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.

Osteoporosis in postmenopausal women

The article 'Clinical risk factors as predictors of postmenopausal osteoporosis in general practice' by Versluis *et al*[1] is an interesting contribution to the study of clinical risk factors in postmenopausal osteoporosis. Diagnosis of osteoporosis is commonly based on bone mass measurements but it is obvious that data concerning clinical risk factors may be helpful in assessment of risk for fragility fractures. The authors have found that three risk factors — a low body mass index, previous fragility fractures, and severe kyphosis and/or loss of height — were significantly associated with osteoporosis. However, we have some critical remarks concerning the study.

First, in the article only bone mass-related risk factors were evaluated, so it would be better to emphasise that in the title.

Secondly, the authors assessed kyphosis and/or height loss as a clinical risk factor and, in parallel, osteoporosis was defined by the presence of severe vertebral deformity and/or a bone mineral density T-score less than –2.5. It is a serious mistake; kyphosis cannot be used in the same study twice. The authors ought to choose whether kyphosis is a diagnostic criterion or is concerned as an independent risk factor for fragility fracture. Risk factors must be distinctly separated from signs of the diseases and cannot simply be exchanged. Therefore, we are convinced that the proposed simplified case-finding strategy cannot be suitable in a diagnostic process. In a recent, excellent review of the literature on bone mass-related risk factors for fracture[2] the authors evaluated the role of a long list of clinical factors but height loss was not considered to be one of them. In that review, similar to the current study, among strong risk factors (relative risk for fracture ≥2.0) were low body weight and prior osteoporotic fracture. It supports the general significance of the study by Versluis *et al*. We consider that the authors ought to repeat the whole analysis without kyphosis and/or height loss as a risk factor for osteoporosis or the diagnosis of osteoporosis would be based solely on bone mass measurements. Such analysis may provide a reliable model of clinical risk factors assessment in general practice.

Thirdly, in the study other important risk factors, such as low diet calcium intake and physical inactivity, ought to be taken into consideration.

WOJCIECH PLUSKIEWICZ
Department and Clinic of Internal Diseases, Diabetology and Nephrology, Head of Metabolic Bone Diseases Unit.

BOGNA DROZDZOWSKA
Department and Chair of Pathomorphology, Silesian School of Medicine, Zabrze, Poland.

ZENON HALABA
Outpatients Medical Care, 'Nasza Rodzina', Zabrze, Poland.

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The paper by Versluis *et al*[1] on clinical risk factors as predictors of postmenopausal osteoporosis in general practice is based on a similar number of patients to those in a one practice pilot study in West Sussex, which we report here. Our results question the conclusion that 71 is a sensible age at which case finding should be replaced by general screening, and suggest that it may be appropriate at a younger age. Further research is needed before such a conclusion can be drawn.

In this single practice pilot there were 699 women aged 50 to 75 years (compared with 494 women 55 to 84 years). Of these, 478 completed questionnaires[2] validated in a 20-minute appointment, and had forearm dual-energy X-ray absorptiometry scans using Osteometer DTX 200 (compared with 494 women having hip scans).

Clinical risk factors were present in similar rates allowing for the difference in age groups (Table 1); 45% overall had clinical risk factors (compared with 55%) and the 55 to 64 years age group had 44% (compared with 43%).

Different risk factors were more prevalent in West Sussex. Fragility fracture, chronic disease (rheumatoid arthritis, coeliac disease, etc.) and low body mass index (BMI<19) were the most common. This may reflect different recording patterns in the computerised medical record, or different disease patterns.

When the West Sussex data is divided at age 65 years there are marked differences found in the results. For patients in the 50 to 64 years age group the risk factors have a high sensitivity and therefore a high negative predictive value that a patient has osteoporosis, i.e. those without risk factors are unlikely to have osteoporosis. This justifies the case finding approach up to this age. For patients aged between 65 and 74 years no such difference exists on our data.

