first year. The majority related to patients with cancer diagnoses (eight were non-cancer). GPs accounted for 55% of callers and community nurses, including Marie Curie nurses, for 34%. The remaining calls were from junior hospital medical staff and nursing homes.

The majority of queries (59%) related to pain control and the conversion of drugs, e.g. conversion of oral morphine to subcutaneous diamorphine and as-required doses of morphine in patients taking slow release preparations; also the setting up of syringe drivers (16%). A small number of calls were requests for advice on nursing management, e.g. wound care and the availability of special equipment, etc.

This survey has shown that requests for advice were predominantly dose conversions of opiate drugs. This was such a common query and it is very surprising to find that this information is not included in any accessible format in the British National Formulary. Doctors on call out of hours (both those working for

deputising and co-operative services) carried only a limited number of drugs with a very small supply of injectable opiates and few, if any, injectable antiemetics. In the UK, there is a 24-hour on-call pharmacy service, whereby a pharmacist can be contacted out of hours via the police and drugs obtained. The majority of doctors who telephoned the advice line did not know about this service.

Out-of-hours palliative care is an important issue and this pilot study suggests that an advice line may improve the provision of palliative care out of hours, by providing specialist advice. However, few specialist palliative care services operate such a policy and many believe they will be deluged by callers.<sup>4</sup> This study did not find this to be the case. The advice line was used appropriately and if more widely available may enable more patients to receive appropriate palliative care in the community at any time of day or night.

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## Correction

In the paper by Bajekal *et al.*, entitled 'Rationale for the new GP deprivation payment scheme in England: effects of moving from electoral ward to enumeration district underprivileged area scores' (*Br J Gen Pract* 2001; **51**: 451-455), the column headings in Table 1 for 'Percentage GP registered population by ward and ED UPA' were incorrectly labelled as: UPA 50, UPA 40, UPA 30, etc. The column headings should have read as follows: UPA 50, UPA 40, UPA 30, etc. We apologise to readers and to the authors

	Mean score for partners (%)	Mean score for PRHO GP (%)
General satisfaction	85.4	85.4
Professional care	84.4	84.2
Depth of relationship	76.4	69.4
Perceived time	77.2	81.1