Letters

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Performance league tables

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League tables are unreasonably simple

EDITOR—Not comparing like with like is the easy and traditional battle cry of those seeking to cast doubt on league tables of health service providers. It seems unfortunate therefore that the tables published for the benefit of the public in the *Times* as the hospital consultants' guide fall at the first hurdle on what seems to be a technical misuse, based on misleading comparisons, of one of the key statistics.[1 2]

Ranking in the league tables is based on both standardised mortality ratios and death rates per 100 000, although these summarise some complex statistical workings.[3] Standardised mortality ratios are a seemingly well understood means of comparing the mortality of a local population with that of a wider population, taking into account the age and sex distribution. But the *Times* supplement misleadingly refers to a standardised figure for mortality ratios of 100 as the national average, a higher figure indicating a higher than average number of deaths. Although this statement might be broadly true, it is also likely to produce biased tables as it misrepresents standardised mortality ratios and misuses this statistic.

Comparing standardised mortality ratios seems intuitive and looks reasonable until one unpicks their construction. A standardised mortality ratio uses the exposed group as the standard, meaning that the wider or national group is not the standard, which is probably where the misperception occurs. Therefore, comparisons of standardised mortality ratios with one another are invalid unless the age and sex distributions of the populations concerned are similar. The extent of the bias in making these comparisons may be small unless there are reasonably large departures from this point, but we do not know how much this departure for any one population differs from another and contributes towards its position in the table.[3]

This point has been raised before both in relation to Dr Foster's league tables and more generally.[4 5] It may be that Dr Foster's tables have some good statistical validity but I find it difficult to tell. There is a good argument to suggest that those participating in furthering public health with good information should stop using standardised mortality ratios. Often we try to represent highly complex issues with simple figures. In these cases we should either avoid using summary figures that require the statistical rules to be bent or acknowledge that simplifying to this sort of degree does not reflect the reality.

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1 Vass A. Doctors urge caution in interpretation of league tables. *BMJ* 2001;323:1205. (24 November.)
2 Dr Foster. Hospital Consultants' Guide. *Times* supplement part I; 19 Nov 2001:22-3.
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Use of language should be more careful in describing league tables

EDITOR—As a cardiologist working in the hospital with the highest overall heart bypass mortality, I note the injudicious use of terms such as health ghettoes and excessive deaths in most commentaries on league tables. This use of language creates undue alarm among the public.[1]

Hospitals with higher surgical mortality tend to be larger hospitals with a higher throughput of cases and surgeons who accept patients at higher risk. League tables can give a true picture only if all units adopt the same selection criteria and operate on similar patients. Each surgical centre and individual surgeon tends to adopt their own threshold for patients at high risk, which would affect the centre's overall mortality. Dr Foster claims that age has been taken into their model for adjusting standardised mortality. In reality, the Society of Cardiac Surgeons accepts that even highly sophisticated models cannot predict accurately operative mortality, in particular for the patients at higher risk. Dr Foster uses a model with simple variables, and one of many deficiencies in this model is that the data that define the degree of urgency of operations are not collected. Without deploying these variables for risk adjustment, they cannot claim that any deaths are excessive.

Statistics on non-emergency operations show that our surgeons are second to none in their skill. The higher overall mortality can be explained by the fact that we and the referring hospitals have asked our surgeons to operate on older patients at higher risk who have been turned down by other centres. We stand by our practice since we know that without an operation, these patients would have had a much lower chance of survival.

The immediate impact of publication of such league tables will lead to many such patients being turned down for surgery. Hospitals with lower mortality cannot be complacent, least of all proud, of their results, unless they can show that their surgeons are as willing to take on high risk cases. Most surgeons will now adopt more defensive practices turning away higher risk patients, and we will never find out how many patients will die or suffer as a result—their statistic will never appear in any league table. Elderly sick patients are particularly vulnerable.

If we have to live with league tables, Dr Foster should also publish detailed information of case mix and volume—a complete picture of patient profiles alongside surgical deaths to allow the public to make informed choices without undue alarm.

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Publication of league tables needs to be open and accurate

EDITOR—Vass's news item urges caution in interpreting Dr Foster's league tables, which show South Manchester University Health Trust second from the bottom.[1] We in this

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trust support initiatives to inform the public about health outcomes and contribute to the register of the Society of Cardiothoracic Surgeons. Unit-specific results are available on our website (www.smuht.man.ac.uk). We have led a regional benchmarking audit on risk stratified data and been involved in other national projects.[2] These indicate that our performance is satisfactory and are at odds with Dr Foster's publication.

