

Letters

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Interpreting differences over time in patient self-evaluation

The survey of patients with hip and knee osteoarthritis reported by Peters *et al* showed improvement or no change in a substantial proportion of patients followed up by telephone after 7 years.¹ Consequently, the authors conclude that osteoarthritis does not invariably deteriorate, but such conclusions bear closer investigation. Outcome assessment involved score criteria including assessment of pain and functional activities. How though might an individual's appraisal of pain or disability reflect either 'true' change (physical improvement) or consideration of other factors?

Longitudinal assessment requires stability of the construct being assessed. It is possible though that responder conceptualisation of what is being assessed alters through a natural process of accommodation and coping with chronic illness. Self-evaluation of pain to which a patient has accommodated may indicate stability or even improvement, even though the underlying physical pathology is marked by deterioration.² The patient effectively re-calibrates their own internal scale for response. Change in outcome may reflect individual coping abilities. That deterioration in outcome score and consulting behaviour were strongly associated may alternatively indicate that both reflect sub-optimal coping strategies.

Restriction to customary functional activities such as walking, working or other physical activities may lead patients to focus on those aspects of their life that are still achievable and from which they can continue to derive value. In doing so, individuals may re-conceptualise their

understanding of 'functional activities' or 'ability to work', and may also alter the way that they implement these activities (such as with the use of a walking stick).

These psychological processes may be considered normal adaptive strategies and allow patients to retain adequate quality of life in the face of physical deterioration. This paradoxical separation of subjective wellbeing and physical status has been observed in various clinical settings. Re-calibration and re-conceptualisation together represent a response shift in patient self-evaluation and may serve to attenuate the observed impact of disease.³ However, the underlying pathology is still present and may continue to disadvantage the patient.

The point here is one of interpretability: what does an outcome measure tell us about the patient's experience and how can it inform us about how experience changes over time? Methods to explore such change processes, including individualised approaches, are emerging to sit alongside conventional assessment.³ We heartily endorse the authors' recommendation for further research on measuring change and especially that patient assessment should be in a broad biopsychosocial model that attempts to understand the individual's unique perspective.

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Unfair treatment

The recent article¹ on patients dying of chronic cardiorespiratory disease demonstrates an important defect in our provision of services. The associated leading article² stated that symptom patterns for patients with cancer or cardiorespiratory disease are similar, including depression, cachexia, fatigue and generalised pain, in addition to the severe breathlessness that characterises advanced heart and lung disease. In fact, quality of life, psychological morbidity and debility often appear to be worse in patients with non-malignant disease. For instance, in a comparison of patients dying of lung cancer and of COPD, 90% of the patients with COPD and 52% of the patients with cancer had clinically important anxiety or depression.³ Despite this, McKinley found that the inverse care law applied: 45% of patients with cancer and 12% of patients with non-malignant disease received antidepressants.¹ Opioids provide effective relief from dyspnoea, with relatively few adverse effects:⁴ opioids were given to 57% of patients with cancer, but only 13% of patients with cardiorespiratory disease.¹

To improve the lot of patients dying from cardiorespiratory disease, the first step is for established treatments to be provided by existing services. In addition, there is a need for continuity of care and expertise, best provided by nurse outreach teams, to promote good palliative care. Palliative care should start early in COPD — smoking cessation, education and self-management affect quality of life and outcomes.⁵ Pulmonary and cardiac rehabilitation are not routinely available despite strong evidence of benefit.⁶ Only

if resources for palliative care services are spread more equitably between cancer and non-malignant disease will our long-suffering patients with COPD and heart failure be given the care their symptoms deserve.

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Bad language

Having lambasted you for years for your abuse of English, I am delighted to see recent signs of improvement. I am now able to read the journal from front to back without hurling it from me in disgust at yet another issue (note: correct use of that word) full of mangled verbiage. And more! Better still, you have a list of banned words! I am so pleased to see this and would like to add a few more. Firstly, 'issue' is grossly overused but I suspect it is beyond resuscitation. Secondly, 'within' is a classic example of using a longer word when a shorter one ('in') is perfectly adequate and to my cortex at least, much more suitable.

Finally, 'around' is set to be the horrendoma of the decade for any of us who like our English wrote proper. Issues around the use of language within the editorial team, for example. Do I have to translate that one into plain English?

So please, be encouraged by praise

from one of your sternest critics and keep up the good work!

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Injecting drug users

As the study by Tompkins *et al*¹ highlights, many injecting drug users receive less than adequate care with regard to hepatitis C virus (HCV) testing and follow up. In response to this situation, an innovative model of care has been developed between Nottingham City Hospital and an inner city GP surgery.

The practice provides enhanced GMS/PMS to an unselected population of substance misusers — many of who are homeless, currently numbering 212 per year. Five doctors have completed the RCGP Certificate, and with support from specialist drug treatment workers work to agreed Shared Care Protocols. Retention in treatment is at the 75% level at 1 year.

Hepatitis testing is offered to all, either serum or buccal depending on ease of obtaining samples. An initial audit of our cohort revealed that the prevalence of HCV infection among 174 currently active clients is 47%, 72% of whom have not been polymerase chain reaction tested. Only one previous patient has been successfully treated with pegylated interferon and ribavirin. Hospital non-attendance rates in Nottingham for hepatitis C clinics are approximately 15–40% (M Holiday and M Nicholls, personal communication, April 2005) and only 11 of our cohort have been seen in secondary care. The highest risk group for new infections are injecting drug users who share among themselves, and mathematical modelling indicates that behavioural interventions may have only a limited effect.² Therefore, the most effective way of reducing the endemic prevalence may be to treat those infected with pegylated interferon and ribavirin,² in order to reduce the pool of infection that can be transmitted.

Our model of care aims to transpose a hospital hepatitis C service directly into the heart of a community of vulnerable clients, by employing a nurse specialist to

undertake caseload management. The three main elements are: to identify new cases of HCV infection by actively testing clients with risk factors; to offer pegylated interferon and ribavirin to clients who would not attend a hospital clinic; and to facilitate a consultant review of clients with obvious evidence of cirrhosis. In addition, the cohort provides real world data on the natural history of HCV infection in injecting drug users that is essential for decision making,³ and we can measure how the efficacy of pegylated interferon and ribavirin translates into successfully treating injecting drug users.³

Treating current injecting drug users may be controversial, but our goal is to facilitate equity of health care and improve the long-term public health of an impoverished and marginalised community.

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The RCGP Council: a worm's eye view

I was recently honoured by the College. Not with a gong or a fellowship but by an invitation to vote in the Election of Members of College Council 2005–2008. I was instructed to read the Candidates' Statements first and, of course, could not refuse. The 12 candidates (I cannot call them the Baker's dozen as the Honorary Secretary only nominated two) were a