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## Health inequalities and deprivation

Congratulations on a timely issue on health inequalities and deprivation (*BJGP*, June 2001). It is arguable that the inequality issue is *the* medical issue of today. Twenty-one years after the Black Report, followed up by such authors as Blane, Brunner, Davey Smith, Marmot, and Wilkinson, it is clear that we cannot have a healthy society unless it is more equal than the one we live in today. How much more equal, and how this can be achieved in a highly market-driven culture with heavy emphasis on individual freedom and responsibility is not clear. However, the direction in which we need to travel is beyond dispute. All your contributors acknowledge and illustrate the extent to which the health of their populations depends on the structures in society. All of them, except one, nevertheless assert that the profession has a central agency role in trying to redress the damage and disadvantage produced by the societal structures.

There is a serious danger here related to the ancient medical self-delusion of megalomania. If doctors take on the role and responsibility of trying to solve problems that are manifestations of end-stage social pathology (e.g. alcoholics, smokers, and other drug abusers; obese diabetics with established vascular disease; people who have already developed cancer or had their first heart attack, etc) the risk is that the patients, the general public, the managers, the government and the politicians will leave it all to us. Paradoxically, the more successful we are in bailing out these boats with a teaspoon, the more difficult it is to

make the political and social changes necessary to generate more upstream health. Observe, for instance, the charmed existence of tobacco companies and their advertising through yet another Queen's speech, even though for nigh on 50 years we have known that their product is lethal. Notice also that a would-be Prime Minister, Ken Clarke, has been on a trip recently to Vietnam to sell tobacco and thereby kill more Vietnamese than American weaponry ever did.

I am a GP on a deprived estate. The surgery has metal shutters and sits within a three-metre-high palisade of iron railings. The NHS gives out care and concern to people who have little elsewhere in their lives. Most other services are poor or non-existent. I am like a prison padre, and as I drive away each evening, the cell door clangs behind me. If the NHS didn't exist maybe these estates really would explode, so that makes me a kind of jailer as well. 'Sometimes I think this whole world is one great prison yard; some of us are prisoners, the rest of us are guards' (Bob Dylan).

When I collude in the medicalisation of social and personal problems, it is possible that I am disabling my patients by diverting them from other strategies that may be more useful and effective. I may be confirming them in the sick role and actually contributing to their ill health. I may well make my patients worse. What a thought. This labelling phenomenon is not new and was described years ago by Sackett, Haynes, and Illich, among others. A further consequence is the demoralisation of the workforce as we grapple with intractable, non-amenable problems using inappropriate and ineffective methods. A sense of futility, personal failure, and victim blaming is

only a breath away.

Clearly we cannot abandon people who are suffering and come to us for help, but we must constantly explore and advocate with them, with each other, and in the larger world, alternative non-medical ways of dealing with the problems. I think it was one Dr Ernesto 'Che' Guevara, a middle class asthmatic, who observed, 'Doctors are the natural advocates of the poor'.

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I write to endorse the views of Debbie Lawlor in her editorial<sup>1</sup> on the health consequences of fuel poverty, but feel that she understates both elements of her argument; the lack of evidence, and consequent impotence of primary care practitioners.

Epidemiological data of the sort she quotes provide only tenuous evidence of a causal relationship between housing and health, mediated as they are by a host of behavioural variables difficult to describe, let alone analyse and thus advise on. Convincing evidence at a more parochial level is even more difficult to find and it is time the situation was remedied.

Laudable and original examples of partnerships between landlords and health care providers are increasing. The subject of Olsen's recent *BMJ* editorial<sup>2</sup> (prescribing warmer, healthier homes), had actually become a reality in Sandwell<sup>3</sup> and Wolverhampton also links housing with primary care professionals in an innovative scheme.<sup>4</sup> However, these remain isolated and exceptional.

