

well has been the use of stop dates on older peoples' warfarin prescriptions, for example for DVT.

If you are not already using this process, I encourage you to get up to speed on modern medication delivery.

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Nurse-led management of hypertension

We read the paper of Voogdt-Pruis *et al*¹ with interest, since we have recently reviewed the literature for nurse interventions in primary care management of hypertension. We would like to offer the following observations:

Firstly, although no previous study has reported from the Netherlands there have been reports of similar studies from Scotland,^{2,3} and England.^{4,5} Three of these demonstrated improvements in blood pressure control with nurse-led interventions,^{2,3,5} while the other did not.⁴

The authors' conclude that their findings support the involvement of practice nurses in cardiovascular risk management. This is based on the demonstration mainly of non-inferior outcomes; however, this can only be justified by inclusion of formal cost effectiveness analysis. Few previous studies of nurse-led care in hypertension have reported cost data, and those UK studies that have done found higher costs associated with nurse involvement, due to increased time spent offsetting the expected savings on salary costs.^{6,7} Therefore, further studies must be undertaken that include formal economic evaluation and determine whether the

increased cost of nurse-led interventions represents good value for money in terms of improvements in patient health outcomes.

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Circumcision

The article by Anwar *et al*¹ in the many

senses of the word. It presented a comprehensive review of the religious beliefs behind the practice of circumcision and, I confess, educated me about the HIV risk. The debate around availability of a safe service in the UK, is obviously an important one. I feel the authors let down their argument in the last paragraph. They say it is a doctor's duty 'to carry out said decision to the best of our ability'. They appear to have made this statement on a one issue basis, without considering the wider ethics. Doctors do not automatically carry out a patients' decision — take for instance the issue of abortion.

However, while the article raises a number of points for discussion I feel that one is omitted. In the case of religious circumcision it is not the patients' decision. A baby boy is the child of parents with particular beliefs, but cannot be said to hold those beliefs at that age. As was pointed out in the article, in the UK there is no medical justification for circumcision, *per se*. There is the need for the profession to consider the possibility that if we assist in a religious circumcision then the boy, at 18, might sue us for 'the cruellest of cuts'. Not every child of Jewish or Islamic parents keeps the faith.

The authors are to be congratulated on bringing this issue to the fore and, hopefully, stimulating further debate.

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The essay on circumcision in the January 2010 issue of the *BJGP* was very interesting.¹ Certainly as far as the Jewish relationship to the topic is concerned it was well informed and demonstrated much insight. However, there is one aspect of the Jewish tradition that was not mentioned and that is the considerable grasp of the genetics of haemophilia displayed in the laws relating to circumcision. If a mother is unlucky enough to lose two sons from failure of the penile wound to stop bleeding, then the commandment to