alternative treatment regimes.

Majeed's⁵ editorial noted that general practices in England could face reductions of 20% in their annual budgets. Is it only a matter of time before prescribing is limited? Could this be based on guidelines with a weak evidence base?

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Asking the shisha question

In an excellent editorial, Jawad and colleagues¹ highlighted the need for increased awareness of the prevalence and health effects of shisha pipe smoking. By not asking about shisha use, GPs may be missing the opportunity to give smoking cessation advice.

In each of the past 3 years, a St George's medical student has conducted a research project on shisha pipe smoking. In the first survey conducted in 2010, Sajjaad Ismail gave a questionnaire to consecutive shisha café attenders in Manchester. The response rate was 85% (202/237). We found that 40% (95/237) of responders did not know

the constituents of shisha, 52% (123/237) were unaware of the health risks, and 40% (95/237) would not tell their doctor about shisha if asked about smoking.

A similar survey by Abdelaziz Elgindi of 103 shisha café attenders in London in 2011 (response rate 94%, 103/110) found that of the 42 responders who also smoked cigarettes, 89% (34/38) reported that smoking shisha relieved the cravings they had for cigarettes compared with only 52% (22/42) who said that cigarettes relieved the cravings they had for shisha ($P = 0.001$). A head of shisha is estimated to contain around 10 times as much nicotine as one cigarette.²

Most recently in 2012 David Rawaf conducted an online survey of medical students at St George's, London, with a response rate of 62% (137/222), of which, 65% (89) were white, 11% (15) Middle Eastern, 10% (14) Indian, 7% (10) Pakistani, with the rest Bangladeshi, black, Chinese, and others. It was found that 79.4% (43) have smoked a shisha pipe before, of which the majority are white (58%, or 25). However, only 12 students were 'regular' shisha smokers (more than once a week), out of those, three smoked cigarettes. Of the regular smokers, six were Pakistani, four were Indian, and one each of black and white origin. The majority of responders (79%, or 108) did not smoke cigarettes, with 77% (83) having smoked a shisha pipe once. As an aside, it was discovered that medical students had a good understanding of the constituents and health risks of shisha, and most (85%, or 116) felt that clinicians should ask about shisha smoking.

As can be seen, shisha smokers are from varying backgrounds, so it is indeed a culture-wide trend, especially among students. However, the dangers are not fully understood by the public, and it is on the shoulders of current and future clinicians to raise awareness.

We agree with Jawad and colleagues that GPs, particularly those working in areas with many ethnic-minority patients, should consider 'asking the shisha question'.

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PHQ-9

The advent of the PHQ-9 has changed depression assessment in primary care in the UK. The 9th question always troubles me when I look at the record of the consultation. The question asks whether the patient has thoughts that they would be better off dead or hurting themselves in some way in the last 2 weeks. When this question scores positively (that is, scores 1, 2, or 3), a GP must further assess and clearly document the patient's suicide risk in that consultation record. This can often be missed in the complexities of the consultation.

We are under enormous time pressure, but this is always necessary. It worries me that the form filling would be considered to suffice.

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Enhancing consultations with interpreters: learning more about how

I am a GP who has worked for 15 years in inner-city London. I also work at the Helen Bamber Foundation for victims of cruelty. This is a non-NHS role and one of my duties is to liaise with our patients own GPs ensuring that they have access to good quality health care. Our patients are often extremely traumatised victims of torture

and trafficking from all over the world and struggle to tell their own stories even in their own language.

I am finding it increasingly difficult to find practices that will agree to any form of translating service. More and more are insisting that patients bring their own translators with them. As Professor Kai states, relatives and friends translating is common, but not ideal, and adds many challenges.¹ This is even more difficult for our patients who are often socially isolated, and, if not, would find it impossible to tell parts of their horrific stories via other family members or friends.

In my own practice I have always used a telephone translating service and, while recognising the fact that this is also not ideal and can be very frustrating, it is far preferable to no translating service at all.

While agreeing with Professor Kai's editorial comments regarding empowering all involved to enhance translated conversations, I feel that there is first a more basic need in ensuring that all practices recognise that withholding the use of translating services is not an option no matter the financial constraints we all find ourselves under.

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