The methodological difficulties

Lawlor outlines in creating a database of rigorous evidence (control and contamination) may be aggravated by issues concerned with more practical but no less important considerations of inter-agency working: different agendas, cultures, and timescales all make 'joined-up researching' difficult to conduct. The problems associated with conducting randomised trials on community-wide interventions are many but not insurmountable, as examples in Newcastle and South Devon demonstrate.<sup>5,6</sup>

It is apparently not enough to decide that citizens of this country, especially the elderly, have a right to a warm home. Primary care practitioners face the probable consequences of poor housing in their everyday contact with patients, while researchers ponder arcane methodological issues and progress is non-existent. If gold standard effectiveness and cost-effectiveness evidence really is required then studies should be funded to contribute to the arguments of those in contact with residents and persuade government that decent housing is not just a right, but a cost-effective one.

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I wish to take issue with the assertion of Smeeth and Heath,<sup>1</sup> that 'Health inequalities occur ... in particular because of inequalities in incomes'.

Numerous studies from different countries have consistently shown an association between poverty and ill

health. Therefore, it is tempting to assume that this association is causal. I think that it may be so in the developing world where poverty may mean having to do without health care altogether. However, I doubt whether it holds true for developed countries such as the United Kingdom.

In the UK, much of the inequality in health between the rich and poor can be explained by two factors; the poor are more likely to smoke tobacco and bottle-feed their infants. In choosing to smoke rather than not smoke, and bottle-feed rather than breast-feed, the poor are choosing the more expensive options. Therefore, it seems doubtful whether they would choose to stop smoking and breast-feed their infants if they had more money. Indeed, with more money at their disposal, they might smoke and bottle-feed even more.

Another explanation of health inequalities that is often overlooked relates to certain diseases with a hereditary component. Epilepsy and schizophrenia are good examples. In the world of work, very few epileptics and schizophrenics are 'high-fliers'. Epileptics face restrictions on the sort of work that they are allowed to do and some schizophrenics are so disabled by their illness that they are unable to work at all. Therefore, they tend to be poor. However, they are not sick because they are poor, they are poor because they are sick.

There are good reasons for trying to reduce poverty in the United Kingdom. However, improving people's health is probably not one of them.

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## Reference

1. Smeeth L, Heath I. Why inequalities in health matter to primary care. *Br J Gen Pract* 2001; **51**: 436-437.

In their article in the June *BJGP* on why inequalities in health matter in primary care, Smeeth and Heath describe such inequalities as an indictment of our society, and call for political efforts to change this. Ironically, the sustained economic prosperity over the last

decade would have readily provided successive governments with the funds to do this, had the political will existed. That no such will exists must be ascribed to the attitudes of the population we seek to help, for we are a society whose notions of aspiration are couched entirely in monetary terms.

Both the affluent and those who are, in relative terms, disadvantaged, perpetuate the complacency described by Galbraith<sup>1</sup> nearly a decade ago. If the middle class is overtly ostentatious, the standard bearers of the deprived — the urban youth — have little difficulty acquiring designer gear and the latest gadgetry. However it manifests, a shallow materialism is pervasive, a fragmented society its fertile breeding ground. The recent general election was woefully bereft of the debate on social issues that should characterise a mature democracy. The public asks of its government only a strong economy; government asks only re-election of itself. We should do a lot better.

I imagine that most readers share the ideals expressed by the authors. It is clear, though, that a governing party so dependent on big industry to bankroll it will place favours to industrialists as a far greater priority than funding the Health Service, let alone ensuring a more equitable one. Those of us working in the public sector are idealists; sadly, our ideals are at odds with the merciless juggernaut of global capitalism that actually governs.

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## Reference

1. Galbraith J. *The culture of contentment*. London: Sinclair Stevenson, 1992.

What a rosy world Liam Smeeth and Iona Heath must live in. They clearly strive for a world of equal incomes (Communist, perhaps?) and unlimited access to care for all. Not surprisingly, they are short on detail. Back in the real world, politicians run the service. Their prime motive in life is power and re-election. Increasing resources requires increased revenues. Increased revenues, whether by direct or indirect means, lose public support. This is mutually exclusive to the afore-

mentioned prime motive. By ignoring this reality the authors contribute to the cycle of raising awareness and expectation. The burden of attempting to meet it lies with frontline providers.

