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Patient-centredness

Although glad that our editorial¹ gained such a quick response in the *Journal's* Back Pages,² we were sorry to find that we had been unable to explain our apparent perversity to Dr Jefferies' satisfaction. To restate our argument:

Patient-centredness has to be our goal. If we fail to understand patients' concerns and perspectives we cannot provide appropriate and effective advice and management, resulting in frustrated doctors as well as unsatisfied patients.

More evidence of better outcomes from patient-centred practice has just appeared.^{3,4} Policy makers have at last taken up the idea that to focus on patients' concerns may provide better health care, but they necessarily deal with broad issues. It is up to us to work out the implementation details; for this we need better research methodology and training. Patient-centredness is hard to measure, so it is difficult to train and reward doctors for good practice. We welcome recent attempts to study it.

We were very surprised that McLean and Armstrong⁵ emphasised the cost of their training intervention at the expense of the impressive and significant gain in patient satisfaction. Even so, we agree that it is important to debate the meaning of a cost that is apparently non-significant in statistical terms. Misunderstanding by patients is so common that the videotape suggestion seems valuable.⁶ We don't suggest that these interventions^{5,6} be widely implemented on the evidence presented, but they are worth considering as we try to improve clinical practice.

It is important that we still debate the issues of what patient-centredness really means and how we can get better at it. If it could be measured then good practice could be rewarded

appropriately. This might even bring added resources to general practice, bearing in mind the current policy context of the NHS.

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Response to 'A seemingly ineffective study on menopausal memory problems'

Your correspondents¹ raise some interesting issues and ask for more clarity about the sample. In terms of the population, the practice involved in the study has a list of 9000 patients with the age distribution the same as the national

average and a full mix of socioeconomic groups with emphasis on 3 and 4. The selection of women was by random number generation, with a specific number being randomly selected from each age band.

The response rate at 50% of those eligible is in keeping with what is typically found from surveys and, indeed, on the more positive side. We would obviously agree that greater participation is desirable, but many bodies of literature are now dependent on such samples. The original sample size as in all studies was calculated to take account of non-responders. In fact we assumed that 40% would not return and also took account of the fact that further women would require exclusion because of the criteria. The requirement for acceptable power was for 39 per group and although some groups are slightly lower than desirable, it is the patterning that is of particular interest.

It is clear from the means and standard deviations that the distributions of the groups are closely matched; certainly there is no indication of difference suggestive of deficit linked with the menopause. This is clearly stated towards the end of the paper: 'In terms of power, while it could be argued that a larger sample may have detected significant differences, the means reported in the descriptive data are very similar (the majority being <1) and where differences are suggested by the data these are not in the predicted direction'. A key issue here is that it's crucial that results that question received wisdom or the status quo in not finding differences as expected should be published. We are all well aware of typical publication bias toward positive results and how this may distort perspectives.

Finally, although your correspondents quip 'that women with the real memory problems simply forgot to

return the questionnaire' all the sample were sent reminders, and the measurement concerned perceived memory problems. The fact that these are strongly associated with emotional distress rather than age or menopause is of importance as it allows an alternative understanding of aetiology.

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Infrared ear thermometry

We read with great interest Hay *et al*'s article on infrared thermometry.¹ They used axilla temperature as the gold standard against which the infrared tympanic membrane temperature (TMT) was compared. The fundamental fault of this study lies with the fact that axilla temperature was not a gold standard for body temperature measurement. It was found to be poorly correlated with core temperature by a previous meta-analysis.² The best reference site would be rectal temperature — the generally accepted gold standard for temperature measurement in children.³ As exercise increases body temperature, the study was further hampered by a lack of stipulated rest before measurement.

In a previous study done in this department, we found infrared thermometers to be reliable in neonates;⁴ previous meta-analysis showed such thermometers to be unreliable.⁵ However, the main problem of the meta-analysis was grouping different infrared ear thermometers as one single entity when each brand should be tested on its own.⁶ The accuracy of TMT could be enhanced by taking two

readings and recording the higher one as representative of core temperature.⁴

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Author's response

We thank Ng *et al* for their response to our paper.¹ They raise the interesting issue of gold standards for the measurement of fever. To our knowledge, there is no such single accepted and universally agreed gold standard. In their review article, they summarise the differences between axillary, rectal, tympanic, and pulmonary artery measures using different types of thermometers, but do not present original data to support their assertion that rectal thermometry represents such a 'gold standard'.² We were conscious of this issue when we analysed our data and wrote the paper; for this reason we discussed in our introduction the rationale for why

we chose to use both measures of agreement and diagnostic accuracy.

The issue of rest prior to thermometry would be important if this was routine in clinical practice. However, we see the results of our study as generalisable to the real world in which children arrive in surgery in varying states of unrest.

It appears that we agree with Ng *et al* more than we disagree: we agree that thermometry using different instruments in different body sites and in different age groups leads to measurement differences. Given that treating fever in the home is widespread,³ the questions that still need addressing are: 1) rather like the differences between clinic and ambulatory blood pressure measures,⁴ which instrument and site best predicts the child's prognosis as opposed to the immediate diagnosis of fever? 2) when should a thermometer be used? and 3) when, and if, a gold standard is established, which instrument and site offers the best agreement?

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