The analysis performed by Dr Foster used statistical data on hospital episodes, which are designed for contracting and activity purposes and are well known for their inaccuracy. These data have been analysed with a risk algorithm that has not been subjected to independent validation.

Dr Foster states that it provides independent, authoritative, health information. It is overseen by an ethics committee, whose role is to ensure responsible, accurate use of data. It prides itself on listening to interested parties and emphasises communication before publication.

We first heard about Dr Foster's initiative by a circuitous route. No direct contact was made with our trust. Despite close relations between the Department of Health and Dr Foster, the Department of Health has not questioned our performance and has disseminated analyses showing satisfactory outcomes. Comparing data from Dr Foster and the Department of Health shows good correlation for most units, but our trust performed significantly worse on the Dr Foster analysis for reasons that we do not understand. This must cast doubt on their methods. Interestingly, the league table published in the *BMJ* showed hospitals ranked according to Dr Foster's analysis rather than that of the department, or indeed the Society of Cardiothoracic Surgeons, which was not mentioned (www.scts.org).

There is a political agenda for openness, but funding of the NHS falls short of European averages and the proportion of this spent on information technology is not compatible with generating accurate information.

Being listed inappropriately low down in a league table creates anxiety for patients and relatives and is damaging for staff morale, recruitment, and retention. This is important given the current underprovision of cardiac services and our desire to fulfil the revascularisation targets of the national service framework. Additionally, there are implications for cardiological referral practice: patients at high risk will be denied operations as surgeons strive to keep their noses clean.

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1 Vass A. Doctors urge caution in interpretation of league tables. *BMJ* 2001;323:1205. (24 November.)
2 Wynne-Jones K, Jackson M, Grotte G, Bridgewater B. Limitations of the Parsonnet score for measuring risk stratified mortality in the north west of England. The North West Regional Cardiac Surgery Audit Steering Group. *Heart* 2000;84:71-8.

Dr Foster's ranking of hospitals in good birth guide is misleading

Editor—Vass reports that doctors' organisations have urged that great caution be taken in interpreting the Dr Foster hospital guides prepared by Sir Brian Jarman's team and published in the *Times*.[1 2] They attempt to compare the performance of hospitals in various disciplines. The warning is justified since the information provided is insufficient to permit meaningful conclusions. Rather than increase public awareness and understanding, as Sir Brian hopes, the guides are likely to confuse, mislead, and cause anxiety.

On 15 July the *Times* published Dr Foster's good birth guide.[3] Region by region, maternity hospitals were listed in order of merit. Having undertaken a regional survey of maternity services, I am well aware of the complexity of comparing different hospitals' performances. On close inspection of the Dr Foster league tables I discovered that the published order of merit had been determined just by ranking hospitals according to the number of births per midwife per year, fewer births being classed as better.

Although adequate midwife staffing is not unimportant, it is absurd to grade the quality of care between hospitals on this single factor. Such a presentation is misleading to the point of irresponsibility. It could be argued that the fewer births per midwife per year might even indicate a hospital's unsatisfactory reputation.

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1 Vass A. Doctor urge caution in interpretation of league tables. *BMJ* 2001;323:1205. (24 November.)
2 Dr Foster. Hospital consultants' guide. *Times* 2001 Nov 19;suppl part I:22-3.
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NHS is national but not uniform

Editor—The article by Adab et al on performance league tables for the NHS presents a good argument for the use of control charts in place of league tables.[1] Charts seem more understandable and are less likely to cause confusion. The statistical problems of league tables are well put and valid.

I disagree with Adab et al as the NHS cannot be regarded as a single uniform organisation. The data from Dr Foster identified that staffing levels greatly affect mortality. Trusts differ in their staff retention rates and policy, and they do not always attract the same quality of applicants. From this point of view, comparing one trust with another may be more similar to comparing Ford with Honda than looking at different units in the same company.

This does not detract from the use of control charts, but it is important not to view the NHS as adhering to a uniform pattern as trusts differ in their priorities, incentives, and abilities. As an outcome measure mortality is still too rare an event to be very sensitive and, no matter how it is presented, will therefore not be very informative. New more sensitive outcome measures need to be developed.

It is also a mistake to look at outcomes without looking at use of resources. As an example, if comparing two coronary bypass units it is not sufficient to know the mortality at 30 days for each unit without also calculating the costs per patient of each unit. This has been the gaping hole in most of the recent published data, including those from the Dr Foster team.