I am a GP in a practice that is not in receipt of deprivation payments (which are conveniently forgotten by those banging the inequality drum). Our reality is a struggle for our patients to access appointments and an inability to make a serious attempt to implement many aspects of clinical governance through lack of resources. It can't really be that we are simply poor managers, as we were recently awarded RCGP Quality Accreditation.

At the same time, as public expectations are raised our hands are tied behind our backs as service providers — there is no money available. Worse still, we are under threat of staff cuts. That's the real knockout punch; as soon as one demonstrates achievement — management perceives that you must be relatively over-resourced and, under the guise of progress in the absence of additional resources, embarks on a redistribution process. They rob Peter to pay Paul (and have something to write about in the annual report).

You may be surprised to hear that I fully endorse the intent of the authors to highlight inequality and seek a strategy to overcome it. This strategy should be a proper public debate about what they wish to pay for, and a move towards a service not run by politicians with such a transparent conflict of interest. In the meantime let's not play 'pass the problem' from one practice to another. Perhaps it's me who lives in a rosy world!

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### Authors' response

We wholly disagree with Cantor, whose opinions directly contradict the scientific evidence. Taking smoking as an example of a health behaviour that Cantor suggests leads to social

inequalities in health:

- In the first Whitehall study of male civil servants, there was indeed a social gradient in smoking, but the social gradients in mortality were the same for people who had never smoked as for smokers.<sup>1,2</sup>
- Poor people are at far greater risk of many cancers for which smoking is not thought to have a causal role.<sup>3</sup>
- There were marked social gradients in death from bronchitis and pneumonia in the United Kingdom in the 1920s at a time when there was no social gradient in smoking.<sup>4</sup>

Cantor also argues that genetically determined ill health leads to poverty, and that this helps explain social inequalities in health. While it is certainly true that some serious illnesses, such as schizophrenia, can contribute to worsening socioeconomic conditions for an individual, 'social drift' as this phenomenon is known, contributes only a very small part to health inequalities overall.<sup>5,6</sup> Throughout the latter half of the 20th century in the UK, health inequalities followed economic inequalities, with health gradients narrowing as social inequalities narrowed and widening as social inequalities widened.<sup>7</sup> Can this really be explained by changes in the genetic make-up of the population?

We agree with both Lakasing and Simpson that tackling the root causes of health inequalities requires political action. In our editorial we clearly stated that:

*'Health inequalities occur because of the way society is organised, in particular because of inequalities in incomes. Reducing health inequalities requires action on many fronts, far beyond the confines of health care.'*

We are therefore surprised by Simpson's perception that we wish to 'pass the problem' of social inequalities in health to GPs. Poverty damages health and the results of this process are present in primary care and have to be addressed. Our view is that, in spite of inadequate resources, health workers in primary care are doing their best to reduce the destructive effects

of poverty and that there is benefit in making this effort explicit. Our desire to push health inequalities up the agenda is not a criticism of GPs, but arises from a recognition that there is an urgent need for greater public awareness and a broader debate, both inside and outside the health service. Only these can rebuild the social solidarity and foster the political courage necessary to tackle the root cause of health inequalities, which is the appalling and widening gap in wealth between rich and poor people. Our response to Lakasing's well-founded pessimism is that the persistence of justice as a focus of human endeavour throughout history offers continuing hope, even in the face of the vested interests of global capitalism.

