

LETTERS

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The Beck Inventory

One of the hardest tasks that a GP has to perform is the qualitative assessment of depressed patients. This is often done in the middle of a busy general surgery quite unexpectedly and in our practice we have less than the optimum 10-minute appointment per patient. The GP has to stop to do a risk assessment to make sure that the patient is safe to go home or refer for further assessment and treatment, and this means that we have to act urgently. There is something very discomfiting to the doctor about asking a patient whether he feels depressed or suicidal or has made any such plans. There is no other process that undermines the doctor so markedly, and which may derail his cognitive ability.

We have found in a recent practice audit¹ that, in spite of many years' experience in the process of assessment and monitoring of our patients, senior and junior doctors have made errors of judgment in both recognition and management of depression. In fact, this has been a crucial weakness in our treatment of mental illness.

Recently, we have introduced to the patient assessment process a self-scored Beck Depression Inventory, which is an easy tool to administer and quite painless to the doctor, almost like taking the temperature, and has taken a great deal of heat out of the doctor-patient relationship. The patient is asked to return to the waiting room briefly to complete a questionnaire in which the patient is free to choose the most appropriate from a large range of questions about his feelings and thoughts at this moment in time — more than many GPs could remember — and this reduces the time delay in

completion. It is an appropriate standardised measure of severity of depression and an adjunct to treatment that is easily scored by either patient or doctor. Afterwards, when the doctor has calmed down, the patient is recalled to the consultation for feedback and scoring and to agree a choice of management interventions. It has parallels to the identification and withdrawal, described by Balint,² in the transference process. It may be repeated at intervals to assess progress with a degree of consistency. We have found that this provides both GPs and registrars with a simple and secure safety net. The risk assessment is crystallised into an objective numerical measurement, which gives the doctor a degree of confidence in the diagnosis and choice of treatment interventions, and in the outcome.

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Editor's note

Details of the Beck Depression Inventory are available from The Psychological Corporation, Halley Court, Oxford OX2 8EJ; tel: 01865 888188; e-mail: tpa@harcourt.com

Intention-to-treat or efficacy analysis?

I was rather baffled by the choice of statistical method in the recent paper by

Banait *et al.*¹ While only a little over half of the 'intervention' group actually accepted the intervention, the decision to use an intention-to-treat analysis makes no distinction between these practices and those that refused. In my view this makes the paper's findings virtually uninterpretable. The problem is compounded by the authors' failure to present us with all the data, which would at least have allowed the reader to analyse the results further and draw their own conclusions. Only in Tables 2 and 5 are the results divided into intervention-accepting and intervention-refusing. Surely this trial is, in fact, an efficacy analysis, in which case the intention-to-treat approach is inappropriate. As a relative newcomer to evidence-based medicine, I hope the authors may be able to enlighten me.

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Reference

1. Banait G, Sibbald B, Thompson D, *et al.* Modifying dyspepsia management in primary care; a cluster randomised controlled trial of educational outreach compared with passive guideline dissemination. *Br J Gen Pract* 2003; **53**: 94-100.

Authors' response

The study was designed to measure the 'effectiveness' of an intervention under pragmatic conditions. The findings are a true reflection of the changes that were observed, as practices 'refusing' participation were included in the analysis. We were not interested in the 'efficacy' of the intervention when used under artificial/ideal circumstances. On-

treatment analysis only defeats the object of randomisation because one cannot assume that there are no systematic differences between groups that might affect outcomes. By eliminating disinterested practices (i.e. 'refusers') from the intervention group, but not the control group, on-treatment analysis would have overestimated the real effect of the intervention. The intention-to-treat analysis was therefore the most appropriate for a trial of this kind.

The following reference may also be useful: Roland M, Torgerson D. Understanding controlled trials: what are pragmatic trials? *BMJ* 1998; **316**: 285.

MARK HANN

NPCRDC, 5th Floor, Williamson Building, University of Manchester M13 9PL, for and on behalf of G Banait, B Sibbald, D Thompson, C Summerson, S Talbot, and the Salford and Trafford Ulcer Research Network.

