Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: http://www.rcgp.org.uk/journal_/bjgp/discussion_forum.aspx

NICE guidelines on fever in children

The NICE guidelines for *Feverish illness in young children* is a document that contains useful practical advice on fever care. It illustrates that when dealing with a feverish child, the issue is to exclude an underlying dangerous infection rather than treating the fever with antipyretic interventions. This gives the opportunity for every clinician to give the same confidence-building message to the public.

- Antipyretic agents (paracetamol and ibuprofen) should not routinely be used with the sole aim of reducing body temperature in children with fever who are otherwise well.
- Antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose.
- Paracetamol and ibuprofen should not routinely be given alternately to children with fever.
- Tepid sponging is not recommended for the treatment of fever.
- Children with fever should not be under dressed or over wrapped.
- The use of antipyretic agents should be considered in children with fever who appear distressed or unwell. Either paracetamol or ibuprofen can be used to reduce temperature in children with fever. Paracetamol and ibuprofen should not be administered at the same time to children with fever.[1]

To build confidence in parents who are caring for feverish children, it is essential that health professionals stop maintaining two medical myths, the first that fevers can get too high and death ensues, and second, that febrile convulsions happen when the temperature gets too high. These two myths are the cause for the widespread anxiety about fever. Furthermore, doctors believe that reducing the temperature makes the child feel more comfortable.

The result of the advice 'to manage the fever' gives parents the impression that the temperature should be reduced and is often advised as such by clinicians. However, the above bullet points illustrate otherwise. This is important because every practicing doctor in the out-of-hours service is aware of phone calls from parents who ring in a panic because they realise that they 'cannot control the temperature'.

This iatrogenic fever phobia is a frequent cause for distress in parents, which has its effects on the child, and the health professionals who deal with the caller.

Due to the frequency of these type of calls, it puts pressure on the OOH service and the outdated advice 'to manage the fever' or 'to control the fever' is potentially resulting in a second call during the same shift when the temperature is not responding and this again is the cause for attendances to the primary care centres and subsequent contacts with the paediatric departments and admissions.

Rather than advising to fear and fight a fever, doctors can give advice that supports the fever process and, as such, build confidence in parents caring for their feverish child. Implementing this NICE advice and organising a public awareness campaign to support the fever process has the potential to create health gains for all involved and financial gains for the PCTs due to less pressure on the services.

Wouter Havinga
Sessional GP, Lightwood lane, Randwick, GL6 6JL. E-mail: wouter.havinga@gmail.com.

REFERENCE

1. NICE Clinical Guidelines. *CG47 Feverish illness in young children: Quick reference*. London: Nice, 2007: http://guidance.nice.org.uk/CG47/quickrefguide/pdf/English (accessed 12 Sep 2007).

Diagnosing depression

We have some concerns about the validity of the study by Gilbody, *et al*.[1] Patients were recruited for a randomised controlled trial of collaborative care for depression in primary care. Thirty-six of 96 (93 in the abstract) patients (37.5 %) were diagnosed with major depressive disorder according to SCID. Such high prevalence indicates that patients were not randomly chosen from practices. Receiver-operating curve statistics was applied on this obviously highly-selected group of patients. This is misleading; any depression screening instrument may demonstrate excellent performance in such groups. For instruments to prove useful in general practice, statistics should be based on representative practice population samples.[2–4]

Kaj Sparle Christensen
Senior researcher, PhD, Research Unit for General Practice, Vennelyst Boulevard 6, 8000 Aarhus C, Denmark.
E-mail: kasc@alm.au.dk

Per Fink
Director, Assistant Professor, Research Clinic for Functional Disorders and Psychosomatics

REFERENCES

1. Gilbody S, Richards D, Barkham M. Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ–9 and CORE–OM. *Br J Gen Pract* 2007; **57(541):** 650–652.
2. Sackett DL, Haynes RB, Guyatt GH, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine.* 2nd edn. Boston, MA: Little, Brown & Co., 2000.
3. Bossuyt PM, Reitsma JB, Bruns DE, *et al*. Towards complete and accurate reporting of studies of

diagnostic accuracy: the STARD initiative. *Fam Pract* 2004; **21(1):** 4–10.

4. Smidt N, Rutjes AW, van der Windt DA, *et al*. The quality of diagnostic accuracy studies since the STARD statement: has it improved? *Neurology* 2006; **67(5):** 792–797.

Author's response

We thank Drs Christensen and Fink for their interest in our work. The results of our initial validation deserve replication in a larger unselected GP population, as we highlight in our discussion.[1] However, for the PHQ–9, our results are broadly in line with the other PHQ9 validation studies (based upon 5026 patients) which are in the public domain at the time of writing. We have recently subjected these data to a systematic review and diagnostic meta-analysis.[2]

Our *BJGP* paper represents the first UK validation of the PHQ–9 and CORE instruments and we felt it important to place these data in the public domain, given the recent emphasis on routine depression assessment under the Quality and Outcomes Framework.

