

While I deplore the aggressive tone of Dr Manassiev's letter, I rejoice in the fact that one commentator found my judgements of complementary therapies unjustifiably negative,<sup>7</sup> while Manassiev believes they are unjustifiably positive. As long as I receive flak from both sides, my position is probably not entirely wrong.

#### Edzard Ernst

*Complementary Medicine,  
Peninsula Medical School,  
25 Victoria Park Road, Exeter, EX2 4NT.  
Email: Edzard.Ernst@pms.ac.uk*

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## Emergency Care Summary in Scotland

We would like to correct some inaccuracies in reply to the essay by Dr Gordon Baird in the Back Pages of the February edition of the *BJGP* in which he made comments about the Emergency Care Summary (ECS) in Scotland.<sup>1</sup>

As Dr Baird says in his article, information should only be disclosed in the interest of the patient. That is the sole aim of the Emergency Care Summary. It contains clinical information on current medication, allergies, and any adverse reactions to medications that are recorded on the GP clinical system. Patients can

opt out of having their ECS information uploaded from their GP record but, even when it is available, the information can only be accessed with the explicit consent of the patient for that episode of care. This means that the clinician has to obtain consent from the patient before accessing their ECS and this facility is only available for clinicians working in NHS 24, out-of-hours organisations, A&E departments, or other acute receiving units. This consent model has been approved by the BMA, the Scottish Government, the GMC, and EU lawyers.

Dr Baird states that the information in ECS may not be accurate but, by limiting the clinical content to prescriptions that have been prescribed electronically and to adverse reactions that have been recorded, and by updating the uploaded ECS twice daily, the accuracy of the record is high and the likelihood of including erroneous data minimal. In addition, Scottish practices have been paid through an enhanced service in 2007/8 to check the ECS data systematically for their patients.

Dr Baird unfortunately muddles the different consent models and guidance for the Connecting for Health Summary Care Record in England and the Emergency Care Summary in Scotland. This is confusing for readers as the two projects differ significantly in detail of both content and regarding future plans.

Dr Baird states that the audit trail can be over-ridden by the ECS user setting 'no notification to GP'. This facility is used to support patient privacy, not to over-write any audit trail. The whole process, including any accesses from end to end, is regularly audited to a very high standard, for example, failed log ins, excess log-on durations, and user profiling. All of this data are available on request via each practice manager.

Dr Baird asks who is going to gain most from this information sharing. In the 2 years since the ECS has been in use across Scotland, evaluation in NHS 24 and A&E has shown that it has been found to be of strong clinical benefit by the clinicians who are entitled to use it. NHS 24 clinicians have been able to deal with queries about medication and dosage without the need to refer the patient for a

face-to-face consultation. ECS has been particularly valuable for clinicians dealing with emergency admissions on public holidays or weekends when there is no access to GP surgeries, and for the 'hospital at night' teams.

Clinicians report that it reduces phone calls to GPs, and that a written list is safer than a receptionist reading a list of medication from a screen. Additionally, clinical pharmacists in acute receiving units for unscheduled care can now take a drug history verified by ECS with consent from patients. The pharmacists even report that some GP practices complain if a phone call is made to check the medication as the GP practices now feel that ECS makes this unnecessary. The outcome of our evaluation is that patient safety is considerably improved by the quality of the information and the amount of time saved.

In summary, in a quote from a clinician: 'this has raised the bar for quality and safety for patients', which reminds us that that is the ultimate goal of the ECS.

#### Libby Morris

*Chair, ECS Programme Board*

#### Stuart Scott

*Joint Deputy Chairman, Scottish General Practitioners Committee*

#### Ken Lawton

*Chair, RCGP Scotland*

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## Author's response

Thank you for allowing me the opportunity to respond to the criticism from Dr Morris and her colleagues. Having re-read the essay, I find it difficult to accept that there are any inaccuracies.

It is true that their consent model has been approved by the BMA, the Scottish government, the GMC, and lawyers; nevertheless, the essay points out that a doctor should only transfer information after patients have been informed of the

disclosure. Many of our patients were unaware of the request to disclose the information to a central database. We therefore had to ensure that this had happened, and did so at considerable personal cost.

Many patients were unaware of the ECS project until we told them; I am glad that this, a central point of the essay, is not suggested to have been inaccurate. I have never challenged the idea that the intentions were to make this information widely available; nevertheless it failed, and we did what we could to put that right.