What's in a title?

Although retired from general practice for several years I still enjoy receiving my *BJGP*, but have become increasingly disenchanted by the titles of the original papers, which I suspect will appeal only to a minority of readers interested in pure research. The February issue of the *BJGP* prompted this letter when I read the 19-word jargon-packed title of the first original paper by Banait *et al*: 'Modifying dyspepsia management in primary care: a cluster randomised controlled trial of educational outreach compared with passive guideline dissemination'. Ugggh! This evokes a response from me of 'Do I really want to read that?'. Had it been simply entitled 'Dyspepsia management in primary care' I would certainly have read at least the summary and perhaps more. In my view, a title should provide a simple statement of the subject matter of the paper, just enough to stir the curiosity of the reader to go in and see what the author has to contribute to the subject. The methods and research techniques used to obtain the information should be part of the content and do not belong in the title. While I appreciate that you have to cater for the research-orientated readers, I feel that it

should not be necessary for all that information to be put into the title in order for the researcher to be able to find it.

The vast majority of your readers are, I suspect, not academics but just ordinary general practitioners who are trying hard to keep up to date and care well for their patients. They would, I am sure, make better use of the *BJGP* without these off-putting titles. You would at the same time have the opportunity to design a more attractive and less cluttered front cover for this excellent journal.

RICHARD PARROTT

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Editor's note

My fault once again. Our 'Information for Authors' document stipulates titles of no more than 12 words, but this one slipped past.

Sickness absence certification: time for a rethink?

The current role of GPs in sickness absence certification means that they are, effectively, custodians of the Statutory Sick Pay scheme.¹ Unfortunately, they are not usually familiar with their patients' workplaces, re-deployment options, or occupational health law. A heavy workload and the lack of communication between GPs and occupational physicians compound these difficulties.²

The recognition of these problems has led to the removal of the responsibility for certification from Dutch GPs; occupational physicians were instead forced to undertake the task, despite their protestations. However, among occupational physicians in this country there appears to be wide acceptance of the role, which many of their GP colleagues would happily relinquish.^{3,4}

The Department for Work and Pensions (DWP) proposes to extend the certification role to other health care professionals.⁵ However, the exclusion of occupational physicians from a list, which includes community psychiatric nurses, occupational therapists, physiotherapists, and practice nurses, is perverse. The NHS Plus initiative⁶ (there are currently more than 90 providers) provides an ideal opportunity to devel-

op a new model for sickness absence certification. Instead of tinkering at the margins of the problem, the DWP should grasp the nettle and consider radical change. We propose the following scheme as a broad basis for discussion and debate:

- In our scheme, GPs would retain sole responsibility for issuing certificates for a mandatory initial period.
- When issuing certificates for longer spells of absence, they would indicate their patient's fitness to attend for assessment by their employer's medical advisor (provided via NHS Plus if required).
- If the patient were not fit to attend, the certificate would be annotated with the reason.
- Having assessed the employee, occupational physicians would be able to issue further certificates as required, and arrange follow-up to reassess capability, until the employee was fit to return to work.
- Occupational physicians would be expected to communicate the outcome of their assessments to GPs in a similar way to current secondary care providers.
- GPs would continue to issue certificates to those patients whose employers decline to exercise the option of occupational assessment.

Our proposals would have many advantages: employers would be engaged in a process that encouraged them to actively manage sickness absence; communication between primary care and occupational physicians would be improved; the administrative workload of GPs would be reduced; and ultimately the doctor-patient relationship assisted. The potential limitations of the scheme require debate but are not insurmountable.

It is likely that large and medium-sized organisations (many already have occupational health services) would initially be most attracted to this model. However, in the longer term, the development of NHS Plus is likely to encourage smaller companies to invest in expertise that should benefit both the health of their employees and their business.

