

Letters

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Edzard Ernst and complementary medicine

Professor Edzard Ernst's frequent articles on complementary medicine are becoming rather monotonous because they are too one-sided. He often points out the dangers of complementary medicines and deplors doctors who use them. He rarely mentions that the establishment has probably failed the patients, making them turn elsewhere. Often, all patients get from the establishment are short-term analgesics or symptom relievers and some of these can have dangerous side effects too.

Patients do get results from complementary medicine given by doctors (many well qualified, FRCP, MD etc) who are well aware they must be careful not to miss hidden pathology. We should aim for toleration in all things.

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1. Ernst E. Popular health advice: entertainment or risk factor? *Br J Gen Pract* 2007; 57: 415 (and more).

Author's response

Dr I E Doney seems to misread my articles and misunderstand my remit. It is my job to research complementary medicine rigorously and without double standards. This necessarily involves exposing risks that can be identified. I am sure the 'establishment' fails many patients, however, this does not mean that quackery should be allowed to masquerade as medicine. To not speak out against this would, in my view, be irresponsible. I recommend that Dr Doney has a look at our book¹ in which we summarise the evidence

for or against complementary medicine systematically and fairly. I doubt that he then can still uphold his accusation of one-sidedness.

Edzard Ernst

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1. Ernst E, Pittler M, Wider B. *The desktop guide to complementary medicine*. Oxford: Elsevier, 2005.

Handshakes and consultations

Mike Jenkins' letter¹ analysing patients' reasons for spontaneous handshaking made interesting reading and, while I think his conclusions are compelling, he should have prefaced his report by emphasising the importance of handshaking for all consultations in this context.

I believe that a form of physical contact with patients of every age is important; it is both bonding and comforting for the patient, and it needs to be no more than a reassuring hand on the arm as the patient enters or leaves the room. This is particularly important when physical examination does not take place, such as in a psychiatric consultation.

While I applaud Dr Jenkins' insight into the social behaviour of his patients, I surely hope that he will also offer all his patients this critical human touch.

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1. Jenkins M. The meaning of the handshake towards the end of the consultation. *Br J Gen Pract* 2007; 57: 324.

Author's response

I feel the letter 'Handshakes and spoof publications'¹ does warrant a published reply.

I am pleased that my pilot study has stirred such interest and find it fascinating this includes such an extreme response. Taking each of the three points raised. Firstly, the study suggests that 1.2% of patients were very happy with their consultation and demonstrated their feelings in this way. Dr Parkes makes the classic error of judgement by comparison when no measurements or standards exist yet. The consensus from my colleagues in general practice is that they receive about one patient-initiated handshake towards the end of the consultation per week. Interestingly, and I know that this is a sensitive and emotive issue, but on enquiring into female GPs' experiences, a patient-hug (from female patients) seems to occur.

Secondly, I was informed the pilot study was not suitable for the original papers section as there was only one subject, that was myself.

Thirdly, we are in total agreement. The phenomenon needs more research in a wider context as outlined by Dr Parkes's broader questions. Of course, however, we may never know unless someone is brave enough to perform the research despite such responses!

Touch in medicine, does seem an emotive and currently a politically incorrect subject as raised and published in this journal by Dr Dougal Jeffries.²

I wonder if some doctors might even feel threatened by issues of touch between patient and doctor?

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1. Parkes G. Handshakes and spoof publications. *Br J Gen Pract* 2007; 57: 411.
2. Jeffries D. In praise of touch. *Br J Gen Pract* 2007; 57: 80.

QOF vs NICE

As a FHO2 (Foundation Year 2 House Officer) in general practice, I recently performed an audit on smoking cessation practice at my surgery. Naturally I turned to 'Gold Standard' national guidelines to set my audit criteria. However, I was rather disturbed by the discrepancies between the 2006 QOF criteria¹ for monitoring smoking status and management of smokers and the 2006 NICE Public Health Guidance on smoking cessation.²

The NICE guidance is the first public health guidance issued on smoking cessation with the emphasis being on prevention of smoking-related complications. The guidelines advocate the use of 'Brief Interventions' (simple opportunistic advice to stop which can be performed by clinicians across the board) and early referral to smoking cessation services.