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## Pitfalls of 'inert' ingredients

I was interested to read Millar's case report<sup>1</sup> on this subject in the July issue of the *BJGP*. Two patients of mine have complained of unusual excipients in ordinary medication. In one case, a patient with a known allergy to E102 was given Oxytetracycline tablets containing this, causing significant ill-effects, for which, happily, she did not blame me. Subsequently, I prescribed Doxycycline for the same patient; she had further side-effects from this, again apparently related to another colourant, E131 on this occasion.

On another occasion I was berated by a patient whom I knew to be a vegan, for prescribing a medication which she described as 'containing the carcasses of insects and cattle'. This seemed to be merely a mark of her eccentricity, however, on enquiring from the chemist, the ferrous sulphate that I had prescribed did, indeed, contain shellac derived from insect shell cases and gelatin derived from beef carcasses. Incidentally, does such pharmaceutical gelatin conform to food standard agency regulations?

It is plain that most of these excipients are, particularly in the case of colourants, largely useless, and as Millar states, are also not used in many countries. Why our patients should have to put up with them remains a mystery.

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1. Millar J S. Pitfalls of 'inert' ingredients. *Br J Gen Pract* 2001; 51: 570.

It would be interesting to know the outcome of the complaint against John Millar by his patient's wife. The patient was informed that there is 'no known cross-reactivity between erythromycin and aspirin,' which is, of course, correct. No doctor can be expected to know all the excipients in all the drugs in the BNF, nor even which brand will be dispensed in most cases. This is precisely the reason for the existence of patient information leaflets. The fact that in this case the patient chose not

to read the leaflet until after an adverse reaction had occurred is hardly Dr Millar's fault.

Clearly, however, it is unacceptable that such information is not available freely to prescribing doctors. If this potential reaction was sufficiently well recognised to be included in the patient information leaflet surely it should have been mentioned in the Data Sheet Compendium, if not the BNF.

In the meantime, the take-home message is that patients must always be advised to 'read the leaflet' and that this advice should be documented.

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## Frequent attenders in general practice

Studies that further our understanding of the natural history of frequent attendance are clearly important. Carney *et al*'s study suggests that the majority of frequent attenders revert to normal attendance within a short time period.<sup>1</sup> They argue that this may render specific management strategies redundant and they emphasise the importance of physical illness. However, their findings should be interpreted cautiously.

The 486 frequent attenders were selected on the basis of consulting more than seven times in the index year with a single diagnosis. It has long been known that frequent attenders tend to present with multiple complaints that vary over time.<sup>2</sup> The effect of Carney *et al*'s sampling strategy would be to identify a group of patients with a greater preponderance of definable chronic physical disease.

The conclusions are based on only 12% (58/486) of the original sample of frequent attenders. They are likely to be a highly atypical group. It has been shown that frequent attenders are five times more likely than controls to move from a practice during a five-year period.<sup>3</sup> The individuals in the current study (who stayed put for 20 years) will not be representative of frequent attenders generally. Men, young people, and those with psychiatric dis-

order will also be under-represented because these groups have greater geographical mobility.

A quarter of frequent attenders in their study had a mean consultation rate of 12 or more consultations per year during the 20 years of the study, a surprisingly high proportion.

Frequent attendance is not a transitory phenomenon. Analysing our own data collected over a five-year period at one practice in Greater Manchester, we found that of 150 randomly selected subjects who attended frequently at baseline, 78% attended frequently during one or more of the following years. Similar results were obtained from a study carried out in Oxford.<sup>4</sup> A study from North America<sup>5</sup> showed that the majority of high users in any one year remained high users in the next year and each consecutive year of high utilisation increased the chances of a subject remaining a high user.

Further work examining the outcome of consulting behaviour is needed. The evidence available to date suggests that frequent attendance persists in a substantial proportion of cases and persistence is associated with emotional distress.<sup>6</sup> We would argue that it is not just a transitory 'state', but a 'trait', with certain individuals being predisposed to frequent consultation. It is unrealistic to propose, as Carney *et al* do, that frequent attendance is a problem that simply goes away.