We would not conclude that this

	All women (50–75 years) Scan for osteoporosis						
	Positive	Negative		Sensitivity	68.2	PPV	22.6
Risk factors present	45	154	199	Specificity	62.6	NPV	92.5
Risk factors absent	21	258	279	Specificity	13.8	LR+	1.8
						LR-	0.51
	66	412	478				
	Women (50–64 years) Scan for osteoporosis						
	Positive	Negative		Sensitivity	80.0	PPV	13.9
Risk factors present	16	99	115	Specificity	66.1	NPV	98.0
Risk factors absent	4	193	197	Specificity	6.4	LR+	2.4
						LR-	0.3
	20	292	312				
	65 –74 years Scan for osteoporosis						
	Positive	Negative		Sensitivity	63.0	PPV	34.5
Risk factors present	29	55	84	Specificity	54.2	NPV	79.3
Risk factors absent	17	65	82	Specificity	27.7	LR+	1.4
						LR-	0.68
	46	120	166				

Table 1. Two-by-two matrices to show the predictive value of case finding in all women aged 50 to 74 years, and in women age 50 to 64 years, and 65 to 74 years. (Method after Sackett et al.[4]) PPV = positive predictive value; NPV = negative predictive value; LR = likelihood ratio.

data can alone make the case for case finding up to age 64 years and screening for age 65 years and above. There are limitations with forearm scanning, and relatively small numbers of patients have been studied. We would suggest that further research is indicated and that our data contradicts the suggestion that 71 years is an appropriate cut-off age for screening. Other countries[3] have already adopted 65 years as a sensible age above which BMD testing should take place. Regardless of additional risk factors, a larger UK-based study is needed.

MIKE HARVEY

General Practitioner, Cuckfield Medical Practice, Cuckfield, West Sussex.

SIMON DE LUSIGNAN

Senior lecturer, Primary Care Informatics, General Practice and Primary Care, Hunter Wing, St George's Hospital Medical School, London SW17 ORE.

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Author's response

The responses of Dr Harvey and Dr Pluskiewicz and their colleagues to our article 'Clinical risk factors as predictors of postmenopausal osteoporosis in general practice' illustrate the current interest in strategies to identify patients with osteoporosis in daily practice.

The study described by Dr Harvey and Dr de Lusignan in a British population with different diagnostic procedures reached conclusions very similar to ours confirming the general validity of the proposed approach. The question regarding an age limit for screening for osteoporosis is extremely important but cannot be confidently answered by either their analysis or ours. This is also the reason that we have been very cautious with our statements. In our study, we included women ten years older than those included in the West Sussex study, which may, at least in part, explain the difference in the outcome. We believe that the issue of an appropriate age for screening for osteoporosis will remain open until relevant, properly designed, prospective studies are conducted.

Dr Pluskiewicz and colleagues criticised the choice of factors selected for patient identification, confusing bone mass-related factors with fracture-related factors (e.g. maternal hip fracture, previous fragility fracture) that are more clinically relevant particularly for general practice. Approaches such as those recommended by Dr Pluskiewicz and colleagues, coupled with the endless lists of risk factors identified in epidemiological studies, temper the interest of general practitioners (GPs) in attempting to identify patients with the disease and are responsible to a large extent for the disappointedly low rates of recognition and treatment of the disease. We defined osteoporosis not only by BMD measurements but also — and in our view more importantly — by the presence of vertebral fractures. This is a much more realistic approach that conforms with the definition of the disease, identifies its whole spectrum, selects patients with the highest risk for new fractures, and is suitable for a busy general practice. Failure to

include recognition of vertebral fractures in the evaluation can result in missing the most seriously affected patients for whom very effective therapeutic interventions are currently available.

R G J A VERSLUIS

General practitioner, Department of General Practice, Leiden University Medical Centre, PO Box 2088, 2301 CB Leiden, The Netherlands.
E-mail: R.G.J.A.Versluis@lumc.nl

Haematuria

The article by Summerton *et al*[1] is interesting in that it provides insight into which factors are useful in assessing the likelihood of urological malignancies in patients presenting with macroscopic haematuria.

However, microscopic haematuria is evidently not so easy to assess, but there is, I suggest, an important question to be asked when a patient is found to have microscopic haematuria — namely, why was the person tested in the first place? A patient does not complain of microscopic haematuria after all — he is found to have it when tested. After working as a GP for many years, my impression is that many people are tested for no clear reason — usually by default — with a multiple testing stick at routine intervals when a protein/glucose dipstix would have been quite sufficient.