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Effect of patient centredness and positive approach

Airing uncertainty can be positive

Editor—Little et al say that doctors should be aware that airing their uncertainties might reduce satisfaction and empowerment.[1] This conclusion is not really supported by their research because the positive approach statements dealt with the patient's problem and not the specific diagnosis. It is possible for the doctor to acknowledge uncertainty about a diagnosis or prognosis while giving the patient a clear positive message about what they can expect to happen, or what the doctor thinks they could do about the problem and what to do if things do not go according to expectation.

This safety net is likely to be perceived as positive by the patient, who may feel even more empowered as the doctor has clearly planned for the uncertainty that all patients know exists. Pretending to know the future or exact diagnosis fools no one and is likely to lessen satisfaction and empowerment. Helping patients to handle uncertainty effectively is an important part of enablement. This clarification of what is meant by a positive approach should be addressed in future research.

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Partnership of patient and doctor may provide key to patient satisfaction

Editor—The observational study by Little et al of the effects of patient centredness on the outcomes of consultations in general practice is empirically rich and informative.[1] We would like to comment on the way studies such as this construct a dyadic model that

implicitly presumes that the doctor bears the major responsibility for patient satisfaction.

Social research with HIV positive people in Australia suggests an alternative approach in which doctors and patients are seen as agents operating in clinical space that is wider than the consultation.[2 3] Although this research has specific contextual limits, it also suggests a way forward that allows increased expertise on the part of the patient to be taken seriously and engages with the changing ways that medical knowledge circulates in the wider society, including the media.

The consultation is a key element in the constitution of clinical space, but it is not definitive of it. HIV positive people in Australia rely heavily on specialist HIV general practitioners for information about their pharmaceutical treatments, but they distinguish between information and wider perspectives on living with HIV.[4] Their negotiation of decisions about treatment occurs in a framework of self care. Patients may pre-empt the consultation at different times and on different issues. For example, decisions about adherence, drug holidays, and the use of recreational drugs seem to be made in the context of mostly well informed self care practices rather than on the basis of a clinical consultation alone.

We are currently exploring the ways in which some of these decisions come home to roost in the consultation and how self care and self harm are understood. If we locate interactions between doctors and patients in an expanded notion of clinical space then both doctors' and patients' perceptions of what is possible in a brief consultation and doctors' expectations of themselves can be shifted into a more productive understanding of how self care occurs. Focusing solely on the consultation increases the pressure and the likelihood of dissatisfaction with the doctor and the practice of medicine.

Patients exercise an increasingly well informed medical gaze as an ordinary part of everyday life. Expecting or requiring doctor consultations to be responsible for all aspects of this by measuring quantifiable units of practice without querying the realism of patients' expectations reinforces the pressures on the consultation. Counsels of perfectibility tend to produce resentment and lower self-esteem, adding to the desire to leave general practice.[5]

We think that a wider understanding of clinical space and cultures of care allows recognition of the productivity of consultations, even as the inherent challenges are acknowledged.

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Somatisation in primary care

Solitary disclosure allows people to determine their own dose

Editor—On the surface, Schilte et al in their study suggest that disclosure of emotional events has no effect on markers of physical health or health related behaviours—a finding at odds with studies published over the past few years.[1–3] A critical difference between the study by Schilte et al and most other disclosure studies is that Schilte et al required participants to talk about a traumatic experience to another person. Most successful disclosure studies, on the other hand, have had participants write anonymously about a trauma for several days in a laboratory, in a neutral setting, or at home.

The study may help show when disclosure can be helpful versus harmful. It may also address recent controversies surrounding critical incident stress debriefing, where people who have experienced recent trauma are pressed to talk about their emotions to people in the context of a group. An increasing number of controlled tests of techniques wherein people have been asked to talk about emotional upheavals to others have found this form of debriefing either to be unhealthy or to have no effect.[4] Having to deal with deeply emotional topics in a social setting forces the listener to help regulate what is and is not said. The social pressure of talking to an "expert" may invite embarrassment or humiliation on the part of the patient. When people are writing or talking into a tape recorder by themselves, they are able to determine how much they are willing to disclose. In short, solitary disclosure allows people to determine their own dose.

Schilte et al suggest that it is not in the physician's or patient's best interest to encourage the deep disclosure of highly traumatic experiences. Separate, equally controlled projects should address whether disclosure in alternative ways (for example, disclosive writing) may bring about the beneficial effects that Schilte et al were originally predicting.