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Narrative-based medicine

John Launer's editorial on narrative-based medicine leaves me uncomfortable.¹ Certainly, narrative-based medicine is more patient-centred than evidence-based health care, which deals with probabilities, statistics, and diseases, and therefore is not directly applicable to the patient as an individual. So, why do I have this sense of anxiety when reading Dr Launer's article?

Cognitive continuum theory places medicine, hierarchically, midway between mathematics and physics, at one end of the spectrum of certainty, and social sciences at the other.² Accuracy in diagnosis is essential — lives depend upon it. Our patients expect us to be as accurate as possible. It is therefore important that we categorise and describe disease processes in order to initiate effective treatment. A post-modern approach would challenge this. Evidence-based medicine claims to represent a more scientific approach to diagnosis and treatment, and is therefore biased towards the experimental/scientific end of the cogni-

tive continuum. It is a tool to be used skilfully for the patient.³

Dr Launer raises my anxiety concerning the scientific credentials of medicine when he mentions 'post-modernism', raising the spectre of relativism in medicine. Each individual presents a unique problem. There is no doubting that. However, while each individual's narrative may be different, the underlying process in physical terms will be similar. Our logical approach should tell us that this patient in front of us has, for example, appendicitis.⁴ Probability can determine the extent to which a response to treatment is likely to be successful. Post-modern critiques of science have been shown, on occasion, to be faulty, and illogical.^{5,6}

We should not forget Kuhn's theory of changing paradigms in scientific revolutions. Clearly, once a theoretical approach has become untenable it should be discarded, allowing the new paradigm to hold sway until this too is swept away.⁷ Kuhn's theory represents a model of 'scientific progress'. I am reminded of Berkeley and Dr Johnson and the subsequent, and continuing, debate concerning 'reality'.⁸ Just how real are the theories offered by post-modern critiques? Doctors are trained to interpret, on behalf of the patient, symptoms that are presented, be they psychological or physical. For our treatment to be effective — or at least as effective as we believe it to be — an accurate diagnosis and application of an evidence-based approach, providing that one is available, should, in all probability, alleviate the patient's problem.

The post-modern challenges to medicine from the social 'sciences' call into question the scientific credentials and effectiveness of medicine. We should perhaps recognise our place on the cognitive continuum. While we need to be aware of other bodies of 'knowledge' and make use of the understanding of the problem by the patient in front of us,⁹ I do not feel confident that adopting a 'post-modernist approach to medicine' will necessarily improve outcomes for my patients. I accept that narrative-based medicine has a place in the consulting room, but is this not just a reflection of a long line of other approaches — Balint comes to mind — that are more patient-orientated?

Balint's approach was a considerable contribution in its day, and it still wields great influence in the consulting room. Only time will tell if narrative-based medicine represents a similar 'giant leap'.

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How effective is simvastatin 10 mg?

The recent MRC/BHF Heart Protection Study¹ demonstrated the benefit of prescribing simvastatin 40 mg to patients at risk of CHD. Expert advice is to use a starting dose of 20 mg simvastatin.² GPs generally start a drug at a low dose and titrate upwards to achieve the desired effect. Experience suggests that many patients achieve target levels on only 10 mg of the drug. Simvastatin will come off patent in May 2003, when the price and pricing structure may change. Lower doses may be better tolerated and could result in significant savings.

The computer in our practice was used to identify patients prescribed simvastatin 10 mg. Some of these were on the medication for primary, and some for secondary, prevention. Of the 303 patients identified, nine were also on other lipid-lowering drugs and were

excluded. No patient was on more than one 10 mg tablet a day. Four patients had stopped taking it, and no pre-treatment level could be found for 18 patients

The notes of the remaining 272 patients were examined to find the total cholesterol level before drug treatment but after dietary advice, and the latest result while on treatment. The average fall in total cholesterol was 28.7%. Pre- and post-treatment, low density lipoprotein (LDL) levels were identified for 199 patients, with an average reduction of 39.8%. This is greater than would be expected from published data,³ but, interestingly, is similar to the change in total cholesterol and LDL in a study where the dose was increased until targets were reached.⁴ Of all patients with a recorded post-treatment LDL, 83% had a level of 3.0 mmol/l or less.