Primary population screening for protein and glucose is a well established practice. For every known diabetic there is one undiagnosed. The earlier diabetes is recognised and treated the better the prognosis. But what evidence is there to justify such unselective screening for microscopic haematuria?[2] Many perfectly well 'victims' have been subjected to expensive investigations and anxiety following such misguided testing. The authors do not discuss this factor but with more critical usage of testing for microscopic haematuria, I'll wager the specificity of further investigations would improve.

Until doctors and nurses resist the temptation to dip multiple test sticks in every urine that comes their way, a great deal of time and money will continue to be wasted.

PENNY WATSON

General practitioner, Wester Hailes Health Centre, 7 Murrayburn Gate, Edinburgh EH14 2SS.
E-mail: mckee@blueyonder.co.uk

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The paper by Summerton *et al*[1] is an important contribution to the task of detecting urological cancers in patients with haematuria.

To be doing our job well, GPs should aim to detect urological cancers promptly and accurately, in accordance with the NHS Cancer Plan.[2]

However, the available evidence shows that the mean time from referral from general practice to a diagnosis of urological cancer is 114.6 days.[3]

Recent reforms to provide an outpatient appointment within two weeks for a patient referred by the GP who suspects cancer may bring some initial comfort. If the wait for a diagnostic procedure is long, the time from an initial referral to diagnosis remains lengthy and unacceptable. The report on NHS Cancer Care in England and Wales quotes an average wait of 88 days for diagnostic endoscopy of the bladder.[4]

There is promise in the development of an assay to detect urothelial cancers in cells collected from patients' urine. A preliminary report has been encouraging.[5]

Is this not an area where the researchers from various disciplines should combine their talents, effort, and any available grant to determine the positive predictive value of the assay alone, the positive predictive value of the patient's clinical and socio-demographic characteristics, and the two methods combined?

WILLIAM HOWE

NHS R&D General Practice, Lostwithiel Surgery, North Street, Cornwall, PL22 0EF.
E-mail: William.Howe@lostwithiel.cornwall.nhs.uk

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Current issues in fitness for work certification

We read with interest this well referenced discussion paper. We do, however, feel that there has been a missed opportunity to stimulate a collaborative approach to address the issues raised, by greater liaison between general practice and occupational health.

Dr Sawney[1] points out that opinion differs as to whether sickness certification is the role of the GP. He also highlights the possible loss of trust if the patient advocacy role is challenged, and the lack of knowledge of the workplace or expertise in the skills required for assessment. His conclusion is that there should be greater ownership of these issues by GPs, with improved training and guidance in how to address them.

A report from the Confederation of British Industry[2] also identifies these barriers. It states that sickness absence costs UK business nearly £11 billion a year, with the cost to society of nearly £23 billion a year. It draws very different conclusions as to how to address this, and suggests that businesses need to take greater ownership of the problem, including having effective rehabilitation programmes supported by quality occupational health provision.

One of the new approaches alluded to by Dr Sawney is that 'subject to successful pilots, which will begin this year, the power to certify incapacity for work will be extended to nurse practitioners'.[3] The implication is again that there will be a training requirement.

We would ask whether now is the time for GPs to be taking greater

responsibility and learning more skills in yet another area. Workload for GPs is likely to be reduced when occupational health is able to lead active rehabilitation programmes in liaison with primary care.

DAVID BEAUMONT

Occupational physician (former GP), Business Healthcare, Mansfield Woodhouse.

JOHN CHALLENOR

President, Society of Occupational Medicine, 6 St Andrew's Place, London.

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Mortality in general practice

Webb and Esmail's analysis of practice-level mortality data[1] and Lee's accompanying editorial[2] shed further light on the uses of mortality data at practice level. However, there is still considerable confusion about the uses of these data. There are two issues that need separating; the practical and epidemiological use of practice-level mortality data to primary care staff, and the use of such data to detect doctors behaving in the manner of Harold Shipman.