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Descriptive use of term should not be confused with its conceptualisation

Editor—Multiple or unexplained physical symptoms cause substantial disability in patients, excess use of medical services, disappointment for therapists, and frustration for physicians.[1] Somatisation is used as a descriptive term in somatoform disorders characterised by physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.[2]

Somatisation is a much broader phenomenon than is reflected in the categories of official diagnostic classifications. The operational definition of somatising patients in the paper by Schilte et al, on the basis of previous studies from Escobar's group, is interesting since most patients with unexplained symptoms do not meet the high threshold of symptoms for somatoform disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV).[3] The criteria for undifferentiated somatoform disorder are, however, overly inclusive.

Some reasons could be elicited for explaining the absence of effect of the disclosure intervention on the health of somatising patients, including the brief period of intervention and the high prevalence of anxiety and depressive disorders found by Schilte et al. Another possible reason is that different treatment interventions must be designed to treat patients with different levels of distress.[4] Despite that, somatisation includes a heterogeneous population, and the descriptive use of the term should not be confused with its conceptualisation. Some support the concept of somatisation as the expression of personal distress in an idiom of bodily complaints with medical help seeking behaviour as adopted in the paper, but others have emphasised the need to define the concept clearly, encompassing coping style and personality traits. The effectiveness of treatment strategies derived from such conceptualisations, such as promoting verbal expression of emotions or psychological conflicts in alexithymic patients, has not been shown.[5] The study by Schilte et al confirms this.

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Author's reply

EDITOR—Pennebaker's theory that written expression is superior to the talking methods applied by us may explain the difference between our negative findings and other positive studies on disclosure. Some other articles on the effect of disclosure through talking did, however, show an effect, although, as Pennebaker points out, this was not as impressive as in written and anonymous disclosure.[1]

Somatisation is an interactive problem. For that reason we chose talking rather than anonymous writing, with the aim of extending the outcome of the talks to the relationship between patient and general practitioner. This may have influenced what patients disclosed. The intervention was offered by us in an open inviting way, reflecting sincere interest in the patient's story and following the patient's frame of reference. Most patients believed that they had disclosed important information and liked the meetings.

We explained our contrasting findings by the difference in the groups of patients studied. Many patients in our study had had problematic childhoods and life stories and were mostly of a lower socioeconomic and educational background. Patterns of healthcare behaviour such as frequent attendance in primary care, a tendency to explain symptoms with a disease model (with external locus of control), a wish to undergo further diagnostic procedures and referrals, and frequent use of symptomatic drugs (painkillers, tranquillisers), physiotherapy, and sick leave are often fixed. Frustration among doctors managing these patients, resulting in patients not being taken seriously and being given a quick prescription or referral, can add further to the somatisation process.[2]

Disclosure through writing or talking can be helpful but does not effectively change the patterns of somatisation, which reflect the healthcare behaviour of patients and their physicians.

Teixeira and Alvarenga-Silva responded to our article from a psychiatric point of view. Somatisation as operationalised by us according to the criteria of Escobar should certainly not be classified as a psychiatric disorder. Most people have episodes with physical complaints that are not explained by organic disease. Low grade somatisation is common, especially in primary care (one in 20 patients) and created at least 20% of the workload of the general practitioners in our study. Effective strategies for somatisation are needed that are not too complex for general practitioners to apply.

An ideal long term disclosure intervention would encompass many contacts with the patient. But patients willing to participate in such long term psychological interventions will visit psychiatrists, psychologists, or social workers, who are better trained. In the Netherlands, most patients, however, are managed by general practitioners, who will usually not be able to find the time for psychological interventions requiring a larger number of contacts.

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1 Smyth JM. Written emotional expression: effect sizes, outcome types, and moderating variables. *J Cons Clin Psychol* 1998;66:174-84.
2 Salmon P, Peters S, Stanly I. Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. *BMJ* 1999;318:372-6.

Deputy editor of *Clinical Evidence* replies to letter

EDITOR—As we are constantly striving to improve our processes at *Clinical Evidence* we are always interested to hear about "missed" studies, as described by Laursen in relation to the article from *Clinical Evidence* on acute asthma by FitzGerald,[1 2] because it allows us to check our search strategies. FitzGerald's piece does not include the Cochrane review by Travers et al merely because of its timing.[3]

In the methods section the search date is stated as having been September 2000. When we carried out the search for the Issue 5 update for this chapter in September 2000 Travers et al's review had not been published. In fact, when we performed the update search in May 2001 for Issue 6 it had still not been published. It first appeared in Issue 2 of the Cochrane Library, 2001.