The performance of any instrument will vary between populations and studies, and sensitivity and specificity are especially influenced by baseline prevalence.[3] However, the baseline prevalence of depression in our study is of a similar magnitude to that found in 'high risk' populations such as those with coronary heart disease and diabetes (where the use of brief instruments is rewarded under the QOF). We therefore also reported likelihood ratios,[4] which are relatively insensitive to baseline risk and are much more informative to clinicians in their clinical decision making.[5] Likelihood ratios are 'portable' and can be readily used to establish post-test probability of a disorder within a plausible range of baseline prevalence estimates. We presented one such estimation using figures commonly encountered in primary care in our paper.

Simon Gilbody
Professor of Psychological Medicine, Department of Health Sciences, University of York. E-mail: sg519@york.ac.uk

David Richards
Professor in Mental Health, University of York

Michael Barkham
Professor of Clinical and Counselling Psychology, Psychological Therapies Research Centre, York

REFERENCES

1. Gilbody S, Richards D, Barkham M. Diagnosing depression in primary care using self-completed instruments: a UK validation of the PHQ9 and CORE-OM. *Br J Gen Pract* 2007; **57(541):** 650–652.
2. Gilbody S, Richards D, Brealey S, Hewitt C. Screening for depression in medical settings with the patient health questionnaire (PHQ): A diagnostic meta-analysis. *J Gen Intern Med* 2007; in Press.
3. Sackett DL, Haynes RB, Guyatt GH, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine.* Boston, MA: Little, Brown and Co., 1991.
4. Grimes DA, Schulz KF. Uses and abuses of screening tests. *Lancet* 2002; **359(9309):** 881–884.
5. Grimes DA, Schulz KF. Refining clinical diagnosis with likelihood ratios. *Lancet* 2005; **365(9469):** 1500–1505.

QOF

I want to drop the humbug. And I want to say 'Bah, Humbug' to whatever unreal world Dr Chris Gunstone[1] lives in.

He may think professions are a 'conspiracy against the laity.' To some extent they are. But the conspiracy is necessary to ensure that the public get a good service. Professions arise in specialist niches where specific knowledge and experience is necessary to work effectively. Most professionals are motivated by their internal drive to perform well in the service of others. Relatively few people can be bothered to put the necessary time and effort to become a competent professional, and our worth arises because of the time and energy we have spent acquiring our skills. Our worth is enhanced because we can be trusted to get on with things, without the need for too much external policing. Our regulators should bear this in mind, for excessive supervision and micromanagement will destroy the motivation of many professionals, and so ultimately reduce quality of service.

The medical profession has a very specific set of knowledge and experience. As a doctor I celebrate owning the 'medical gaze'[2] and that I know how to use it well. It is a valid and necessary perspective on the world. I do not claim it is all encompassing, but to be ignorant of the medical perspective on things is to be partially blind, and most politicians are partially blind on many topics, so they need good professional input to help them. Most politicians are sensible enough to gather such intelligence.

The profession must have a major say on issues of health and illness[3] and must give evidence to the policy makers as to what is effective or not. There is no evidence that the Department of Health has any clear idea of what health is, nor any coherent strategy for achieving it. Indeed the Department is lost in an endless cycle of fire fighting exercises[4,5] and desperately needs a route out from them.

As doctors we are a major and valid voice within society, and have a very important role both with, and beyond, the treatment of our individual patients. The patients we see day by day are often the physical signs of much that is wrong with our body politic, for example social inequalities and family breakdown.

This country needs a powerful and assertive medical profession to draw attention to the many problems within its society. Maybe our role as doctors should be more political than it currently is.

Peter Davies
GP, Keighley Road Surgery, Illingworth, HX2 9LL. E-mail: www.krshalifax.co.uk.

REFERENCES

1. Gunstone C. QOF. *Br J Gen Pract* 2007; **57(542):** 748.
2. Foucault M. *The birth of the clinic.* London: Routledge, 1973.
3. Davies P. Between health and illness. *Perspect Biol Med* 2007; **50(3):** 444–452.
4. Webster C. *The National Health Service: a political history.* 2nd edn. Oxford: Oxford University Press, 2002.
5. Klein R. *The new politics of the NHS: from creation to reinvention.* 5th edn. Oxford: Radcliffe Publishing, 2006.

Vitamin D deficiency

The paper by Mytton, *et al*,[1] rightly points to the growing recognition of vitamin D deficiency in the UK, particularly among black and ethnic minority groups. Their study looked at patients with abnormal vitamin D levels, finding high rates of