My study, therefore, clearly demonstrates that the stethoscope is not a vector for MRSA in the community. This observation strongly suggests, but does not prove, that MRSA presents a problem in the UK that is confined to the hospital environment.

STUART SANDERS
General Practitioner
22 Harmont House, 20 Harley Street, London W1G 9PH.
E-mail: drsanders@msn.com

REFERENCES

1. Jevons, MP. 'Celbenin'-resistant staphylococci. *BMJ* 1961; **1:** 124–125.
2. Derbyshire D. Labour is to blame for superbugs, says Howard. *The Daily Telegraph*, 2 September 2004. http://news.telegraph.co.uk/news/main.jhtml?xml=/news/2004/09/02/nmrsa02.xml (accessed 6 Dec 2004).
3. Sanders S. The stethoscope and cross infection. *Br J Gen Pract* 2003; **53:** 971–972.
4. Smith MA, Mathewson JJ, Ulert IA, *et al.* Contaminated stethoscopes revisted. *Arch Intern Med* 1996; **156(1):** 82–84.

C-reactive protein values in viral respiratory infections

We welcome the paper by Melbye *et al* on the course of C-reactive protein (CRP) response in upper respiratory tract infection.[1] It provides valuable insight, broken down by virus type. However, the design of the study may possibly limit the generalizability of its results.

From the title and the abstract we are tempted to believe that all episodes that were treated with an antibiotic, were excluded. However, it is not clear to us what the indication for antibiotic prescription was. In the methods section, we read that, 'subjects were excluded if a bacterial infection was suspected and antibiotics were prescribed'. The ambiguous word in this sentence seems to be 'and'. When patients were prescribed antibiotics, did the investigators verify that it was a bacterial infection or did they assume that the GP had thought this?

Without doubt, the authors are aware of the fact that GPs frequently prescribe antibiotics for diseases of viral origin. The seriousness of the disease might well have played a role in the decision to prescribe antibiotics, indicating that those patients who were seriously ill were not included. Perceived patient preference is another reason. Further studies are needed that take a more comprehensive view on CRP in respiratory tract infections presented to general practice.

JOHANNES C VAN DER WOUDEN
Senior Lecturer
Department of General Practice, Erasmus Medical Centre, University Medical Center Rotterdam, Rotterdam, The Netherlands.
E-mail: j.vanderwouden@erasmusmc.nl

MIRIAM MONTENY

MARJOLEIN Y BERGER
General Practitioner

REFERENCES

1. Melbye H, Hvidsten D, Holm A, *et al.* The course of C-reactive protein response in untreated upper respiratory tract infection. *Br J Gen Pract* 2004; **54:** 653–658.

Author's response

We wanted to demonstrate the natural course of the C-reactive protein (CRP) response during viral respiratory infections, and none of the patients described in our study were treated with antibiotics.

Our material is, as van der Wouden *et al* comment on, not sufficiently representative of the upper respiratory tract infections we meet in general practice. The most severe viral infections may have been excluded, and we know from previous studies that CRP values above 100 mg/l may be found in influenza and adenovirus infections.[1] I agree with van der Wouden *et al* that more systematic research is needed in this field. However, some useful information may be obtained from our study.

The CRP response in viral respiratory infections has some typical features. The maximum CRP value is reached when the illness has lasted 2–4 days, and falls rapidly over the following days. Values below 10 mg/l is the rule after 7–10 days in uncomplicated cases. These features have also been indicated by other studies.[2,3] This knowledge can be taken into consideration when results of the CRP test are interpreted in patients with acute cough or a flu-like illness.

HASSE MELBYE
Professor of General Practice
University of Tromsø, Tromsø, Norway.
E-mail: hasse.melbye@ism.uit.no

REFERENCES

1. Ruuskanen O, Putto A, Sarkkinen H, *et al.* C-reactive protein in respiratory virus infections. *J Pediatr* 1985; **107(1):** 97–100.
2. Whicher JT, Chambers RE, Higginson J, *et al.* Acute phase response of serum amyloid A protein and C reactive protein to the common cold and influenza. *J Clin Pathol* 1985; **38(3):** 312–316.
3. Melbye H, Straume B, Brox J. Laboratory tests for pneumonia in general practice: the diagnostic values depend on the duration of illness. *Scand J Prim Health Care* 1992; **10(3):** 234–240.

Time to acknowledge the workings of the 80/20 principle?

Julian Tudor-Hart has devoted his life to demonstrating and exposing the inverse care law[1–3] and the rule of halves.[4] There is a part of me that shares his anger that such inequitable distributions exist and persist.