When the next update search is performed we will search Embase, Medline, and the Cochrane Library from Issue 2 of 2001 onward. This will retrieve Travers et al's review, which will be incorporated into the next update.

Although the eight month update cycle of *Clinical Evidence* means that a chapter may not include a recently published study, the explicit nature of the search date should make the reasons for any such omissions clear.

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1 Laursen LC. Article from *Clinical Evidence*. *BMJ* 2002,324:428. (16 February.)
2 FitzGerald M. Acute asthma. Extracts from *Clinical Evidence*. Acute asthma. *BMJ* 2001;323:841-5. (13 October.)
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Quality of Cochrane reviews

Quality of Cochrane reviews is better than that of non-Cochrane reviews

EDITOR—Olsen et al assessed a sample of Cochrane reviews from 1998 and highlighted some areas where improvement is possible.[1] They found that 29% of reviews had major problems, including inappropriate methods and conclusions. As they say, improvement is still possible, but this figure nevertheless represents a major improvement on the quality of non-Cochrane reviews.

We have reviewed the methods of 480 systematic reviews on the database of abstracts of reviews of effectiveness (DARE) at the University of York.[2 3] Methodological details of the reviews were coded and checked by two reviewers working independently. We found that only half (52%) of the reviews had systematically assessed the validity of the included studies; that most systematic reviews were unlikely to be comprehensive (they had searched either one or two databases); and that overall only a quarter (26%) of reviews met three key methodological criteria (relating to a thorough search, assessment of the validity of the included studies, and investigation of heterogeneity). Narrative reviews were less likely to meet all three criteria (20% *v* 30%, $P = 0.02$) and more likely to be coded by raters as inconclusive.

Up to half of non-Cochrane reviews are thus potentially misleading. Against this, Olsen et al's estimate of 29% for Cochrane reviews compares favourably. Although more recent research syntheses are likely to be of higher quality, particularly if reviewers follow current guidelines,[4 5] problems with the reliability of systematic reviews will probably remain. Since our study was conducted the criteria for including systematic reviews on the database of abstracts of reviews of effectiveness have been revised (from October 2000 onwards) to ensure that only reviews of potentially high methodological quality are included.

We would support Olsen et al's suggestion that users of any systematic review should assess its reliability. We would also recommend that for a critical assessment of the quality of non-Cochrane reviews users should first look at the database of abstracts of reviews of effectiveness.

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Another study found that most Cochrane reviews are of a good standard

EDITOR—We would extend Olsen et al's observations on Cochrane reviews.[1] Last year we undertook a study of the utility of the Cochrane Database of Systematic Reviews in informing health policy and practice.[2] We produced summary documents listing the conditions or diseases reviewed; the statements of evidence and effect; and, where available, conclusions for policy and practice for the reviews from collaborative review groups that covered cancer (including tobacco addiction), vascular disease, and fractures. In assessing the Cochrane reviews we scrutinised high profile sections (review title, abstract, objectives, conclusions, synopsis), just as a busy healthcare professional would do.

When necessary we inspected other sections of the review. Although we did not critically appraise review methodology, we recorded any errors, discrepancies (including discordance between the conclusions of effect and the available evidence), and other items needing clarification. We reported such information direct to the coordinators of the collaborative review groups.

We sent specific comments on 62 of the 159 reviews processed in Issue 2, 2000, of the Cochrane Library. Although most comments were minor, the inappropriate interpretation of results leading to spurious conclusions was considered likely in two reviews, the disregard of problems with the unit of analysis was thought likely in four, and sections were missing in two. Failure to collect outcome data on adverse effects of treatment and quality of life and function was also commented on in several reviews.

Our experience confirms that most Cochrane reviews are of a good standard. This is a considerable achievement, especially given the unpaid and voluntary nature of the work. The regularly updated electronic publication and the comments and criticisms facility offer great advantages. For instance, in cases where reviews with serious defects cannot be remedied speedily their temporary removal is important. Like Olsen et al, we emphasise the importance of feedback from users of the Cochrane Library.

Finally, Olsen et al conclude that readers should themselves assess the reliability of individual Cochrane reviews, and they emphasise the need to learn the skills of critical appraisal. We support their recommendation, but we are concerned that this may seem like advice to let the buyer beware. Given the broad readership (including lay people) of Cochrane reviews, the main emphasis must be on good quality and reliable reviews that people can trust.