The analysis of Webb and Esmail demonstrates the limited use this data has as an epidemiological tool. The numbers are small, the confidence intervals are wide and for the majority of the causes of death listed the results are not statistically significant. The work required by practices to undertake this sort of analysis is unlikely to produce tangible benefits to patients. Patterns of care are unlikely to be substantially altered and any results are likely to be in keeping with what staff already know from their local knowledge.

What needs further exploration is the analysis of practice-level Office of National Statistics (ONS) mortality data. Current discussion on this has focused on the difficulties of producing a failsafe statistical calculation that will detect doctors who are killing patients.[3-5] What is needed however is not a failsafe statistical process but rather a system that prompts the right people to ask the right questions. We have analysed practice level mortality data for general practices in East Sussex using methods akin to those previously published.[3] The data confirm the view that practices treating more deprived populations and practices delivering services to nursing homes and hospices have higher mortality rates compared with other practices. This does not mean the data are useless; rather, we are exploring the use of tolerances for these and other factors so that the data can be rendered more informative.

The data on their own however will never answer the question of whether high mortality rates are as a result of a general practitioner killing patients. What they can do, is direct the attention of relevant primary care trust staff to ask further and more meaningful questions. To ignore this data because of problems in interpretation is to focus too much on mortality data as a statistic, rather than as a valuable information resource, which, along with other data can inform future appropriate action. More analysis and discussion of practice level mortality data is required. The consequences of doing nothing because of real and perceived data inadequacies are, as we have seen, disastrous for patients and doctors.

THOMAS J SCANLON

Consultant in Public Health and general practitioner, Brighton and Hove City Primary Care Trust, 6th Floor, Vantage Point, New England Road, Brighton BN1 4GW.

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Restricting the use of thioridazine

In 2000 the Committee on the Safety of Medicines in the UK published restricted indications on thioridazine. It was effectively removed from use in primary care, following reports of sudden death from ventricular arrhythmia. A prolonged QTc interval in the ECG was presumed causative and this effect is greatest with thioridazine. However, haloperidol is implicated to a degree — as are newer antipsychotics — a recent review concluding that at this point in time an atypical antipsychotic without concern does not exist.[1]

We performed a study to explore the impact of the restrictions in a rural general practice setting. A questionnaire was devised and mailed to 40 GPs in a rural Irish county (population of 50 000). The response rate was 72.5%. Management problems and adverse effects associated with thioridazine discontinuation were reported by 17 GP's (63%). Newer atypical antipsychotics were prescribed by 81% of GP's. There was increased service demands; 70% of GPs reported an increased attendance at GP surgeries, while 44% described up to a 50% increase in referrals to the mental health service. Significantly, only one GP had no patient on thioridazine.

We assumed that as a long established medication, the impact of discontinuation would be conspicuous at the primary care level. The findings support this supposition. Moreover the process appears to have considerably increased the GPs' workload and frequently resulted in specialist consultation. It seems likely in view of the nature of the adverse effects reported that neuroleptic withdrawal[2] would account for most of the distress experienced by patients. Most GPs (67%) reported satisfaction with alternative agents; however, 37% described adverse effects associated with the use of alternative agents. Atypical antipsychotics carry risks, notably weight gain,[3] hyperlipidaemia, and new-onset diabetes.

The most salient issue emerging from the present study relates to the manner in which future restrictions of

widely used neuroleptics are to be implemented, a prospect not unlikely in that all antipsychotics — including atypicals — carry the risk of QTc prolongation. It seems inconsistent that while the decision to continue the drug required supervision by a psychiatrist the management of discontinuation did not. This placed an unfair burden on doctors in primary care. Any future removal of similar medications should be appropriately resourced to allow for adequate education in advance and support for active liaison between primary care and mental health services.

P BAILEY

GP Trainee on North Eastern VTS (GP), Department of Psychiatry, Cavan General Hospital, Cavan, Ireland.

V RUSSELL

Consultant Psychiatrist, Cavan Monaghan Mental Health Services.