However, I wonder whether what Tudor-Hart has described in the medical context is actually another example of the Pareto principle of asymmetric rewards, popularly known as the 80/20 principle. We see multiple examples of this principle in action. For example:

- A university department that is doing well gets a better research assessment evaluation, and so more money with which to do better still.
- An author who has been published once is much more likely to be published again, even if new and better authors are emerging.
- Twenty per cent of patients will take up 80% of available appointments.
- A surgery with many settled and loyal

doctors is more likely to be attractive and so recruit and keep more and better staff.
- About 80% of NHS resources are spent on patients in their last 6 months of life.
- A very good football player will aim for the reserves at Arsenal, Chelsea, or Manchester United sooner than accept first team regularity at Norwich or Portsmouth.

To those that have, more shall be given. No organisation seems to be immune to the workings of this principle. We can protest against it, but those using it will carry on powering ahead anyway. The question comes as to how we start to use it to improve the lives of everyone in our society. The concepts of tipping points and critical masses need to be understood. The recent attention to the concept of lifetime trajectory observation is a hopeful sign of this developing in our thinking.

There seems to be no political will, or available mechanism, to counteract the workings of the 80/20 principle. Perhaps instead it is time that we learnt to go with this rule?

PETER DAVIES
General Practitioner
Shelf Surgery, Halifax HX3 7PQ.
E-mail: npgdavies@blueyonder.co.uk

REFERENCES

1. Tudor-Hart JT. The inverse care law. *Lancet* 1971; **1:** 405–412.
2. Tudor-Hart JT. *A new kind of doctor.* London: Merlin Press, 1988.
3. Tudor-Hart JT. Inverse and positive care laws. *Br J Gen Pract* 2004; **54:** 890.
4. Wilber JA, Barrow JG. Hypertension — a community problem. *Am J Med* 1972; **52(5):** 653–663.
5. Koch R. *The 80/20 principle: the secret of achieving more with less.* London: Nicholas Brearley Publishing, 1997.

Mis-manage-meant

Charlotte Williamson doubts whether we should continue to 'manage' patients.[1] At first I thought the offence was the perceived gender specificity, with her preferring the term 'personage' but I soon realised it was merely political correctness raising its head again. 'Personage' is an archaic term for an important or distinguished person (for we are all distinguished in our own way), so she will no doubt be in favour of such a description for patients. I have, of course, introduced another debated term: 'patients'. In these equal but patient-centred partnerships, who are we to manage 'patients'? We should be:

> *'Entering, as equals, into due discourse, at our mutual convenience, with mutual respect, for our mutual wellbeing, ensuring that we are left mutually feeling, and being, improved medically, physically, spiritually and socially'.*

(Well, it was the woolliest mission statement I could come up with!) Perhaps 'mutual' should be banned from the language, certainly when used as nauseatingly.

Let's abandon this ongoing debate about words or terms that may be outdated or just might appear condescending, imply passivity, or suggest superiority in knowledge or experience. I, for one, am going to continue to 'manage' and treat my patients. But with increasing bureaucracy, performance review, and now semantics I might not be able to manage at all.

DAVID CARVEL
General Practitioner
Biggar Health Centre, Biggar ML12 6BE.
E-mail: David.Carvel@lanarkshire.scot.nhs.uk

REFERENCES

1. Williamson C. Managing patients. [letter] *Br J Gen Pract* 2004; **54:** 870.

The politics of phraseology

I was sorry to see another example of an innocent phrase being subjected to political analysis and thought of as suspicious of unacceptable medical professional attitudes. Of course 'managing patients'[1] can be interpreted as doctors acting patronisingly, but almost any form of words can be so misjudged if the reader wishes to see inherent political bias therein. Perhaps 'managing the illnesses of patients in a democratic partnership style' would grate less in today's highly charged correctness climate, but what a portentous phrase. How many more well motivated descriptions must be changed before patient liaison groups are satisfied that doctors are actually trying to help patients rather than to exert power over them?

ANTHONY JOSEPH
3 Edgbaston Road, Smethwick B66 4LA.

REFERENCES

1. Williamson C. Managing patients. [letter] *Br J Gen Pract* 2004; **54:** 870.

Correction

Frequency of consultations and general practitioner recognition of psychological symptoms. *Br J Gen Pract* 2004; **54:** 838–842.

The author is The MaGPIe Research Group. The details about authorship are as follows:

The MaGPIe (Mental Health and General Practice Investigation) research group consists of a management committee and an advisory committee. The management committee that undertook day-to-day oversight and management of this study consisted of John Bushnell (JB), Deborah McLeod, Anthony Dowell, Clare Salmond, and Stella Ramage. The advisory committee consisted of Sunny Collings, Pete Ellis, Marjan Kljakovic, and Lynn McBain. Members of both committees were involved in the detailed planning of the study and have reviewed this paper. JB drafted the paper and is the corresponding author.

All authors are affiliated to the University of Otago at Wellington School of Medicine and Health Sciences, New Zealand.