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1 Olsen O, Middleton P, Ezzo J, Gøtzsche PC, Hadhazy V, Herxheimer A, et al. Quality of Cochrane reviews: assessment of sample from 1998. *BMJ* 2001;323:829-32. (13 October.)
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Reye's syndrome revisited

Outdated concept of Reye's syndrome was used

EDITOR—The paper by McGovern et al is based on a non-specific definition and an outdated concept of Reye's syndrome in spite of recent convincing data relating to this issue.[1] Reye's syndrome is no longer a specific clinicopathological entity but a descriptive term covering a group of heterogeneous disorders of infectious, metabolic, or toxic aetiology.[2]

All symptoms in the first case, including the neurological complications, can be explained by the influenza A infection.[2] Moreover, the confusion lasting for only 48 hours might have been the result of using antiemetics in a patient who had been vomiting almost hourly for 24 hours.[2] Urine toxicology screening does not exclude this additional complication.

In the second case, exhaustive virological investigations and liver biopsy were not performed, and the metabolic screening is incomplete. In both patients the diagnosis of Reye's syndrome is therefore put forward—in the best case—by default.

We are surprised that McGovern et al ignore the misleading biases in the epidemiological studies suggesting a link between Reye's syndrome and aspirin.[2 3] The studies were performed on series of children with heterogeneous disorders, which already invalidates their results. In the studies that recorded correctly all drugs given before admission, the use of not one but two drugs was significant—namely, aspirin and antiemetics.[2] Neither is the decline of Reye's syndrome an argument for a link with aspirin; evidence shows that this decline is the result of medical progress leading to more correct diagnosis of infectious, metabolic, or toxic disease.[2 4]

When promoting paracetamol and ibuprofen it would be wise not to conceal their side effects—for example, the hepatotoxicity of paracetamol, which can occur even at minor overdoses given during a few days. This was documented by Rivera-Penera et al and discussed in an accompanying editorial by Heubi and Bien, who assumed that the estimates of the occurrence of paracetamol toxicity are the tip of the iceberg of the total number of cases seen in the United States.[5]

We end with a question about the five cases seen over 13 years mentioned by McGovern et al in their introduction. Two cases occurred in February 1999, and in both the child had been given aspirin. What had been given to the other children?

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Authors' reply

EDITOR—Neither nosology nor nomenclature should be regarded as static but as dynamic disciplines that evolve as understanding of causation and pathogenesis bear on clinical experience and its reporting. But Casteels-Van Daele et al go too far in saying that Reye's syndrome is no longer a clinicopathological entity but a term embracing heterogeneous, disparate disorders. On the contrary, increased understanding has come about by the adoption of a standardised definition that enables case ascertainment—epidemiology as a springboard for biological research.[1] In Northern Ireland children with encephalopathic illnesses are referred for investigation and management to a single tertiary unit, and paediatricians maintain a high degree of vigilance so that inherited metabolic disorders are unlikely to masquerade as Reye's syndrome or vice versa.

Remarkably few patients have been seen since 1986 (when the Committee on Safety of Medicines warned professionals against use of aspirin in children), by contrast with previous numbers. In 1979-80 there were nine; in 1981-82, 10; in 1983-84, 25; and in 1985-86,11. This action and continuing case surveillance has been rightly regarded as a triumph in primary prevention of a devastating childhood illness.

We appreciate that Reye's syndrome is not a single entity, but broad consensus remains that a major identifiable variant is associated with aspirin taken for the symptoms of febrile illness, of which our cases are examples.[2] Our primary concerns are in relation to warnings on sales over the counter, and the age limit above which aspirin is—erroneously, in our opinion—regarded as safe. Another concern is case surveillance, especially in the event of further influenza outbreaks. With reference to the specific cases described, the first patient had not received any medicine

except aspirin; antiemetics are not usually given in Northern Ireland for brief gastrointestinal upsets in children. Even if the patients had received alternative treatments, evidence linking drugs other than aspirin with Reye's syndrome has never been accepted or sustained. The other three patients seen between 1986 and 1998 were each atypical, had low Reye scores, and were not linked to use of either drug.

Clear thinking is crucial to understanding this spectrum of encephalopathy—Reye's-like syndromes associated with an inherited metabolic disorder, Reye's syndrome that meets the non-specific, diagnostic criteria, and "classic" (aspirin associated) Reye's syndrome that we must try to prevent.[1 2]

We have demonstrated biological plausibility using cultured fibroblasts from recovered patients with Reye's syndrome. Salicylate within the therapeutic range and its metabolites reversibly inhibit activity of β-oxidation at 3-hydroxyacyl-CoA dehydrogenase of the mitochondrial trifunctional enzyme—quite the opposite response to that found in control cells.[3]

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Demand for prostate specific antigen testing in primary care

Screening through back passage as well as back door?