The fall in LDL may be greater in these patients because dietary measures were not tried for long enough; before this, drug treatment or prescribing a drug may have acted as a daily reminder to maintain a low fat diet. Perhaps most interestingly, in view of the results from the study in which doses were gradually increased, is the possibility that some patients respond unusually well to a low dose of simvastatin and do not need a higher dose. Whatever the reasons, the present study suggests that it is well worth trying a dose of 10 mg simvastatin before resorting to higher doses or more expensive drugs, as many patients will achieve satisfactory lipid levels at significantly lower cost.

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simvastatin treatment in patients with combined hyperlipidaemia in clinical practice. *Arch Fam Med* 2000; **9**: 898-905.

Screening for gastrointestinal complications of diabetes

The Royal College of General Practitioners published an information sheet in 1999 regarding the workload of general practitioners. It stated a prevalence rate of 5.1 per 1000 in males and 4.3 per 1000 in females for type 1 diabetes. The prevalence rate was 9.6 per 1000 in males and 7.0 per 1000 in females for type 2 diabetes. Thus, any general practice in the UK has a large number of patients with diabetes mellitus. Many GPs are now running diabetes clinics in their surgery with the help of trained nurses. These doctors and nurses have traditionally been trained to look for complications of diabetes, including those in the renal, ophthalmic, cardiac, and neurological systems, but not for gastrointestinal complications. Diabetes mellitus is a systemic disease and it affects many systems of the body, including the gastrointestinal system. This letter aims to highlight some of the gastrointestinal problems that are seen in patients with diabetes.

Oral candidiasis is common in patients with diabetes and causes reasonable discomfort.¹ Treatment with nystatin is simple and rewarding.² There is recognised evidence that lichen planus is associated with diabetes³ and that better control of hyperglycaemia improves lichen lesions. Lichen planus manifests as shiny purple lesions on the skin and whitish purple reticulated lesions in the mucocutaneous areas, including the oral cavity.

Diabetes is a known cause of nerve palsies. Ninth, tenth and eleventh cranial nerve palsy gives rise to dysphagia and nasal regurgitation. Gustatory sweating is seen in patients with autonomic neuropathy from diabetes.

Oesophageal reflux is common in patients with diabetes. Dysphagia owing to poor oesophageal motility is also well recognised in patients with diabetes.⁴

Gastroparesis is an important complication of diabetes. Reduced stomach motility gives dyspepsia and gastro-

oesophageal reflux.⁵ All stages of gastric motility may be affected. Gastric hypotonia may give rise to postprandial abdominal fullness. Postprandial hypomotility of the antrum is recorded with rising levels of hyperglycaemia.⁶ With the reduction in the level of hyperglycaemia towards normality, antral motility improves. A study from China published in 1994 showed evidence of reduced blood flow in the stomach mucosa in patients with hyperglycaemia. In diabetic ketoacidosis, the stomach may dilate acutely. Thus, ketoacidosis in patients with insulin-dependent diabetes mellitus (IDDM) may present as an acute abdominal emergency. Many physicians recommend nasogastric intubation routinely in these patients.

Diabetic autonomic neuropathy leads to diarrhoea that is at its worst postprandially and in the early hours of the morning. It responds well to tetracycline for unclear reasons. For similar reasons constipation is common in patients with diabetes. Rectal dilatation is known and faecal incontinence owing to anal sphincter malfunction also occurs. In patients with diabetes and leakage of intestinal anastomosis, pancreatic islet cell transplantation improves healing. The rectum has also been used as the site for islet cell transplantation.

Recently, a syndrome has been described consisting of sclerosing cholangitis, ulcerative colitis, and IDDM.⁷ Coeliac disease is also associated with diabetes. It is now recommended that any patient with diabetes who experiences unexplained weight loss and diarrhoea should have their anti-endomysial antibody measured, along with serum IgA levels.