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Bladder catheterisation

Despite the morbidity, long-term catheterisation of the bladder (LTC) remains the routine management for many patients with loss of bladder control. The problems are familiar to medical and nursing staff responsible for these people and numerous publications have stressed the need for further research on this subject. Up to 50% of catheters block, creating a burden aptly termed 'crisis management'.[1] The universal catheter for urethral/suprapubic, male/female catheterisation was introduced by Dr Foley in 1937.[2]

In May 1999, about 300 letters to local general practitioners and nursing staff informed them of the start of a weekly assessment clinic at Southmead Hospital for patients experiencing problems with LTC; this resulted in 50 referrals in four weeks. Over 18 months 100 patients attended the clinic. The majority were severely disabled from neurological conditions, such as multiple sclerosis, CVA, or spinal injury and dependent on a carer, often a relative or nurse as well as hospital transport, wheel chair and hoist.

Recurrent catheter blockage was the major cause for referral (85%); some catheters required changing up to three times a week at unpredictable times of the day or night, causing distress for patient, carer, and an unscheduled demand on nursing services. Macroscopic examination of the catheter revealed crystalline deposits within the lumen in 61 and flexible cystoscopy identified bladder stones in 38 of these patients. Owing to the size of the stone burden, 19 patients were placed on the waiting list for litholapaxy, waiting up to 15 months for admission. Microbiological examination revealed infection from *Proteus mirabilis* in 90% of stone formers.

The message is simple. If patients with long-term catheters experience recurrent blockage, the catheter should be cut open along its length with scissors and the lumen inspected for crystals; if present, flexible cystoscopy is indicated. A small clinical trial of domiciliary cystoscopy was performed using a battery-powered flexible cystoscope (KeyMed Ltd) which greatly facilitated examination of selected immobile patients.

Research on this subject is challenging. A multidisciplinary approach is required, supported not only by clinicians and nursing staff but by microbiologists, engineers, material scientists, etc. The government LINK programmes provide opportunity for clinical, academic and industrial partnerships. A team at the BioMed Centre of the Bristol Urological Institute is participating in a £2.4 million Foresight LINK Award to address the problems of LTC and to develop an improved system.

ROGER FENELEY
DANNY PAINTER
ANN EVANS
DAVID STICKLER

Bristol Urological Institute, Southmead Hospital, Bristol BS10 5NB.

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Prescribing costs and patterns

Walker and Mathers report that practices with diverse prescribing patterns can work together effectively to control prescribing costs if exposed to an appropriate intervention.[1] Unfortunately their study ignores the motivation of the collective ethic of the practices in the commissioning group pilot, and any potential financial incentives. At baseline the comparison group of nine practices consisted of eight former fundholders, whereas the study group of nine practices had only four former fundholders. This is reflected in the baseline prescribing data — less expensive nic/PU, less volume of prescribing, and a higher generic prescribing rate for the comparison group. This group (mainly of former fundholders) had, over previous years, come well within budget and no doubt valued the efficiency savings generated through being part of the fundholding scheme. Over half of the study group practices prior to 1998/1999, would have had the opportunity to receive only relatively small prescribing payments as part of the incentive scheme for non-fundholding practice, though it appears that these practices generally did not receive payments owing to overspending their allocation.

Being part of a commissioning group allowed these non-fundholders (five out of nine in the study group) to reap greater financial benefits that they had previously been able to do under the non-fundholding incentive scheme. These savings could be reinvested in commissioning additional healthcare for the whole community. Also acceptance of a cash-limited prescribing budget may have stimulated the expectation of prescribing change by the participating general practitioners as well as a commitment to the values of the wider group. Yes, the reported initiative did incorporate important features associated with successful implementation of change but perhaps the key motivation for change in the study group was the altruistic focus associated with a collectivist perspective, something that did not exist in the

comparison group.

MICHAEL WILCOCK

Pharmaceutical Advisor, Cornwall and Isles of Scilly Health Authority, John Kaey House, St Austell, Cornwall, PL25 4NQ.

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Telephone consultations

McKinstry *et al* seem less then enthusiastic about the use of telephone surgeries.[1] We have found them to be useful in managing workload and they have been appreciated by patients. We would like to offer some encouragement to GPs thinking of offering telephone surgeries. Our five partner suburban practice originally introduced telephone surgeries last year to manage demand for same day appointments but they rapidly evolved into an alternative means of consultation. We are now able to offer same day consultations routinely for most of our patients by reserving 50% of our appointments for on-the-day booking and ensuring that sufficient slots are available on the basis of patterns of previous demand.