Editor—Donovan et al highlight the fact that current policy for testing amounts of prostate specific antigen (PSA) amounts to screening by the back door.[1] They do, however, overlook another insidious form of screening by PSA. Men who present with the well known prostatic type symptoms in primary care typically receive PSA testing as part of their work up, either from their general practitioner or after referral. But these symptoms are not good markers for prostate cancer—in fact, men with obstructive urinary symptoms are no more likely than men without symptoms to have prostate cancer. In other words, in terms of prostate cancer, these men are asymptomatic.

To perform a PSA test in these men therefore amounts to screening, which seems to be overlooked by general practitioners and urologists alike, even those who are clear that PSA screening is a bad idea. It could be argued that this group is particularly inappropriate for PSA testing as most will have benign prostatic hypertrophy, a common cause of PSA false positives. Educating patients is being put forward as the answer to salvaging a situation which has arisen because PSA testing is, like a mountain, "there." I think that this is only half the answer—we need to get our own house in order too, otherwise a retirement free of anxiety will be a thing of the past for most men.

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Can the demand for PSA testing in primary care be managed?

Editor—Donovan et al highlight the fact that screening for prostate cancer using the prostate specific antigen (PSA) test will become increasingly prevalent in the NHS in the United Kingdom.[1] In 1998, my colleagues and I carried out a postal questionnaire survey to determine the views of all general practitioners in North Staffordshire on prostate cancer screening in primary care.[2]

A copy of the national guidance document was enclosed with our questionnaire because most general practitioners were not involved in commissioning, and we assumed that most would not have come across its contents. Our survey received a response rate of 71% (168/238) and offered some quantification of the demand for prostate cancer screening as perceived by the responding general practitioners. Our results showed that 9% (15) of respondents screened asymptomatic men for prostate cancer using the PSA test and 13% (21) asked their patients first about prostate cancer screening. On the other hand, 64% (106) reported that patients asked them about prostate cancer screening. Over half (93) believed that patients should be allowed to choose for themselves whether they wished to be screened or not, but only after having been counselled about the benefits and harms of screening with the PSA test.

This group of general practitioners were also asked if national guidance had changed their views about prostate cancer screening. Nearly 10% (16) of respondents replied that it had, that is, not to screen for prostate cancer on receiving this type of guidance. One key inference from this for the future for the Department of Health and NHS Executive was to disseminate any new, clear, and unambiguous guidance on prostate cancer screening in a timely manner to general practitioners to influence their clinical behaviour. Otherwise there may remain several general practitioners requesting PSA tests, which could be detrimental to the overall health of the men screened. Some of these tests may have been prevented if general practitioners had received national guidance to inform their clinical decision making. This quota of PSA tested men will also probably contribute to the total number of men screened, to whom Donovan et al refer as creeping in by the back door.

It may be possible to manage some of the demand for PSA testing in primary care. But healthcare professionals must continue to take great care in making the decision to undertake any screening, especially when the evidence base is poor.[3]

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Despite author's opinion, radiology guideline was correct

Editor—Godfrey writes of a patient who presented with what he thought was plantar fasciitis, possibly with a calcaneal spur; he did not send her for radiological examination because a guideline said that it was not recommended in such cases.[1] He later found out that she had metastatic cancer, and he decries the guideline saying that routine radiography was unnecessary.

But the guideline in question was correct: radiography to detect calcaneal spurs is a waste of everyone's time. If the putative diagnosis is plantar fasciitis then ultrasound examination of the soft tissue is more useful—if imaging is required at all.

Of course, if things had happened differently, and the patient had been known to have metastatic disease and had presented with disabling pain in the calcaneus, then no radiologist would have refused an *x* ray examination to determine whether there was a bone lesion to account for it.

No matter how useful and evidence based a guideline is, there will always be occasional cases where it seems to fall down. It is clearly unusual for a patient to present with metastatic disease in the calcaneus; for this to be the only symptomatic lesion must be vanishingly rare. To discard the guideline on the basis of one such case would be to fly in the face of reason.

As has been said in a different context, "hard cases make bad law."

