

households (96%) were obtained from the Council Tax website.⁴

It is clear from the findings (Table 1) that CTVB locates smokers and could be used to flag those consultations in which discussion of smoking habit would more often be time-effective. Though daunting, it is a simple task to append registration details of patients with the CTVB of their current address using the website.⁴ Armed with this information, one knows the likelihood of being with a patient from a smoking household to be 50% for those living in CTVBs 'A' or 'B', as opposed to a 20% chance for their CTVB 'D' and above counterparts. Thus, GPs and nurses in primary care can know when smoking advice is more likely to be needed and make time for it; and UK general practices 'loaded' with many patients in lower CTVBs can justify enhanced resources for smoking cessation activity.

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Table 1. Percentages of homes, categorised by council tax valuation band, inhabited by smokers.

Council tax valuation band	Households with ≥1 smoker (%)
A	26 (55)
B	58 (45)
C	30 (28)
D	11 (16)
E+	16 (22)

χ^2 , 4 degrees of freedom, 34.27, $P < 0.001$

Palliative care in end-stage COPD

Thank you for publishing the two studies^{1,2} which provide some thought-provoking evidence on the patterns of care provided to COPD patients in the last year of their life, as compared to cancer patients in a similar situation.

A terminal phase of an illness can generally be recognised when the shared decision-making forum of patients, nurses, doctors and carers acknowledges the prospect of an early and inevitable death. Disseminated cancer and motor neurone disease are generally recognised by the lay population for what they are: processes that, barring miracles, inevitably kill and against which doctors have no effective weapons. Without the pressure to perform futile life-prolonging heroics, doctors are free to concentrate on what they can do to help the patient under these circumstances.

End-stage patients who do not have these diagnoses quite possibly perceive themselves, and are perceived by their carers, as potential candidates for interventions that might prolong their life, irrespective of whether or not this is actually the case. Because of the uncertainty and the non-inevitability of death in these patients, I suspect that doctors are altogether more fearful of being seen to 'write patients off', which is what a palliative-based agenda might be seen to do, and instead pursue a policy of 'doing what they can' even if this might be less comfortable for the patient concerned. I think this is particularly likely in cases in which influential relatives live at a distance, or appear infrequently, professing strong views. I also think it more likely among patients from lower social classes (among whom deaths from COPD are more prevalent anyway), where cultural barriers prevent empathic communication and might undermine a clinician's confidence in embarking on an effective-palliative, as opposed to an ostensible-curative, policy.

The recent spate of cases, reported in the media, where agonised parents of terminally-ill babies have fought to compel paediatricians to prolong their lives, should serve as reminders to us that this area of

medicine is fraught with potential ethical challenges. Careful evidence-based strategies will be needed to get patients and their relatives clearly on board, so that doctors can act in the interests of their patients without fear of serious complaint.

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Correction

Jepson R, Weller D, Alexander F, Walker J. Impact of UK Colorectal Cancer Screening Pilot on primary care. *Br J Gen Pract* 2005; **55**: 20–25.

On page 24, paragraph two, it incorrectly states that:

'... practice staff members in Scotland were more likely to think that it would substantially impact on workload than practice staff in England: 44.7% (95% confidence interval [CI]= 20.6% to 32.6%) versus 26.6% (95% CI = 38.3% to 51.2%) in Scotland.'

The authors would like to amend this to:

'... practice staff members in Scotland were more likely to think that it would substantially impact on workload than practice staff in England: 44.7% (95% CI = 38.3% to 51.2%) and 26.6% (95% confidence interval [CI]= 20.6% to 32.6%) respectively.'