

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.uk

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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

parents given smoking advice were as a result of the child suffering with acute otitis media. In addition, we could only identify parents who were registered with our practice. There was no way of including adults in the home who were not parents or guardians.

This audit was presented to the partners, and a plan was made to put up reminders to discuss smoking with the parents of any children presenting with acute otitis media. The audit is to be repeated in 1 year to allow sufficient numbers of cases to present.

We realise that this is just one of many motivational factors that can be used to encourage patients to stop smoking, but smoking cessation is such a high priority that this window of opportunity should not be overlooked. Prevention rather than prescriptions must remain our ideal in the management of otitis media.

#### Ryan Kerstein

Royal Free Hospital, General Practice,  
Pond Street, London.  
E-mail: ryan.kerstein@gmail.com

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## How can we remove barriers to HIV testing outside of a GUM setting?

Approximately 32% of patients infected by HIV in the UK remain undiagnosed.<sup>1</sup> Delayed HIV diagnosis is responsible for HIV presentation at lower CD4 T-cell count and such patients respond less well to antiretroviral therapy.<sup>2</sup> At least 35% of HIV-related deaths in 2005/6 in the UK were

attributed to late diagnosis of infection.<sup>3</sup> Furthermore, delays in HIV diagnosis and initiation of antiretroviral therapy contribute to horizontal and vertical transmission of HIV infection.<sup>4,5</sup>

A recent study examined the factors which were significantly associated with GUM clinic patients (not exclusively attending for HIV testing) agreeing to GP contact. These factors included heterosexual orientation, initial GP referral, and not considering HIV testing to have negative implications for future mortgage and life insurance applications.<sup>6</sup>

Two factors have been reported to us that impair the ability of non-genitourinary practitioners, both in primary care and other specialist care settings, to perform HIV testing. The first is pre-test counselling. We would argue that, as in other disease areas, the pre-test counselling is no longer necessary as there are clear health benefits in knowing about an HIV diagnosis which outweigh perceived disadvantages. This is consistent with a general move towards 'opt out' HIV testing in GUM clinics and antenatal services.<sup>7</sup> In rare, high risk, or acutely unwell cases, pre-test counselling may be the preferred option, but for the majority of patients it is not required. The second barrier cited is that of transparency about HIV testing for insurance company medical reports. However, the GP and insurance applicants are not required to notify insurers when negative tests are performed.<sup>8</sup>

The life expectancy of a 25-year-old HIV-positive person, who is hepatitis C negative, has been estimated to be greater than 35 years<sup>9</sup> and this will increase as newer anti-retroviral drugs become available. Like other chronic and manageable conditions, an early diagnosis is essential to maximise individual and community health but this can only be achieved by the removal of barriers to widespread HIV testing across all hospital departments and primary care. We urge that the earlier diagnosis of HIV infection is made a clear priority and that the role of specialist genitourinary clinicians to enable better training, clear referral pathways, and the destigmatisation of testing in all care settings are key parts of the development of local sexual health networks.

#### Tristan J Barber

Specialist Registrar GUM/HIV

#### Anatole Menon-Johansson

Specialist Registrar GUM/HIV

#### Simon Barton

Clinical Director HIV/GUM Directorate  
St Stephen's Centre, Chelsea and Westminster  
NHS Foundation Trust, London.  
E-mail: simon.barton@chelwest.nhs.uk

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## Benzodiazepine tolerance, dependency, and withdrawal syndromes and interactions with fluoroquinolone antimicrobials

I investigated reports of an abnormally high incidence of adverse reactions to