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.

Intuition … or good mathematics?

I remain to be convinced that 'intuition' exists. T Greenhalgh[1] gives two examples, both of which look to me like extreme cases of Bayes' theorem in which one factor ('no previous history, behaving strangely') deservedly received a weighting that overwhelmed the other components.

I too have the odd diagnosis I am proud of. We all have. But I can think of several where I 'intuitively' got the odds wrong (including the one when I roared up to a patient's house at top speed, to find him not just dead but stiff).

Her article appears to rely on a spurious distinction between 'evidence' and 'context', which then justifies the contrast of experienced and 'naïve' practitioners. But the examples and the definition merely describe the rapid, accurate computation of probabilities. In the same way that I would like to know the course, distance, and going before I bet on a horse, skilled practitioners should include in the computation of diagnostic probabilities the nature of the person with the illness. This is not intuition, it is just better mathematics.

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Reference

1. Greenhalgh T. Intuition and evidence — uneasy bedfellows? *Br J Gen Pract* 2002; **52:** 395-400.

Cervical screening

Quite properly, cervical screening undergoes periodic debate and change.[1] Recruiting the whole population that is deemed appropriate to screen, and engaging the attention of all women to the endeavour, are clearly central to success. This process ought to begin at or around puberty.

Encouraging a woman in her early twenties, who may have been sexually active for a decade or more, that now is the right time to start having tests for something that has not previously appeared on her self-interest radar, will be a sterner task than continuing a process of regular stigma-free sexual health care activity that dates from first intercourse — or, arguably, even before that.

In March 1996, in the *British Journal of Obstetrics and Gynaecology,* I listed almost 40 conditions that I could readily recall diagnosing during first pelvic examinations, the presence of which had not been disclosed or known about by the patient. Since then, after discussion with bacteriology and genitourinary medicine units, we have started to screen as widely as possible for STDs, including chlamydia, and have found a steady stream of them. A worrying proportion of first liquid cytology smears at 20-plus years of age are now reported as having high-risk type human papilloma virus (HPV) infection present and associated cytological changes with colposcopy are recommended.

How sure are we about the natural history of cervical cancer? Surely it is a dynamic thing. In my *BJOG* letter I recalled that we had had three recommendations for colposcopy in girls under the age of consent. Were these solely maturation changes that would spontaneously resolve — upon what evidence? How will we ascertain the veracity of that view in 20 years' time when retrospective analysis of early smears will no longer be possible? What of those young teenagers with numbers of partners far into double figures, a proportion of whom will already have high risk HPV now, who will not have a first smear for a decade or more?

The message that a high profile sexual health care activity — having a smear — is only important between 25 and 50 years of age, needs to be phrased ever so carefully. The importance and routine stigma-free nature of other forms of screening must be bolstered and actively promoted too. From the gravely disadvantageous position of my male gender, I venture to assume that one vaginal smear or swab is little different from another — if all are known, from the outset of sexual activity, to be simple, worry-free, easy and 'good for you', the public health will be so much better served.

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References

1. Wilson S, Lester H. How can we develop a cost-effective quality cervical screening programme? *Br J Gen Pract* 2002; **52:** 485-490.

Tuberculosis in primary care

We are grateful to Singh *et al*[1] for highlighting the growing challenge of managing the UK's part of the global tuberculosis epidemic. From our experience of running a TB control programme we are familiar with world standards of care, and are concerned that UK policy is lagging behind the best current evidence. In particular, there are three emphases that deserve to be highlighted from your editorial, which are vital to successful management in primary care here as elsewhere.

1. Early diagnosis depends on a high index of suspicion and prompt investigation of suspect cases. The International Union Against Tuberculosis and Lung Disease and the WHO agree on this definition: ‘a person with a cough lasting more than three weeks without a known other cause’. GPs may want to add to this other criteria, for example ‘high risk groups’, such as the homeless or recent immigrants, to ration investigations. The Department of Health seems to agree with this position.[2]
2. The cornerstone of diagnosis is sputum smear microscopy, a simple and cheap test that can be collected in general practice without special facilities. Results can be telephoned back to the surgery by the lab in 24 hours, and provides more accurate information on diagnosis, prognosis, and infectivity than culture or any of the DNA-based tests currently available. It is almost certainly underused in current practice.[3]
3. The key to successful treatment and control of TB in our communities is compliance with a drug regimen of up to four drugs, taken for 25 times longer than most antibiotic courses that we generally prescribe for acute infections. Internationally, directly observed treatment (DOT) is considered the gold standard method for improving compliance. The urgent challenge is to develop assessment tools that will predict those needing full DOT and to develop patient-friendly systems for delivering it. We also need to develop imaginative methods for improving and monitoring the compliance of other patients not receiving DOT. These might include nurse-provided health education, financial or in-kind incentives, weekly dispensing of pre-packaged medicines, and electronic reminders.[4] As long as there is international travel, HIV, homelessness, poverty and an ageing population in the UK, we can anticipate an increase in patients with TB in our surgeries.[5]

