doctors who have hoop jumping to face. Currently I have to hoop jump to access the top marks of various GCSE coursework assignments. For example, in physics I have to state my findings 'in the simplest way possible,' before I can go back and describe it all again in greater detail. (Why not just explain in detail in the first place?)

I'd be willing to accept the devolution of the GP role if it meant practising would entail less responsibility; however it seems practitioners must now bear the brunt of nurses', pharmacists' and a host of other people's medical mistakes. So is it worth the 2 years of A levels, many years of medical school and then the good old MRCGP for a job with less medicine and more responsibility? (Or perhaps the late-home, tired-parent views aren't representative!)

**Guy Rughani**
*Age 15 Years, Sheffield*
*E-mail: amar.rughani@sheffield.ac.uk*

# Telephone reviews of chronic illnesses

We write in response to the news that national arbiters for the GP contract are to rule on whether telephone reviews for patients with asthma count towards Quality and Outcome Framework targets.[1] Not to allow this would be a major setback to those who are developing and implementing innovative service provision models, which aim to increase access and offer choice of routine care to patients with long-term illnesses. The decision by West Wiltshire, and Kennet and North Wiltshire Primary Care Trusts, not to allow telephone-based asthma reviews, may be charitably described as unnecessarily restrictive in their interpretation of the contract; although cynics may speculate that this is a cost-saving exercise in the aftermath of practices' unexpected 'over performance' in achieving quality targets.

Patients with long-term diseases do not have equal opportunities of access to care. As clinicians, we fix times and locations of interactions with patients that are strongly biased in our favour. Ministers have expressed concern about this and are calling for longer opening hours. Providing the choice of remote reviews for chronic disease is a more practical solution which, if used appropriately,[2] can provide care that is effective, cost-effective and valued by patients.[3] It is a perverse ruling that encourages practices to 'exception report' those patients unable or unwilling to attend face-to-face reviews, rather than encouraging clinicians to offer convenient remote consultations.

Studies have demonstrated improved access, in the context of asthma reviews in primary care,[4–6] and we have strong theoretical grounds for believing that this benefit is also likely to be true for a range of other chronic disorders. Furthermore, the telephone is only one of a growing array of communication channels (email, SMS text messaging, etc) now available that can facilitate delivery of convenient and accessible care. A 'ban' on telephone consulting would be a retrograde step that could impact negatively on the use of these other communication modalities.

It is ultimately patients who will be the losers if the decision to disallow telephone consultations is upheld. Telephone reviews are now acknowledged by the British Thoracic Society/Scottish Intercollegiate Guideline Network asthma guidelines;[7] they should similarly be embraced by the Quality and Outcomes Framework.

**Bernard Fernando**
*Clinical Research Fellow (Hon),*
*Division of Community Health Sciences: GP Section,*
*University of Edinburgh*
*E-mail: B21Fern@aol.com*

**Hilary Pinnock**
*Clinical Research Fellow,*
*Division of Community Health Sciences: GP Section,*
*University of Edinburgh*

**Aziz Sheikh**
*Professor of Primary Care Research & Development,*
*Division of Community Health Sciences: GP Section,*
*University of Edinburgh*

## REFERENCES

1. News story re Wiltshire PCTs. http://www.ehiprimarycare.com/news/item.cfm?ID=1556 (accessed 2 Jan 2006).
2. Pinnock H, Hoskins G, Neville R, Sheikh A. Triage and remote consultations: moving beyond the rhetoric of access and choice. *Br J Gen Pract* 2005; **55**: 910–911.
3. Pinnock H, Bawden R, Proctor S, Wolfe S, *et al.* Accessibility, acceptability and effectiveness of telephone reviews for asthma in primary care: randomised controlled trial. *BMJ* 2003; **326**: 477–479.
4. Pinnock H, Mckenzie L, Price D, Sheikh A. Cost-effectiveness of telephone or surgery asthma reviews: economic analysis of a randomised controlled trial. *Br J Gen Pract* 2005; **55**: 119–124.
5. Gruffydd-Jones K, Hollinghurst S, Ward S, Taylor G. Targeted routine asthma care in general practice using telephone triage. *Br J Gen Pract* 2005; **55**: 918–923.
6. Car J, Sheikh A. Telephone consultations. *BMJ* 2003; **326**: 966–969.
7. The British Thoracic Society/Scottish Intercollegiate Guideline Network. British guideline on the management of asthma, November 2005 update. *Thorax* 2003; **58** (S1):i1-i94. http://www.brit-thoracic.org.uk (accessed 16 Jan 2006).

# Imaging in sinusitis

We write to inform you of the results of our recent audit relating to imaging in cases of suspected chronic sinusitis.

All facial X-ray requests over a 6-month period at Hope Hospital, Salford, were audited. We found that 54 plain X-rays were performed in cases of suspected sinusitis. Of these, 34 were reported as normal, 16 were abnormal and four were unavailable for review. Forty patients were subsequently referred for further ENT review. We found no correlation between X-ray findings, incidence of referral and eventual treatment. Of 54 plain X-ray requests, 50 originated from primary care (either family GP or emergency hospital GP), three requests were from Accident and Emergency and one was from a non-ENT outpatient clinic.

