

available on the internet (www.blackhealthagency.org.uk/drupal/video) or can be ordered as a DVD from the Black Health Agency at cost price. Copies have already been requested by agencies as diverse as refugee community organisations, Citizens Advice Bureaux, and tutors of English as a foreign language, as well as health organisations. We believe that going beyond traditional healthcare organisations is the key to getting information out to the people who need it most.

A qualitative evaluation of the film was overwhelmingly positive and provided useful feedback on how it could best be used, in combination with information on local services. GPs working in areas with high numbers of new immigrants, asylum seekers or otherwise, might like to direct their new patients to the film in order to ease their transition into the NHS.

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Diabetic feet

In their recent publication 'Patients' perspectives on foot complications in type 2 diabetes: a qualitative study', Gale and colleagues highlight the discrepancies between clinicians' and patients' views of diabetic foot complications. The authors state that 'this particular study is, to the authors' knowledge, the first to investigate perceptions of foot complications among people with type 2 diabetes who do not have personal experience of ulceration.'¹

We would point out that this topic has been extensively investigated by our group using both qualitative and quantitative methods and that our studies

included both patients with and without previous foot ulceration. The findings of this large Diabetes UK- and American Diabetes Association-funded study have been described in a number of publications.^{2–4}

The combination of patient interviews with our clinical experience informed the development of the Patient Interpretation of Neuropathy (PIN) questionnaire, an instrument assessing patients' common-sense misperceptions about diabetic foot complications, their levels of understanding of foot problem-related medical information, and foot problem-specific emotional responses that are associated with foot self-care.⁴ The 39-item PIN fully covers the themes described by Gale *et al*; such as, the vascular model of foot complications (PIN: 'good circulation in the feet means that a person will not get foot ulcers on their feet'),⁴ which leads to the engagement in ineffective foot care (PIN: 'Engaging in activities such as walking or massaging my feet can improve circulation in my feet');⁴ or dissatisfaction with practitioners (PIN: 'I feel angry about healthcare providers not telling me what is really going on with my feet').⁴ Additionally, the PIN assesses a number of patient misperceptions that are not described in Gale's study including those that are shaped by neuropathy-related peripheral insensitivity. These, for example, include the belief that the development or worsening of foot ulcers would be accompanied by pain. Importantly, the PIN provides the coverage of one of the most important determinants of foot self-care; that is, patient understanding of ulcer causes with a focus on the intrinsic risks (for example, hard skin formation), as our interviews demonstrated that patients lack understanding about the causal links between diabetes-related nerve damage and ulceration.

The PIN has been validated in a sample of 495 patients at risk of foot ulceration (64% no personal experience with ulcers). It showed good ability in discriminating between those with and without foot ulceration and a strong relationship with foot self-care.

We would therefore encourage GPs to introduce this succinct yet comprehensive questionnaire to their practice as part of a foot risk assessment, as it allows identification of the patients' views and misperceptions about foot complications, which could be attended to during medical consultation. Copies of the PIN can be obtained by logging onto www.dialex.org.

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Palestine

I am bemused on two counts as to why the *BJGP* chose to publish Lesley Morrison's essay — Stories from

Palestine and Israel.¹

Firstly, it has no relevance to health concerns that I can determine other than in the most superficial way, or is it a contribution to the increasingly popular sport of Israel-bashing?

Secondly, Lesley Morrison's apparent mix of ignorance and naivety is breathtaking. Was she unaware that Israel is suspicious of foreigners who travel from Israel to the West Bank in view of the ever present risk of security being compromised? Then to visit Jenin of all places, regarded by Israel as the centre of militant terrorist activity and a Hamas stronghold in Fatah controlled territory. The place from which numerous suicide bombings and other armed incursions were launched during the second Intifada. The building of the wall has stopped these offensives against Israel's citizens but caused further frustrations for Palestinians.

No matter, if one waves one's British passport at the checkpoint there should be no problem in re-entering Israeli territory! But innocent foreigners, particularly young women, are considered by Israel to be very vulnerable to becoming 'mules' for terrorists. She may have friends in Israel and in Palestine and yet Lesley Morrison appears to be impervious to Israel's genuine security concerns. Her last paragraph gives the game away as to where her sympathies lie. Fair enough, but the *BJGP* should not be so easily lured into bias.

Freddy Shaw

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Patients with learning disabilities

With reference to the letters following and original article by Mike Fitzpatrick,¹ I find it hard to believe that our own patients' experience could be so very

different to those in the study GPs' populations. I would agree that there may well be access difficulties to many of these patients, as there are to those with mobility problems, or indeed those who simply live away from good public transport and do not drive, albeit difficulties of a different nature and solutions. There will also be those for whom certain types of services will pose specific obstacles, such as the mentioned smear programme. I cannot claim we are offering a perfect service to all, but then perfection would mean none of our patients were ever ill anyway, which clearly we don't achieve for any group of patients.

However, we see patients with learning difficulties in surgery far more often than the figures quoted. We have a good number of patients with learning disabilities who consult on their own, with some finding their own way to the surgery, and others making their own appointments.

It might be interesting to see if we consult with them disproportionately on days we have open surgery rather than appointments. (We have 'phone-up-and-be-seen' surgeries every morning, and some evenings, but 'turn-up-and-be-seen' surgery on Wednesday afternoons and all branch surgery sessions).

We are only a small practice with three partners and 4500ish patients, but I would estimate we see patients with learning difficulties most weeks. We would therefore be reluctant to drag every single one of them in for an annual MOT solely because they had a learning disability. We prefer to treat them as normal patients, making allowances where necessary in the same way as we would for a deaf, blind, or arthritic patient. Some we see regularly, some we never see because they are healthy (many of our 'other' patients we see only every 20 years or so if they remain well!), and some do not wish to see us.

Some patients with learning difficulties are under ongoing care from specialist teams, in which case we probably would have little to add to their specialist care, although we would still be happy to see

them where they had an independent GP problem.

Perhaps the difference lies in the fact that we see them more as ordinary patients, some of whom have individual needs or allowances or peculiarities, rather than as a 'problem group'. I suspect there might be something in the fact that if a patient presents with a chest infection, I treat them, and code the attendance, as for a respiratory problem, not a learning difficulty, even if one co-exists. Have our patients become so mainstream that their learning disability is not noticeable, and they function satisfactorily? I am thinking that is perhaps what we should be aiming for after all, not sticking them with different labels? Again, maybe the same is true for many other GPs and so that is why the statistics appear to show that no one ever sees them. If the learning disability is stable, it does not need any changes in the treatment plan, and therefore is not coded as a reason for consultation.

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The future for general practice

Jeremy Gibson writes about what future there is for general practice.¹ I agree when he is in favour of a clear career structure with the opportunities and incentives to progress,² but I wonder when he states that the days of the single-handed GPs are passing and that Darzi's centres loom.

He indicates that practices have to get bigger still, containing at least 30 full-time salaried GPs, under the auspices of primary care trusts and that these larger organisations will give more room for GPs to grow professionally. There will be