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References

1. Singh S, Madge S, Lipman M. Tuberculosis in primary care. *Br J Gen Pract* 2002; **52:** 357-358.
2. Department of Health. *Interdepartmental Working Group on Tuberculosis. The prevention and control of tuberculosis in the UK. September 1998.* London: DoH, 1998.
3. WHO. An expanded DOTS framework for effective tuberculosis control. WHO/CDS/TB/2002.297. Available on http://www.who.int/gtb/dots/index.htm
4. Holmes A and Garner P. Tuberculosis. In: *Clinical evidence 6*, *BMJ,* 2001.
5. Joint Tuberculosis Committee of the British Thoracic Society. Control and prevention of tuberculosis in the United Kingdom: code of practice 2000. *Thorax* 2000; **55:** 887-901.

Annual health checks for adults with severe learning disabilities in primary care

The National Minimum Standards Care Homes for Younger Adults Regulations (Standards 19.4) states ‘Service users are offered annual health checks (including attention to vision and hearing; medication; and, illness/disability unrelated to primary disability/condition)’.[1] The regulations came into operation on 1 April 2002. They do not specify who will do the annual health checks. In 2000, 53 400 adults with learning disabilities had residential care places.[2] This suggests that, in England, most GPs will have on average two such patients requiring annual health checks.

In 1997, we received funding to offer health checks to our patients identified as having significant learning disabilities on a practice-held register. Out of a total practice population of 14 410, 57 adults and children (37 males and 20 females) with moderate, severe, and profound learning disabilities were initially identified. A substantial minority of adults (18/47) were in residential care.[3] During the five-year study, further patients joined the practice so that an average of 56 adult patients, both those always in the community and those in residential care, were offered annual checks. The attendance rate was 77.5%. A structured health review questionnaire covering most of the 15 international consensus targets[4] was used by the learning disabilities nurse and GP. About three-quarters of all patients seen needed ‘in house’ (primary care) interventions, such as lifestyle advice leading to monitoring obesity, ear checks leading to syringing, review of associated locomotor, hormone, skin, digestive system, epilepsy or other CNS conditions leading to treatment, medication change, and blood tests. Other patients required referral to the consultant in the psychiatry of learning disabilities (often for anticonvulsant upgrade), and to locality community learning disability team members (for respite care, behavioural, speech and continence problems), or to other specialist colleagues; for example, dentist, optician and orthopaedic surgeon.[5]

People with learning disabilities are thought to have two-and-a-half times as many additional medical conditions than their peers,[6] yet are less demanding. Because of difficulties in communication, advocacy and access, patients with learning disabilities may not be getting as good a service as other more articulate patients. The ‘Valuing People’ strategy of facilitators and health action plans may help to rectify this inequality but there are increasing training and resource implications for primary care, which still have to be addressed.[7]

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References

1. *National minimum standards for care homes for younger adults. A statement of national minimum standards.* Published by the Secretary of State for Health under section 23(1) of the Care Standards Act 2000, 2001. London: DoH.
2. Department of Health. *Valuing People: A*

new strategy for learning disability for the 21st century. London: DoH/HMSO, 2001; Cm5086.

3. Martin GHB, Martin DM. A register for patients with learning disabilities in general practice: workload implications of ex-hospital patients. *J Learn Disabil* 2000; **4(1):** 37-48.
4. Beange H, Lennox N, Parmenter TR. Health targets for people with an intellectual disability. *J Intellect Devel Disabil* 1999; **24(4):** 283-297.
5. Cassidy G, Martin DM, Martin GHB, Roy A. Health checks for people with learning disabilities — addressing needs through psychiatrists and nurses in community learning disability teams working together with general practitioners and primary health care teams. *J Learn Disabil Nurs Health Soc Serv* 2002; **6(2):** 123-136.
6. van Schrojenstein Lanteman de Valk H, Metsemakers JF, Haveman MJ, Crebolder HF. Health problems in people with intellectual disability in general practice: a comparative study. *Fam Pract* 2000; **(17)5:** 405-407.
7. Martin GHB. 'Valuing people' — a new strategy for learning disability for the 21st century: how may it impinge on primary care? *Br J Gen Pract* 2001; **51:** 788-790.

