

manner to their patient's concerns even though they were dealing with 'same day' presentations.

Finally, with the planned extension to nurse prescribing it can be presumed that nurse practitioner consultation time lengths may shorten as they will no longer be discussing with patients the arrangements for getting prescriptions signed.

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## Deprived people less likely to get treatment to prevent heart disease

At Nottingham City PCT, with our own set of inequalities due to deprivation, we were very interested to read Peter Brindle *et al's* powerful paper.<sup>1</sup>

It is clearly an important issue that the recommended risk assessment tools may be contributing to these health inequalities.

I have three questions I would like to

invite the authors to comment on:

1. For our deprived areas of Nottingham, what practical implications does this have? I hope it will not be long until the QOF addresses primary prevention but at present at the practice level we have no means of altering primary care activity. Perhaps we could all look at those in the deprived areas who are at increased vascular risk but who currently score below the threshold for action with renewed priority ... to help reduce the inequalities rather than further increase them.
2. Table 2 of the paper highlights considerable differences between the Framingham and the less healthy Scottish populations. Presumably there are also some differences between Scottish and English populations; is it a measure of dietary or deprivation differences generally? In interpreting this paper south of the border how should we take account of these differences?
3. Finally, how, I wonder, do the authors see this evidence being taken forward so that change happens in the way we make objective assessments of risk? I am aware of other risk tools such as [www.riskscore.org.uk](http://www.riskscore.org.uk) which is also based on data outside of the UK. Is there a better tool for us to use at the practice level?

In the meantime, the challenge to us all is to look wider at 'whole person risk', including ethnicity, and employ clinical judgement, recognising the influence of the non-Framingham risk factors.

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### Author's response

I am grateful to Stephen Willott for his interest in our paper, and I am pleased

he has responded with three very challenging and current questions. Our paper and other work suggest that the Framingham risk score underestimates cardiovascular disease risk in people from deprived areas and with low socioeconomic status relative to more affluent people.<sup>1,2</sup> This fits with a body of work showing that risk scores tend to under predict in high-risk populations and over predict in low-risk populations. The reason for this is that the limited number of variables in a risk score developed in one population, cannot fully account for variations in risk when applied to other populations. Currently, we can only speculate about what risk factors are missing from the Framingham equation that social deprivation seems to be a surrogate for. Dietary differences may indeed be one of them.

Willott notes that national differences in disease rates exist, but greater differences exist within countries. For example, there is a 10-year difference in life expectancy between two parts of Bristol only 3 miles apart. Currently, there is no 'off the shelf' risk calculator that adjusts the Framingham score for these differences, but the data is available to develop it and national guideline bodies have noted the limitations of the current system. When appropriate adjustments for social deprivation are made, the distribution of resources needed to implement these adjustments should recognise the increased workload of practices serving deprived areas.

Willott recognises ethnicity as another limitation of the present system. ETHRISK, a web-based risk calculator currently undergoing peer review, provides some guidance in that area.<sup>3</sup> There is likely to be a significant interaction between ethnicity and social deprivation that needs to be recognised and further evaluated, as it makes no sense to adjust for ethnicity and then social deprivation if both factors are present in the same person. Until the Framingham risk score is modified, it remains in its current form the best available guide to targeting preventive treatment. As Willott suggests, it should

be supplemented with the confident use of clinical judgement.

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## Limited resources?

The editorial by Ryan and Watson<sup>1</sup> begins, 'In publicly provided healthcare systems, when limited resources are coupled with unlimited demand, decisions have to be made about the efficient allocation of scarce resources.' If a supermarket manager wrote an editorial claiming that demand for food is infinite and it is therefore impossible to keep his shelves stocked, we would wonder how he kept his job. So why do we take seriously the claim that medical services, which, unlike food, most people tend to avoid as much as possible, are subject to 'unlimited demand'?

Nobody would deny that some new medical procedures are costly and that their availability can involve difficult decision-making. Most people would also agree that such decision-making should be transparent and evidence-based. But the best efforts of NICE and others cannot compensate for the fact that there is, in the NHS, no effective mechanism for measuring demand and ensuring that it is met. This is not because demand is unreasonable, let alone infinite: it is simply because there

is no mechanism for matching demand with supply.

So we need to do more than try to make resource allocation transparent and evidence-based. We also need to see that it is followed by the money to pay for it. The present system of funding the NHS from general taxation is admirable in principle but fails because no politician is willing to argue the case for greater taxation. If, on the other hand, there were a ring-fenced ('hypothecated') health tax, then there would be a mechanism for the public to be properly involved in debate about resource allocation, and to come up with the money to pay for what they really want.

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## Research governance: major barrier to medical student research

For her special study module on sexual health and research, a second year medical student (RY) decided to do a questionnaire survey of access to sexual health care among attenders aged <25 years in the waiting room at a genitourinary medicine (GUM) clinic. The time allotted for the special study module was 1 day per week for 10 weeks. Her protocol, patient information sheet and questionnaire (available from the authors) were seen by the chairman of a local research ethics committee and deemed to be borderline audit/research.

The brief, anonymous questionnaire was not particularly intrusive. It asked about age, sex, ethnicity, employment, ease of finding the GUM clinic, whether they preferred coming there to seeing

their GP, and two questions on knowledge of sexually transmitted infections. The patient information sheet made it quite clear that there was no obligation to complete the questionnaire and that this would not affect treatment.

The GUM physician at the clinic (at a hospital outside London) was supportive and the findings might have been useful. However he referred the proposal to the research governance manager. This was fatal. She wrote:

'... It would not be possible to expect a student project to be approved in the time constraint you have indicated ... It is likely that an Honorary Contract will be required for this study. In order for such a contract to be issued, a Criminal Records Bureau Check will be undertaken. CRB checks are currently taking approximately 6 weeks. If the study is also involving vulnerable groups, it is likely that an Occupational Health Check will also be required. Both these checks would be conducted by the relevant Human Resources department.

In my view this is research and not audit. There are no apparent standards set with which to compare. The proposed research question is dealing with a very sensitive subject on potentially vulnerable individuals. There would be serious concerns with regard to the data access, especially as the researcher does not appear to have access to this information in the course of their work at this clinic.

The research question and questionnaire have the potential of creating situations for the participants that the researcher may be unable to deal with, therefore involving other departments without their prior knowledge. Safeguards for both the researcher and research population must be in place — access to further counselling etc as a basic minimum.

Please do not hesitate to contact me