The comment about potential inaccuracy was directed towards records that contained 'supposition and conjecture'; this does not apply to the ECS. I did not state that the information in the ECS may be inaccurate. However, handwritten prescriptions will be excluded (we have an average of two power cuts a week here). Only yesterday we had an example of a patient whose details had been wrongly extracted from the database as a result of human error. She was quite capable of giving a clear history.

I did suggest that 'profligate information sharing' might lead to people wishing to opt out of a public health care system. The ECS does not constitute such a level. Nevertheless it appears that this first small step on a great (and potentially very positive and exciting) journey was not well understood by the public.

I still believe that the most effective part of the audit trail is a GP knowing that primary care records have been accessed. I know there are other safeguards, and I make no suggestion that these will be anything other than assiduously adhered to. But the best bank in the world is not secure when thousands of people have the key!

While clinicians report that it reduces phone calls to GPs, I wonder if this is really a good thing? Perhaps if Dr Morris had phoned we would not have to slug this out in print. Many assertions about the benefits of ECS described are anecdotal, and I would be interested in a peer reviewed published evaluation that showed 'that patient safety is considerably improved'. I would be able to recommend this much more positively to patients if that were the case.

#### Gordon Baird

GP, Sandhead Surgery, Sandhead, Wigtownshire. E-mail: Gordon.baird@nhs.net

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## Summary Care Record

Mark Davies *et al*<sup>1</sup> describe the primary purpose of the Summary Care Record thus: 'to improve patient care by ensuring that limited but important clinical information is available' (in circumstances such as emergency A&E attendance, etc).

Do we have any evidence that lives have been lost through the absence of such information, or saved, through the availability of such? Given the cost of the Summary Care Record, one would have thought that such a record would provide more than mere convenience.

It seems to me that many clinicians are less than keen about the Summary Care Record because they cannot see that the above primary purpose justifies such a massive undertaking. Not surprisingly, some of us feel that behind it lies socio-political expediency. 'Giving control to patients'<sup>1</sup> — giving control to government, seems more likely, with GPs like civil servants, feeding the system.

#### Joyce Longwill

GP Principal, Kingsway Medical Centre, Kingsway, Billingham, Stockton-On-Tees. Email: joyce.longwill@nhs.net

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1. Davies M, Eccles S, Braunold G, *et al*. Giving control to patients. *Br J Gen Pract* 2008; **58**(548): 148–149.

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## Otitis media: prevention instead of prescription

Acute otitis media is one of the most frequent childhood infections, with up to 85% of infants having an episode by their first birthday.<sup>1</sup> Though frequently self-

limiting, it is not without significant economic implications. It is estimated that otitis media costs the American healthcare system US\$3 billion per year.<sup>2</sup> The most common symptoms experienced are fever and otalgia, which is often severe.

Recurrent otitis media, defined as three or more episodes in 6 months, has been associated with hearing deficits and speech delay. Even an isolated episode of acute otitis media can have severe complications including mastoiditis and intracranial spread of infection. Eespite this prevalence and associated morbidity, our treatment options are limited.

Antibiotic therapy has not been shown to reduce its duration or risk of complications substantially.<sup>3</sup> Therefore, there is increasing emphasis on addressing the modifiable risk factors for acute otitis media, which include attendance at nursery school (relative risk [RR] 2.45), parental smoking (RR 1.66), and the use of a pacifier (RR 1.24).<sup>4</sup> While it is difficult to persuade parents against the use of a pacifier, for example, using an episode of acute otitis media as a prompt to offering smoking advice may improve the health of both parents and children alike. We decided to investigate our cohort of children with otitis media and audit the number of parents that had been given smoking cessation advice.

The gold standard was proposed that 100% of parents should have been given cessation advice within 6 months of their child's diagnosis.

Sixty-one children were diagnosed with otitis media in a period from January 2004 to December 2007, of which seven had recurrent otitis media. Ninety parents were identified using Vision, the surgery's computer system, of which 41 (45.6%) were smokers at the time of their child's infection. Twenty-four (58.5%) parents had been given smoking advice at some point, but only 11 of these were given advice within 6 months of the diagnosis of acute otitis media.

Of the seven children with recurrent otitis media, five had at least one smoking parent and there were seven smoking parents in total. None of the parents in this high risk group had been given any smoking advice.

We were aware that not all of the