Learning from death

Elizabeth Lee[1] states that 'a body of research evidence shows that... care is better in specialist palliative care settings than at home or in hospital'. The references she quotes show no such thing, nor were the patients studied similar.

I am concerned that patients, families and primary care teams may be persuaded that palliative care must be better in hospices. Hospices, hospitals and general practice offer different but complementary services. Rather than a fruitless search for which is better, we should be working together to ensure that the best possible care is given wherever the patient dies, which for a majority of patients ought to be their own home.[2]

This is helped by a systematic review of deaths in general practices since 'a retrospective search for avoidable factors in individual deaths is perhaps the most stringent form of self criticism available to any clinical team'.[3]

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References

1. Lee E. Learning from death. *Br J Gen Pract* 2002; **52:** 267-268.
2. Townsend J, Frank AO, Fermont D, *et al.* Terminal cancer care and patients' preference for place of death: a prospective study. *BMJ* 1990; **301:** 415-417.
3. Tudor Hart J, Humphreys C. Be your own coroner: an audit of 500 consecutive deaths in a general practice. *BMJ* 1987; **294:** 871-874.

Diabetic control and retinopathy

The article by Saum and colleagues[1] on the association between retinopathy and glycaemic control in patients with type 2 diabetes mellitus deserves further comments. First, the authors reported a low prevalence of diabetic retinopathy in their population. The authors indicate reasons for their under-ascertainment. This may also be owing to the low sensitivity of the technique used for the eye examination. There is a lack of studies on the sensitivity of slit lamp biomicroscopy to detect diabetic retinopathy by optometrists in a primary care setting.[2]

Secondly, the authors conclude that they had demonstrated a strong relationship between the presence of retinopathy and poor diabetes control, as assessed by glycaemia using $HbA1_c$. Although the odds ratio reported for $HbA1_c$ may indeed be high at 2.73, the wide 95% confidence interval of 0.9 to 2.7, crossing 1.0, suggests that this result is not statistically significant. Only diabetes duration remaining statistically significant (OR = 2.88; 95% CI = 1.1 to 7.7). Thus it appears that patients had a significantly long duration of disease, a known risk factor for development of retinopathy,[3] rather than poor glycaemic control to account for the presence of retinopathy.

Perhaps the small number of patients ($n = 23$) may have been a factor to explain the failure in finding a significance with glycaemic control and retinopathy used in the multivariate analysis. The United Kingdom Prospective Diabetic Study,[4] a large prospective study of patients with newly diagnosed type 2 diabetes mellitus, clearly demonstrated that poor glycaemic control and high blood pressure were associated with a higher incidence of retinopathy and other microvascular complications.

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References

1. Saum SL, Thomas E, Lewis AM, Croft PR. The effect of diabetic control on the incidence of, and changes in, retinopathy in type 2 non-insulin dependent diabetic patients. *Br J Gen Pract* 2002; **52:** 214-216.
2. Hart PM, Harding S. Is it time for a national screening programme for sight-threatening diabetic retinopathy? *Eye* 1999; **13:** 129-130.
3. Klein R, Klein BE, Moss SE. The Wisconsin epidemiological study of diabetic retinopathy: a review. *Diabetes Metab Rev* 1989; **5:** 559-570.
4. Stratton IM, Kohner EM, Aldington SJ, *et al.* UKPDS 50: risk factors for incidence and progression of retinopathy in Type II diabetes over 6 years from diagnosis. *Diabetologia* 2001; **44:** 156-163.

Telephone consultations

Telephone consultations continued to be viewed with circumspection,[1,2] yet for some the reality is of its completed integration into our working life. In my own practice, computer records from 1991 show that my daytime pattern of consulting has settled at approximately 52% as office visits, 43% as phone consultations, and 5% as home visits (approximate list size = 2000, annual daytime consulting rate = 9000) and my two partners show similar percentages. My own experience has also supported my research,[3] with the phone consultation being used as an alternative, and not as an additional access, to the doctor.

