

Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to jhowlett@rcgp.org.uk, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Letter from a Dutch uncle

As I read the inner cover of September's *BJGP* I noted once again the preponderance of researchers whose surnames contain an almost implausible combination of vowels or suspicious frequency of diphthongs. Not for the first time and, like a bygone Eurovision Song Contest, the Dutch scored highest on the Original Papers count.

I am happy to read and learn from articles originating elsewhere in the world and delight in the cosmopolitan culture of this proud journal. I do wonder though as to why quite so many articles appear from the Benelux and Scandinavian countries. Perhaps ours is truly the pinnacle of publishing excellence that Danish researchers can only aspire to. I have a nagging suspicion though that many such papers are received on the back of rejections from reviewers elsewhere on the continent.

I am curious that an antibiotic study should exclude 'families that had not mastered the Swedish language'¹ and yet its intended readership is not subject to such denial. I am bemused by the relevance of studying prescribing habits that stray from those of the Dutch College of General Practitioners' guidelines.² I am perplexed that our Editor must 'again' apologise to 'non-UK readers' for content found elsewhere within the *BJGP*.³ I know the *BMJ* struggles with the word 'British' in its title and has considered abandoning it for something more 'international.' Perhaps it delayed because the *Icelandic Medical Journal (IMJ)* got there first (by almost a century!) with those particular initials.

May I suggest that the, otherwise helpful, little coloured box: 'How this fits in' should be extended to mention the country in which the study was conducted

and how it relates (or literally translates) to British general practice.

It is not a safe assumption that research findings anywhere within these ever expanding European boundaries apply throughout or even elsewhere. Many cultural and practical differences exist and in a medical context alone these would include incompatible or different: X-ray facilities and guidelines; Ethics committees; Notification of diseases; Organisation of health services; Politics and pharmaceuticals, Hospital management; Out-of-hospital care; Bed availability and usage; Infrastructures and Attitudes. I appreciate this has a most unfortunate acronym but I do hope my point is not lost in translation.

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The use of cardiovascular risk factor information in practice databases

Tom Marshall¹ shows how routinely collected general practice data can help identify patients at risk of cardiovascular disease (CVD). Practice-held information

could become an important resource for targeting preventive care, particularly when combined with automated software, as he suggests. However, there are a number of issues highlighted by his paper.

Marshall has excluded those already on blood pressure and cholesterol lowering therapy from his modelling. Such patients should ideally have their risk estimated using 'pre-treatment' values. However, these values are often unavailable in general practice databases. The Coronary Heart Disease National Service Framework² recommended using the hypertension register as a rich source of high-risk cases, where there is a potential for further reduction in risk even if blood pressure control has been achieved. We believe that such patients should be included in any automated search strategy.

We have designed a new software tool, the 'e-Nudge', which has been programmed by the clinical software company EMIS. Currently being trialled in the West Midlands,³ the e-Nudge works both opportunistically (through screen alerts when high CVD-risk patients' notes are opened), and systematically through the creation of continually updated lists available to practice teams. It works on the assumption that 'most recent' values will generally be lower than 'pre-treatment' values in patients on drug therapy. While neither approach is perfect, this maximises the usefulness of general practice data for case finding.

Tom Marshall assumes that once the at-risk population is identified, opportunistic case-finding is effectively random. However, risk factors for CVD are also predictors of consulting rates, which increase with age,⁴ and in socioeconomic groups IV and V⁵ in which smokers are more common. The likelihood of a patient in Marshall's higher risk deciles consulting will therefore be greater than average, increasing the efficiency of opportunistic screening, so

that a combination of opportunistic and systematic strategies may be the best way forward. Either way, case-finding must be an ongoing activity since new patients will continually be entering the high risk group as they age.

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Privatising primary care

I couldn't agree more with the excellent editorial by Allyson Pollock and David Price ('Privatising Primary Care') in August's *British Journal of General Practice*. The representatives at the BMA's Annual Representative Meeting this summer voted to oppose the privatisation of the NHS. It's unfortunate, in my opinion, that my college, the RCGP, has not taken this line, but perhaps the *BJGP* could consider publishing papers regarding evidence as to the effectiveness or otherwise of privatised primary care, for example in the US. I have been going to the US fairly often over the last 30 years and it is my experience, both personally and from talking to medical

friends, that only a small proportion of the population there receive what we would consider an adequate primary care service. American publications by Barbara Stansfield and the Commonwealth Fund of New York support this point of view.

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Domestic violence in practice

Fitzpatrick describes the interest in interpersonal violence as a 'vogue for wallowing in degradation reflecting a misanthropic view of humanity and a pessimistic outlook towards the future'.¹ He states that, because of wider social progress, there is a decline in the scale of domestic violence.¹ Fitzpatrick also describes his experience elsewhere:

*'I inquired whether (my GP colleagues) had noticed a recent upsurge in domestic violence. But no; like me, they had certainly encountered the occasional case, but thought it not a very common problem ...'*²

Unfortunately, research reveals that domestic violence remains common and often undetected by doctors.³

Far from misanthropy and pessimism, recognition of the existence of interpersonal violence and its damaging effects is the first step towards raising support for the sufferer, whether that support takes a social, medical or psychological form. Failing to recognise the problems caused by inter-personal violence may well be misanthropic.

Fitzpatrick suggests that improving the quality of human relationships should be a social not a medical project, and presents these approaches as alternatives. Fitzpatrick believes that reframing social problems as illnesses encourages individual dependency.¹ However, the naming of the condition described by writers ancient and modern (for example, Samuel Pepys in his

diary, and testimonies of 'shell shock') as 'post-traumatic stress disorder' (PTSD) liberates the patient by acknowledging that an individual's symptoms are a recognised response to life-threatening trauma. Armed with this understanding of how domestic violence is affecting them, patients often find the strength to improve their situation.

Fitzpatrick quotes cases of transcendence of abusive experiences (Bryan Magee and John McGahern)¹ Indeed, research shows that 2/3 of those experiencing life-threatening trauma are resilient to developing PTSD,⁴⁻⁶ but one can hardly ignore the other third. These are the ones who do not manage to transcend their experience, and who are thus more likely to be seeing their GP. It would be helpful and humane if their doctors recognised their PTSD, and correctly attributed its source. If the doctor has not asked about past trauma in the consultation, other less helpful socially constructed labels such as 'frequent attender', 'heartsink patient' and 'personality disorder' may be attached to the patient instead. The alternative of not recognising the source of their problems is more likely to leave these patients as disabled victims. My paper³ gives doctors the tools to become less ignorant of interpersonal violence in a way that is respectful of patients.

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