We have a telephone surgery each day from 8.30 am which deals with an average of 17 patients. Each partner holds one telephone surgery each week on his day on call. Appointments for the doctor to ring back can be made up to 24 hours in advance but 90% of the requests are received on the day. Patients have learnt to book calls with a particular doctor and there is no limit to the number of calls accepted.

During the three months from 1 January this year I personally consulted with 138 patients by telephone with an average consultation time of 5.2 minutes compared with an average of nine minutes for face-to-face consultations. One patient consulted on three occasions, and four on two occasions. Twelve were seen later the same day, four of them by the nursing team and one by home visit. Seven were seen within three days at the surgery at an appointment booked at the time of the telephone contact.

One advantage for the practice is flexibility for the on-call doctor who can attend to urgent matters without keeping patients sitting in the waiting room. It has become unusual for doctors to be interrupted by telephone calls from patients at other times of the day. The doctor holding a telephone surgery does not need a fully equipped consulting room, just a telephone and access to the records, which is useful in our overcrowded building.

Our patients have learned to use the service discriminately and enjoy the advantage of being able to consult at home, at work or on a mobile. Fewer patients waiting in the waiting room means a more relaxed atmosphere.

Provided that telephone consultations are not used as a barrier to access to a doctor we find them a useful additional service for our patients.

HELEN JOESBURY

General Practitoner, Woodseats Medical Centre, Cobnar Road, Sheffield, S8 8QB.

Reference

1. McKinstry B, Walker J, Campbell C, *et al.* Telephone consultations to manage requests for same day appointments: a randomised controlled trial in two practices. *Br J Gen Pract*: 2002; **52** 306-310.

It is unlikely that the randomised controlled trial over a period of four weeks involving 388 patients seeking a same-day appointment by McKinstry *et al* contributes anything of relevance to telephone consultations and managing demand.[1] I am a single-handed GP with a list size of around 2800. I use the EMIS clinical system which has a simple facility to record consultations according to place and I have recorded consultation activity for the past five years (Table 2).

Total consultation activity increased by about 10% in the third and fourth years and in the last year was just 4.5% greater than what it had been at the start of the study. Telephone consultation activity has increased nearly five-fold and now accounts for over 20% of all consultations. Face-to-face surgery consultations and home visits have decreased by 11.8% and 28.9%, respectively. In the first year of data collection just 10% of patients made one or more phone consultations. Last year this had increased to 29% of the registered population.

In March 2001 I carried out a survey of a random 24% sample (n = 211) of all patients who had had a telephone consultations within the preceding 12 months. Replies were received from 155 (73%) patients. Over 97% of patients were satisfied that telephone consultations answered their immediate need though 16% would have preferred a surgery consultation.

One clear message from this data is that changing to telephone consultations is a slow process if it is to be successfully achieved and any benefit that they may have to meeting demand is likely to be compromised if the government imposes unrealistic targets.

MORRIS DOUBLET-STEWART

Grasmere Street Health Centre, Leigh, Lancashire.

Reference

1. McKinstry B, Walker J, Campbell C, *et al*. Telephone consultations to manage requests for same-day appointments: a randomised controlled trial in two prac-

Table 2. Consultation activity for the past five years. Numbers are annual rate (percentage) per 1000 registered patients.

Date	Surgery consultations	Telephone consultations	Home visits	Total
1/4/97 – 31/3/98	2668 (88)	133 (4.4)	225 (7.4)	3026
1/4/98 – 31/3/99	2580 (81)	388 (12.0)	221 (7.0)	3189
1/4/99 – 31/3/00	2589 (77.8)	538 (16.1)	202 (6.1)	3329
1/4/00 – 31/3/01	2494 (74.5)	658 (19.7)	194 (5.8)	3346
1/4/01 – 31/3/02	2354 (74.5)	648 (20.5)	160 (5.0)	3161

tices. *Br J Gen Pract* 2002; **52:** 306-310.