For the practice, the problems of phone consultations are now more prosaic. We have to routinely ask for patients' mobile phone numbers and also reflect on the added cost of this type of call for our phone bill (patients book appointment times for the doctor to phone them back).

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References

1. McKinstry B, Jeremy Walker, Clare Campbell, *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.
2. 'Be warned.' *Medeconomics* June 2002; 36.
3. Bown A, Armstrong D. Telephone consultations in general practice; an additional or alternative service? *Br J Gen Pract* 1995; **45:** 673-675.

Pilot study of patients' perception of an appointment system

This survey was designed to gain an understanding of the patient's concept of our appointment system. It also questioned our practice's adherence to an individual list system, in a political climate where ease and speed of access, rather than continuity of care, seems to take precedence. Patients' views on the appointment system at a specific practice were assessed and the questionnaire ascertained whether they valued continuity of care or immediate access.

The questionnaire was distributed to urgent and non-urgent patients, who made the first 140 appointments in the month of October at one practice. The practice is situated in Livingston, which is suburban and has a varied mix of patients from different socioeconomic classes. It has a higher proportion of younger patients (average age 37.5 years). The practice has a patient population of 13 000, with three full-time GPs, five part-time GPs, a retainer and a registrar.

All seven questions were answered anonymously by 140 patients (Table 1). This represents 1% of our patient population. Results indicated that 26% of patients didn't understand the system. Most patients (91%) were prepared to wait to see their own doctor for a routine problem. The opposite was true for urgent problems, where only 14% were prepared to wait. Many patients (12%) didn't know what sort of appointment they had made.

Under the section on comments, patients were generally positive about the service they received, some made useful suggestions and seemed to be aware of the pressures that their GPs were under. This survey indicated that the patients valued continuity of care and seeing their own GP for ongoing issues. For urgent problems, they preferred seeing any doctor and were not prepared to wait. There was an opportunity here to educate patients about the appointment system, and to ensure that the reception staff were clear about what they said to patients.

Our health centre has decided to defend its stance on maintaining continuity of care, in spite of the political climate. We feel, having listened to the opinion of our patients, that we can justify our position.

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GP involvement in child protection

Dr Carter and Dr Bannon draw attention to the serious consequences of missing child abuse, and the importance of GP involvement.[1] The substantial adverse publicity in fatal cases detracts attention from damage caused by unnecessary or excessive intervention. As a consumer group we would like GPs to consider another aspect: the need to protect children from unnecessary and damaging separation from their parents and their siblings when they are receiving reasonable or even excellent care. If social work intervention were a drug, suppliers would have to prove that benefits outweighed adverse effects in order to obtain a licence. At present no such evidence exists.[2]

For the past 40 years our work has been supporting mothers and improving maternity care. However, during the past three to four years, we have seen an escalation of social service investigations of childcare affecting pregnant women and young children. Even when the intervention has been brief and has not been followed by allegations of parental failings, the severity of damage done to the whole family, parents' confidence and judgement, and their trust in the health care system has astonished us. Two mothers developed post-traumatic stress disorder. Another with a long-term condition requiring hospital monitoring has dropped out of care.

Even in families needing some assistance, social work emphasis seems to be on obtaining care orders (creating great stress) at substantial legal cost rather than providing support. In some cases, we suspect that enthusiasm to improve adoption statistics is affecting attitudes towards mothers of young children. We were mystified by social workers' opposition to a woman with severe postnatal depression entering a mother and baby unit where we had found a place for her. Adoptive parents were already chosen, despite the fact that the mother was the successful parent of two healthy, happy, well-behaved schoolchildren. Fortunately, voluntary workers enabled her to

Table 1. Results of appointment questionnaires.

Questions			Answers	
			Yes	No
Do you know that this surgery runs an individual list system (i.e. you can only see the doctor that you are registered with, for routine problems)?			103	36
For a routine problem, would you be willing to wait a few days extra, to see your own doctor?			1281	12
For an urgent problem, would you be willing to wait longer to see your own doctor?			20	119
Do you generally prefer to see your own doctor, when possible?			116	24
Would you be happy to see any doctor for a routine appointment?			75	75
Would you prefer a no-appointment system? This may mean having to wait longer on the day.			27	111
	<1 day	<3 days	<1 week	<2 weeks
What do you think is a reasonable waiting time for a routine appointment?	9	71	48	11
	Same day	Next day	Three days	One week
What do you think is a reasonable waiting time for an urgent appointment?	68	41	31	0
My appointment today is:	Urgent	Not urgent	Don't know	
	40	83	17	

recover and successfully manage her family, who are all doing well, though with some residual damage from avoidable separations.