Patients with pancreatitis may have hyperglycaemia at presentation. Pancreatic carcinoma and diabetes are associated, but it is debatable whether diabetes is a risk factor for pancreatic cancer. The Italian Pancreatic Cancer Study Group found that diabetes in patients with pancreatic carcinoma is frequently of recent origin and that diabetes is not a risk factor for pancreatic carcinoma.⁸

Fatty infiltration of the liver is common in patients with diabetes mellitus. This is usually asymptomatic but can

be a cause of hypochondrial pain and dyspepsia. Up to 40% of patients with cirrhosis and 44% with chronic active hepatitis may have diabetes.⁹ Various explanations have been forwarded for this association, such as hyperinsulinism owing to diminished degradation of insulin by the liver, an increased peripheral resistance to insulin¹⁰ or a decreased degradation of glucagon. In general terms, effects of liver disease on diabetes are greater than the effects of diabetes on the liver.

The fetal liver is enlarged in pregnant diabetics¹¹ by the 18th week of gestation, but reduces in size with a reduction in maternal glucose level.

Patients with diabetes are more prone to development of gallstones. Many factors contribute, including lithogenic bile and gall bladder hypomotility. Hypertriglyceridaemia seen in diabetes predisposes to gallstones much more than the increased cholesterol level. Acute hyperglycaemia reduces gall bladder motility in IDDM. Erythromycin induces supra-normal gall bladder contractions in patients with autonomic neuropathy.¹²

These are just some of the indicators in the natural history of diabetes mellitus that point to the possible need for screening for gastrointestinal complications. New onset dyspepsia, bowel irregularity, abdominal pain, oral cavity infections, and rapid weight loss are a few such examples that could lead to, for example, a need for testing for anti-endomyosial antibodies or liver function tests.

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MSD Foundation leadership courses

Two years ago, we recruited former members of the MSD Foundation leadership courses, which had been held throughout the British Isles between 1983 and 1992, for the purpose of carrying out a survey of their subsequent careers and their views on the courses.¹

We were able to trace 295 attenders (probably about half the actual total) and received follow-up information from 157 out of the 253 (62%) who had been correctly identified. Not surprisingly, virtually all of those who responded had gone on to take some kind of subsequent leadership role, usually within general practice. Seventy-two per cent had or had had salaried posts in undergraduate or postgraduate departments, 46% had roles within the Royal College of General Practitioners, 29% with the British Medical Association/LMCC, and 38% with PCGs/PCTs/LHCCs.

We collected views on what those who had attended had found most useful. Statements about having gained confidence predominated. Participants had also gained skills and insights into the management of groups and came to recognise what they could properly contribute to professional life outside

their practices. They had important comments to make on problems about work/personal life balance — taking on leadership roles often becoming an added problem in this area.

Although the vast majority were positive about the courses, nine responders (6%) had found the experience negative or harmful, and a further 11 (7%) were critical about aspects of the management of group dynamics.

Given the increasing importance of professional leadership in the rapidly changing world of modern primary care, we encourage those interested in leadership in particular, and in post-graduate training generally, to read the full report of our study, which is available from John Howie at the e-mail address below.

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Reference

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Electronic transfer of prescription-related information

Terry Porteus's paper on stakeholder views regarding sharing of specified items of information with pharmacists is welcome. Electronic transfer of prescriptions (ETP) is a key component of the NHS's national IT programme. When commissioning ETP pilots in 2000, the Department of Health set out various 'key professional principles'. The second principle states that 'access to data relating to identifiable patients must require the consent of the patient or their nominated representative'. The principles¹ also include references to confidentiality and workload. The workload issues are important — while the benefits to the Prescription Pricing Authority's workflow and to pharmacies' cashflow are obvious, GPs will need to fully understand the workload consequences of ETP. Perhaps the pilots will have found solutions for the GP workload risks.