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- attenders in general practice: a retrospective 20-year follow up study. *Br J Gen Pract* 2001; **51**: 567-569.
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  6. Gill D, Sharpe M. Frequent consulters in general practice: a systematic review of studies of prevalence, associations and outcome. *J Psychosom Res* 1999; **47(2)**: 115-130.

I was fascinated to read Carney *et al*'s research in the July issue of the *BJGP*,<sup>1</sup> which showed how their data collection allowed them to look back at a cohort of frequent attenders from 20 years ago. However, the methodological problems of the research raise questions concerning the validity of the results, the conclusions, and of the 'How this fits in' box.

The authors acknowledge the retrospective nature of this study. Of their original cohort of 486 patients, 58 had remained with the practice and were studied. It is hard to be sure if these patients are truly representative of the 88% who were lost to follow-up, or that some confounder — perhaps the presence of physical disease — had made them more likely to stay with the practice. The cross-matched low-attending group had an average of six attendances per year, which is above average. We are only given data about the prevalence of physical or psychological disease in the 14 very high attenders, of whom six were receiving treatment for depression. There is research evidence that GP's vary considerably in their ability to detect depression,<sup>2</sup> and this may have resulted in a relative underestimate of the prevalence of psychological rather than physical problems.

Much that is known about 'illness behaviour' points to personal,<sup>3</sup> social, and cultural<sup>4</sup> determinants of consulting behaviour. This accords with GPs' experience that some patients with a

condition, such as ischaemic heart disease consult frequently, while others come rarely.

Surely the interesting question is: why does *this* patient with physical disease come frequently?

It is hard to find believable support from this paper for the assertion from the summary, and the 'How this fits in' box, that physical illness determines long-term frequent attendance, or for the conclusion that better chronic disease management is the answer.

This raises the question of how to write the 'How this fits in' section so that it informs the skimming reader without misleading. Simple messages are most likely to be remembered — but are not the whole truth without discussion of the strength of the evidence on which they are based.

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### Patients and doctors with hearing difficulties

With reference to the article in the Back Pages,<sup>1</sup> I was surprised to find no mention of the use of the fax machine. Almost every practice has one, many homes have them, and they are easy and cheap to run. Communications are written, and ambiguity is avoided. They can also be used with PCs.

I have personal experience of this. My elderly deaf father uses one, and thinks it's the best thing ever. He had no difficulty learning how to use it. When my mother had a prolonged terminal illness at home he was able to use it to communicate with the doctors, the nurses, and the family, easily and effectively. My children send him

pictures on it too.

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### Reference

1. The Docker's Daft Pension Rocket ship. *Br J Gen Pract* 2001; **51**: 600-601.

### *Chlamydia trachomatis*: opportunistic screening in primary care

Tobin *et al* in the July issue of the *BJGP*<sup>1</sup> address an important issue. However, their conclusion that they have 'shown a prevalence of 10.9% for *Chlamydia trachomatis* among sexually active women', is flawed. Only around one-third of the women meeting the inclusion criteria supplied a sample and no evidence is presented to suggest that this group is representative.

The inclusion criteria are also subject to question. It is likely that those women who are sexually active but not in receipt of family planning services were at greater risk of acquiring a sexually transmitted infection. The addition of previous pregnancy or abortion would have improved the inclusion criteria.

Finally, it is highly desirable to present confidence intervals around point estimates. In this case the 95% confidence interval for a *C. trachomatis* prevalence of 10.9% is 5.5% to 16.4%, indicating the wide range of plausible values. This range has important policy implications. Should the actual prevalence be nearer the upper end of the confidence interval a more systematic approach to screening may be justified.

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### Reference

1. Tobin C, Aggarwal R, Clarke J, *et al*. *Chlamydia trachomatis*: opportunistic screening in primary care. *Br J Gen Pract* 2001; **51**: 565-566.