The quality of evidence on which action is taken is sometimes highly questionable. When our clients have accessed their social service records under the Data Protection Act, the discrepancy between the notes and what we ourselves saw and heard at the same meetings has been surprising. In some cases it seemed to us that social workers made up their minds at an early stage, and thereafter, only gathered supporting evidence. Action may be taken on the basis of Chinese whispers, repeated in so many files that their accuracy is taken for granted. The breaches of confidentiality we have observed of sensitive medical and social data has been deeply worrying and could have adverse effects far into the future of the children concerned. We have seen examples of selectivity, bias, inaccuracy, and misinterpretation in social work presentations, and these are too seldom challenged in family courts

Case conferences are often held at times when it is impossible for busy GPs to attend. However, since they are the ones who may have to help pick up the pieces and cope with families after the social workers have gone, we hope they will remember that 'child protection' also involves protecting children from unnecessary and avoidable separation from the birth family, or having their parents demoralised.

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References

1. Carter Y, Bannon M. GPs and child protection: time to grasp the nettle. *Br J Gen Pract* 2002; **52:** 514.
2. Macdonald G. Social work: beyond control? In: Maynard A and Chalmers I (eds). *Non-random reflections on health services research.* London: BMJ Publishing Group, 1997; 122-146.

Carter and Bannon[1] have done a good turn to vulnerable or mistreated children by highlighting the dual needs for better training in child protection within general practice and for better organisational planning across the various professions working with the same population, in every Primary Care Trust. Where frontline parenting and family interventions have failed to remove the danger to these children, the survivors may be taken into Local Authority care (becoming the 'looked-after children'). Roughly a third will reside in a care home and two-thirds live with a foster family, but individual children frequently move back and forth between these two settings and periodically run away from both. They may not only change address but experience placements many miles from their birthplace and from any familiar adults, like teachers or school nurses. Those from impoverished neighbourhoods, with poor health or with disabilities are the least likely to find adoptive parents, especially as they make difficult life transitions such as puberty.

The national initiative *Quality Protects* has raised awareness that, for many of these mentally and physically hurt young people, their health deteriorates further during care. Compared with their contemporaries in more stable families, these children[2] are more likely to leave care in adolescence: regularly using illicit drugs, regularly harming themselves, often pregnant and alone, or exploited by extremely hazardous child prostitution. Their lifetime attainments in education and employment are generally dismal, although meeting a few skilled, trustworthy adults can make a big difference in their life story. Adults in their twenties with a history combining severe child abuse and inadequate/chaotic care make up a disproportionate number of psychiatric inpatients, prison inmates and the 'young homeless'. Bad experiences of parenting can also make them damaging parents themselves, without the sort of social capital (wise grandmothers, good neighbours and networks of friends) that most of us take for granted.

The new PCTs bring together GPs and practice nurses with their community colleagues in School Health and Social Services. Thanks to the openness of NHS participants (such as Dr David Colin-Thome, the primary care 'czar') at meetings like the recent Community Care Live (London, 22 May 2002) one can finally see social workers working imaginatively alongside GPs to make PCTs viable and vibrant. Since 1989, Working for Patients and The Children's Act, this is the first year that the systems will actually be in place for a genuine health service/local government partnership to promote children's wellbeing. Furthermore, PCTs and their partners are exhorted to be 'learning organisations'. Even with the most difficult groups (the clientele of Youth Offending Teams) it has proved possible to include adolescents themselves in planning their local health system[3]. GPs could truly 'fulfill their role'[1] in protecting the health of the most marginalised young people if they influence colleagues across their PCT to grow acceptable and multi-talented services for looked-after children.

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References

1. Carter YH, Bannon MJ. GPs and child protection: time to grasp the nettle. *Br J Gen Pract* 2002; **52**: 514.
2. Caan W. *Your shout. Mental Health Promotion Update 3*. London: Department of Health, 2002, 16-17.
3. McKay I, Caan W. Free expression: tailoring health services to young offenders in Barking & Dagenham and Havering. *Listen to me: Consulting young people on health and health issues*. Ilford: Barnardo's, 2002; 91-100.