I cannot concur with Mrs Porteus's final conclusion that 'ETP is likely to be acceptable to all users'. Her figures suggest to me that patients' concerns and anxieties need to be further explored and assuaged before ETP is acceptable to them.

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Reference

1. URL: <http://www.doh.gov.uk/pharmacy/etpprin.htm>

GP pay — shooting elephants

I believe Brian Keighley¹ has fundamentally misunderstood Paul Hodgkin's piece and purpose in raising the issue of GP pay.² Hodgkin does not say that he himself holds the beliefs expressed in the constructs he iterates and calls our 'elephants'. He has simply brought to our attention the constructs that are definitely out there — I come across them frequently.

Paul Hodgkin also recognises the danger to the profession of allowing these elephants to sit in the shadows, and of us being unprepared for when one of them may get pushed into the centre spotlight by some other agency (or even the NHS negotiators or the government). Interestingly, there is indeed some danger from newer generations of doctors who do not understand the pay system, as Keighley suggests, but the main dangers are those identified by Hodgkin — especially the midwives, who do not understand why GPs get items-of-service payments, not only for the work they do, but also that of our own staff, nurses, and others.

While we have the opportunity to correct the misconceptions of GP trainees — at least trainers are supposed to ensure they understand the system, and they represent an 'internal' faction — we are left wide open to attack by being unprepared to deal with 'external' factions if they should decide to 'go public' over one of these elephants. Indeed, the 'elephant' term becomes even more apt as a metaphor for the enormity of the job we would have of trying to explain any one of these items

to the lay public.

If GP trainees and practice managers and GP accountants and union leaders have difficulty understanding the arguments and explanations (I could give examples of each if needed), then how can we expect the media and general public (let alone the NHS Confederation) to even begin to understand — or even believe — the first part of any explanation. If they do not, then they won't read any further!

Paul Hodgkin is very sensible and entirely right. We are vulnerable because of these archaic and complicated convolutions. Unfortunately, I think they will get no better with the new system. Observers are going to think we receive the 'global sum'. And just to add to this, there have been revelations in the national press of a pay deal for GPs of between 30% and 50% over three years; this is untrue, all that has been promised is for the global sums to be 30% to 50% higher, but this already includes amounts for premises improvements, staff pay changes, and the taking on of extra work, only part of which we do at the moment. This is another elephant that the government can easily use (in fact I think it is deliberate, and deliberately leaked) to stir up mistrust of us among the public as well as our colleagues in allied professions.

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Why a medical student (still) wants to become a GP

Bilal Ali and Melvyn Jones published¹ their results of a research on students' attitudes toward a career in general practice. The results were as follows: general practice is not popular in the general population; it is more popular among female students; its popularity increases significantly when students have already had teaching in general practice, and they are then more likely to choose it as a career (22% versus 9.6%).

Student gender and GP teaching had the same important effect on this choice in a questionnaire survey carried out in Italy, where undergraduate teaching of general practice has only just begun. Research in Milan, Naples, Padova, Varese, Modena, and Torino indicated that about 90% of students expressed an interest in a career in primary care.

Students blame their limited, confused, and often incorrect knowledge of primary care, for indicating general practice as their second choice of career (78%). A survey² at Modena University indicates that students are often surprised to learn how general practice differs (and may even be substantially better than) their preconceived ideas.

These results demonstrate the importance of tutor-based teaching, and communication between GPs and specialists, and indicate that even if they eventually decided not to become GPs, at least their attitude towards the work of a general practitioner is changed for the better. A continuous and holistic relationship with patients is recognised as the most desirable aspect of GP work, bureaucracy and comparatively low professional standing the worst.

In contrast to the UK, Italy has no shortage of available places; however, there are many applicants to a limited number of vocational training places, chiefly because there were too many certified during previous years. Places are now also limited for undergraduates; however, in a few years, we hope to certify the first specialised GPs who are prepared to undertake this discipline, and who have made an informed choice about their careers.

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