Examination of the current guidelines and evidence regarding appropriate imaging in suspected sinusitis suggests that this current practice is now outdated. Guidelines from the Royal College of Radiologists discourage the use of plain facial X-rays in suspected cases of sinusitis. Plain X-rays have been shown to have low sensitivity and specificity for sinusitis and expose

patients to unnecessary radiation. Imaging is generally indicated in chronic sinusitis if operative intervention is being considered and in these cases computerised tomography will define preoperative anatomy and in addition has high diagnostic sensitivity.

In conclusion, chronic sinusitis is a clinical diagnosis in which plain X-rays are diagnostically unhelpful.

**MP Newton Ede**
*E-mail: newtonede@doctors.org.uk*

**JC Hobson**
*E-mail: jonathanhobson@gmail.com*

**TJ Woolford**
*Department of ENT Surgery,*
*Hope Hospital,*
*Manchester M4 6HD*
*E-mail: Timothy.Woolford@CMMC.nhs.uk*

### REFERENCES

1. Royal College of Radiologists. *Making the best use of a department of clinical radiology guidelines for doctors.* 5th edn. London: Royal College of Radiologists, 2003.
2. Okuyemi KS, Tsue TT. Radiologic imaging in the management of sinusitis. *Am Fam Physician* 2002 Nov 15; **66**: 1882–1886.
3. Burke TF, Guertler AT, Timmons JH. Comparison of sinus x-rays with computed tomography scans in acute sinusitis. *Acad Emerg Med* 1994; **1**: 235–239.

# Non-bacterial acute conjunctivitis

The problem with studying treatment for acute bacterial conjunctivitis is making sure that only bacterial cases are included, and not viral, chlamydial, allergic, etc. Treatment generally starts before microbiological confirmation of a bacterial cause.

The study by Rietveld *et al*[1] shows that fusidic acid is similar to placebo in the treatment of 'all-comers' with an acute conjunctivitis. It is important to note that most of these cases were not bacterial conjunctivitis — nearly 70% had no isolation of a bacterial pathogen. It is therefore to be expected that fusidic acid would not be effective for the majority of these patients. Nevertheless, the study is useful in that it provides no support for blind prescription of fusidic acid for acute conjunctivitis of undetermined cause.

The study was not meant, however, to address the treatment of acute conjunctivitis caused by bacteria. I was therefore surprised to find the study being used to support the conclusions of Professors Sheikh and Hurwitz in the same issue,[2] relating to the treatment of acute bacterial conjunctivitis specifically.

**Nadeem Ali**
*Specialist Registrar in Ophthalmology,*
*James Cook University Hospital,*
*Middlesborough*
*E-mail: nadeem.ali@nhs.net*

### REFERENCES

1. Rietveld RP, ter Riet G, Bindles PJE, *et al*. The treatment of acute infectious conjunctivitis with fusidic acid: a randomised trial. *Br J Gen Pract* 2005; **55**: 924–930.
2. Sheikh A, Hurwitz B. Topical antibiotics for acute bacterial conjunctivitis: Cochrane systematic review and meta-analysis update. *Br J Gen Pract* 2005; **55**: 962–964.

# Assisted suicide debate

I have just received the November Journal here in Australia and was incensed to read the letters against assisted suicide and euthanasia and cheering the decision of the College. What right do the writers have to decide that my life should be prolonged against my wishes? Is it an edict of their mythical God? As for suffering being good for you — I did not spend years training to relieve suffering in order to be able to say to patients 'You suffer a bit chum, it's good for you.' I do not believe it would have been appreciated. Perhaps I should have gone to theological college?

**Harry Friend**
*4 Kenny Place,*
*Hackett,*
*ACT 2602,*
*Australia*
*E-mail: friendly@homemail.com.au*

# Has cancer had an impact on your life?

I would like to ask your readers: has cancer had an impact on your life? If so, Macmillan Cancer Relief needs to hear from you. Have you been diagnosed with cancer? Or perhaps someone close to you has? If so, you'll have valuable experience and views on the various ways in which cancer can impact on people's lives. This is your opportunity to have your say and enable Macmillan Cancer Relief to help even more people cope with cancer both now and in the future.

Macmillan needs to hear from people with cancer, and also close relatives and friends, because we understand that a cancer diagnosis doesn't just affect the individual. Our survey is being conducted by an authorised research organisation so all personal data will be kept confidential and secure. You will not be named in any published research findings, unless you tell us you want to be.

If you are happy to take part in Macmillan's new 'Impact of Cancer Survey 2006', please visit www.impactofcancer.com now and fill in our online questionnaire. If you prefer the telephone, you can call 020 7861 3279. To register from Tuesday 3 January 2006, between the hours of 9–5, Monday to Friday.

Thank you for enabling Macmillan Cancer Relief to help more people affected by cancer.

**Peter Cardy**
*Chief Executive,*
*Macmillan Cancer Relief,*
*89 Albert Embankment,*
*London SE1 7UQ*

**For further information please contact:**
Julia Anderson or Liz North, Macmillan Cancer Relief Press Office.
Direct line 020 7840 7821
(out of office 07801 307068)
E-mail: janderson@macmillan.org.uk