### Chronic fatigue syndrome

The study of Hamilton *et al* in the July issue of the *BJGP*,<sup>1</sup> claims that a higher consultation rate in people with chronic fatigue syndrome (CFS) before they develop the diagnosis supports the hypothesis that behavioural factors have a role in its aetiology. A similar case-control study of mothers and fathers of Down's syndrome children showed that both mothers and fathers had significantly more recorded illnesses before the birth of the child and that the mothers had significantly more psychosis, neurosis or self-poisoning.<sup>2</sup>

The problem with such findings is deciding what they mean. No-one would suggest that Down's syndrome is caused by 'behavioural factors,' so why should anyone believe that of CFS? There is no more evidence that increased frequency of attendance before diagnosis points to behavioural factors in CFS than that it points to non-dysjunction in the germ cells of mothers of Down's syndrome children.

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## Recruitment of practices to primary care trials

In much primary care research the recruitment of practices is an essential step before patients can be enrolled. In the UK, invitations to practices are usually made by letter to the GP partners whose joint consent is a prerequisite to research in their practice. However, the actual trial work is often carried out by practice nurses for whom this may be a valued extension to their usual role.

It is not known whether such practice recruitment is more effectively carried out by initially approaching GPs or

**Table 1.** Effect of profession of recipient or joint recipient of invitation letter on agreement to participate in trial.

Letter sent to:	Number	Agreed to participate (%)	Odds ratio (95% CI)
Senior GP	62	3 (4.8)	1
Senior practice nurse	60	7 (11.7)	2.59 (0.63-10.5)
Both	60	8 (13.3)	3.01 (0.76-12.0)
Total	182	18 (9.9)	

practice nurses, nor whether a follow-up enquiry increases effectiveness. We wish to report the results of a pilot study comparing these different strategies during the recruitment phase of an ongoing randomised controlled trial.

Between November 1999 to April 2000, 182 practices in Southern England were invited to participate in a study into the management of night cramp, in which the trial work was to be carried out by practice nurses. Having obtained ethics approval from the respective LRECs, invitation letters were randomly sent to either the senior GP partner, the senior practice nurse, or to both, and half of each group received a follow-up phone call. The main outcome measure was the written agreement to participate in the night cramp trial of all GP partners and a named practice nurse.

Eighteen practices, out of the 182 practices invited, agreed to participate in the night cramp trial. Sending the invitation letter to the senior practice nurse or to both made a small but not significant difference. (Table 1.)

No benefit from a follow-up phone call was demonstrated. Comparing the 90 practices who received no follow-up phone call with the 92 practices who did, the numbers agreeing to participate in the trial were 10 (11.1%) and 8 (8.7%) respectively; the respective odds ratios (95% CI) were 1 and 0.77 (0.29-2.06).

Comparisons of those practices agreeing to participate, with those who did not, showed that slightly more were rural (39% versus 31%), more had a senior partner with MRCGP (44% versus 35%), but both the number of partners (4.4 versus 4.0), and years since qualification of senior partner were very similar (29 versus 28.5). None of these differences reached significance.

This was a pilot study based on

recruitment to only one trial, and responses may have been influenced by the subject of the host trial. The decision to approach the senior GP and senior practice nurse rather than, for example, all GPs and practice nurses, was taken for practical reasons, but may not reflect usual practice. For these findings to reach significance, and to be more broadly generalisable, a much larger study involving recruitment to a number of different host trials would be needed.

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## The Back Pages

I would like to suggest that the time has come to shed the rather silly little image of the naked male doctor from the Journal! Mildly amusing at the time it first appeared, it has now passed its 'sell by' date.

If you can't bear to do this, why not get the woman who drew the image to produce an equivalent one of a naked female doctor and print it for a few months in the interests of sexual equality!

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## Correction

In the May issue of *BJGP*, the book reviewed on page 428, *Depression: social and economic timebomb*, was edited by Ann Dawson and Andre Tylee, and not Ann Davidson, as was incorrectly stated. We apologise for this error.