Using QOF targets we are currently identifying: 1) smokers, 2) smokers with chronic disease, 3) smokers with chronic disease who get advice/referral. We do not routinely know: 1) the smoking status of all those on GP lists every 15 months, 2) if the smoking status of non-smokers has changed, 3) if smokers without chronic disease are getting advice/being referred/being offered pharmacotherapy. As part of the 2006 guidelines, NICE publish recommended audit criteria which are poorly comparable to the QOF targets but which tackle these shortfalls mentioned. I find this particularly surprising considering that the NICE guidance preceded the publication of the GMS contract.

In the current environment where smoking-related disease, and more specifically, cardiovascular disease, is the number one burden to the NHS, I agree that we need to embrace a more comprehensive set of guidelines for the management of smoking. In order to achieve this goal, however, there needs to be some clarity and stream-lining of guidance between primary care and major clinical governing bodies. I would like to see

accelerated efforts to establish this relationship and encourage a response to this letter from both parties.

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1. BMA. QOF2 Clinical Indicators. *Guidelines in Practice*. May 2006. (Records & Information 22; Asthma 3, 4, 5; Smoking 1, 2) London: BMA, 2006.
2. National Institute of Clinical Excellence (NICE). *Brief interventions and referral for smoking cessation in primary care and other settings. Public health intervention guidance no 1*. London: NICE, 2006.

Computer records

In Scotland, the first step towards a centralised medical database has already occurred. Described as the Emergency Care Summary (ECS), patient consent has been obtained by a single mailing to each household. Using this as an assumption of informed consent, data has been extracted from general practice clinical systems.

We had misgivings about this consent process being adequate. Considering all the options, including the possibility of an 'opt-in' mandate, we decided to mail patients individually to offer an opt-out of this information sharing.

We have so far received 287 opt-out requests for a list size of 1710. For Scotland, there have been a total of 620 opt-outs for a population already included of 5 million. Our figure of 16.5% compares to a national average of 0.01%; a factor 1330 times greater.

Our results question whether the governments' strategies of obtaining consent for the release of such information reflect proper process. Many patients refused because they were unaware that consent to allow data migration had been obtained.

There is still time to evaluate the usage of the ECS to see how often it has been used and to define the benefits of better clinical outcomes. In the final analysis, before we can obtain informed consent for these new and relatively untried programs, we need to understand the benefits for individual patients clinical outcome as well as being clear about the extent of any potential for inappropriate or malicious use of information.

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Developing primary care treatment of depression

Tylee and Walters¹ make a good case for the development of a chronic disease model for the management of depression in primary care. Some of the figures that they quote deserve further comment. It is of concern that between 30 and 50% of patients treated for depression with antidepressants in primary care do not show a response, while only 30% achieve remission. It is also of concern that only 10% of patients on antidepressants complete an adequate course. Finally, it is of concern that 76% of patients with residual symptoms relapse and that 12 months after diagnosis, 45% of patients with severe symptoms remain depressed, and 40% of patients have a relapsing remitting course over a decade. These facts clearly lead up to the statement that 40% of patients with depression are eligible for 'step 4' secondary care interventions.

It is interesting to see how these statements appear to be born out in practice. We work in a community mental health team with a catchment population of 60 000. Out of these, in 10 months 456 patients were seen in the clinic. Of these, 63 had a diagnosis of recurrent depressive disorder, 12 had psychotic depression, 28 had anxiety and depression, 73 were seen for depressive episodes, and 41 had bipolar affective disorder. Although it is clear that depressive illness makes up the bulk of the morbidity which we treat, there is clearly concern that these figures are unlikely to be equivalent to the 40% of depressed patients of our population who are eligible for secondary care services according to the figures quoted by Tylee, hence Tylee is right that many patients who are in fact eligible for treatment in secondary care are in fact treated in primary care.