Telephone consulting continues to tempt us with its possibilities and to beguile us with its complexities. McKinstry *et al* have provided a very good example of the challenge we have in trying to understand the role of the telephone in consultations.[1] While the authors make explicit the possible time saved by doctors when using the telephone to manage requests for same-day appointments, I believe that the acknowledgment and discussion of a second message would help clarify the other conclusions they draw.

This message, that some requests for same-day appointments can be managed exclusively on the telephone, may be obvious, but it is important. This takes the idea that the telephone can be used exclusively for consulting, one step further from previous work.[2-4]

If one assumes that the role of the telephone consultation is the same as a face-to-face one, then a direct comparison, such as in this trial, is reasonable. However, a telephone consultation might serve one of two purposes: provision of a complete consultation, or provision of a sorting service to select the most appropriate access for the patient. It is unclear what service the telephone appointments in the study were providing. Many telephone consultations will end with the suggestion that the patient needs to be seen but not necessarily on the same day. The secondary outcomes measured in this study might simply be reflecting this fact. For example, an increased attendance rate for those who had a telephone appointment may just be demonstrating the legitimate sorting role of a telephone consultation. The authors have, perhaps, alluded to this in their comment about 'safety-netting appointments', but it is not a clear point.

It does not seem surprising to me that blood pressure was measured more frequently in face-to-face consultations, that allow physical contact, than in telephone consultations that deny contact. I would question blood pressure as a valid proxy outcome for chronic disease management in this situation. Indeed, the fact that 12 out of 181 patients who had a telephone appointment, had their blood pressure measured suggests there is more information in this study which could help clarify the discussion and conclusions further. Telephone consulting is beguiling indeed.

MICHAEL INNES

NHS R&D primary care researcher development fellow, Department of Primary Care and General Practice, The University of Birmingham, Edgbaston, Birmingham, B15 2TT.
E-mail: m.a.innes@bham.ac.uk

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Author's response

Our study examined one specific aspect of telephone consulting — its use in the management of demand for same-day appointments. Both practices that took part in the study had already been running telephone consultations for some time and continue to run them now. They think they are a useful safety net for potentially serious symptoms, but we feel that some of the calls we handle are for very minor problems. In many instances these are problems that patients would not have presented to the doctor in a surgery appointment, but indeed might have sought advice from a pharmacist or possibly put up with their symptoms until they got better.

We went to great lengths in our article to draw attention to the problems of such a small trial, but despite this, a well conducted randomised controlled trial is worth considerably more than any observational study. Only in such a trial can effects such as case mix, appointment availability, and doctor personality be controlled for. Unfortunately, from the data presented by Dr Joesbury and Dr Doublet-Stewart we cannot deduce what patients wanted from the service. Patients who wanted telephone advice are likely to be more satisfied by it than those who wanted a face-to-face appointment but didn't get one. Additionally, it would appear that some telephone calls in their surveys are being used for follow-up consultations. This might be a time-effective way of dealing with such consultations, but no properly conducted study has been done to examine this.

We chose BP measurement as a proxy for opportunistic health promotion. We realise this is not entirely satisfactory as BP examination may have been primarily a diagnostic test rather than a screening or follow-up intervention. We fully expected fewer BP checks to be done in the telephone arm of the trial (on those patients who after triage need to be seen), but some may have argued that such tests are infrequently conducted in face-to-face same day appointments and so it was important to establish if this were true.

We presented our study to highlight concern that telephone surgeries may not be all they seem. We agree with Michael Innes that further research on how different types of consultation are handled by phone are required.

BRIAN MCKINSTRY

Director, Lothian Primary Care Research Network, Department of Community Health Sciences, University of Edinburgh, Levinson House, 20 West Richmond Street, Edinburgh EH8 9DX.

Correction

In the letter titled 'Reducing benzodiazepine prescribing' by Pam Armstrong in the April 2002 issue of the *BJGP*, we wrongly stated that CITA stood for Centro de Investigación y Tratamiento de la Adicción, in Madrid. However, in this case it stood for Council for Involuntary Tranquilliser Addiction. We apologise for any confusion this may have caused.