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Dishonest doctors should not continue to practise

Editor—Dishonesty and fraud are not acceptable behaviours in the NHS, and doctors should not be held to a lower standard than lawyers, who cannot be dishonest and continue to practise.[1 2] "The overwhelming

majority of patients and professionals would not dream of stealing from the NHS. But a small minority of patients and health service staff are doing just that. Every time they commit fraud patients' care suffers. Those who are exploiting the system are not only cheating the taxpayers, they are depriving patients of the care they need,"[3] said Alan Milburn MP; he is a fellow privy councillor of the lords who overturned the ruling of the General Medical Council that Dr K Manzur should be erased from the medical register.

The Manzur judgment has torpedoed the government's stance on fraud in the NHS, which drains millions away from frontline care each year. Privy councillors listening to appeals should perhaps be advised to take advice from their fellow privy councillors in the Cabinet as to what is or is not in the public interest.

The message sent out by the GMC was the correct one. Consultants hold a position of power and responsibility that demands trust when carrying out professional duties. They should expect that to abuse that position by lying, cheating, and committing fraud will result in erasure.

The GMC had marked the boundary of what was considered reasonable behaviour expected from a doctor. That is its responsibility as regulator of the profession. Contrary to what seems to be the belief of some politicians, journalists, and sections of the public, the GMC's professional conduct committee can make an unbiased decision that does not always favour the doctor. The external perception of the GMC is not helped by its good intentions being sabotaged by the Privy Council.

Would Mr Milburn really wish to condone senior NHS staff lying and taking money for personal gain, to the detriment of patient care, and then presenting financial accounts in such a way as to avoid being held to account for such behaviour? Fraud and dishonesty are unacceptable, and erasure was the correct course of action so as not to undermine "the integrity of doctors in the public's perception," as their lordships remarked during the proceedings.[4] Doctors should be held to the same standards as lawyers in their professional behaviour.

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Clinical medication review by pharmacists would improve care

Editor—Unsurprisingly, Zermansky et al found that the involvement of pharmacists improves the quality of medication management for older people.[1] Repeat prescribing was poorly monitored in older people, but the authors miss an opportunity for a more rigorous analysis of this problem.

In the United Kingdom incrementally dispensed drugs require a doctor's signature to validate each increment–an expedient adopted for administrative convenience and the probity of pharmacists. This results in general practitioners having to sign many pieces of paper each day. Such a practice undervalues their time, and the sheer number of individual items inevitably affects quality control.

The challenge of adequately reviewing complex drug regimens cannot be accommodated in the 7-10 minute intervals that define general practitioners' clinical practice in the United Kingdom. The role of the pharmacist is also degraded, being reduced to that of a passive dispenser, who might occasionally issue warnings in the case of overlooked interactions.

Zermansky et al show how different things could be. With a structured, shared approach, the respective talents of doctor and pharmacist could be better harnessed, to the benefit of both patient care and the professional satisfaction of both parties.[2] It would be interesting to see the results of longer term follow up of these cohorts of patients to see if differences in outcome emerged. The true long term impact on the workload and job satisfaction of doctors and pharmacists could also be assessed.

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Dementia is being avoided in NHS and social care

Editor—Older people requiring residential care are being classified according to a taxonomy that has existed, in custom and practice, since the National Assistance Act 1948. A minority of care homes and nursing homes is designated for elderly mentally infirm people; most are for people who are not elderly mentally infirm, or, in the case of nursing homes, for frail elderly people. The term "elderly mentally infirm" is undefined and extraordinarily plastic. It is sometimes limited to people with dementia, sometimes extended to other mental illnesses.

Homes for such patients are more highly staffed and can demand higher fees than other homes, but they are rare, and often full. Elderly mentally infirm patients wait in hospital beds longer. Social workers tend to imply that elderly mentally infirm means, additionally, having behavioural problems. Patients with quiet dementia are thus excluded from specialist care. Registration departments at local or health authorities do not, however, embrace this nuance and may insist that any non-specialist home resident found to have dementia is transferred to accommodation for elderly mentally infirm people. Most homes therefore turn a blind eye to dementia.

Neither is the position clear at The Department of Health, which regards care for dementia as a specialist function of residential care, rather than being arguably its main activity (F E Matthews, T R Dening, unpublished data).[1] The first direct survey of non-elderly mentally infirm residents of nursing homes in England has found a prevalence of probable dementia of 74%, not related to duration of stay.[2] This allows us to ignore the implications of dementia for the staffing levels, training, and support of staff in most homes. We consign people without cognitive impairment to homes in which they will be surrounded by people with dementia, but about whom nothing can be said. The need not to recognise dementia permeates medical and nursing staff in acute medical and orthopaedic wards.

We think that dementia care has become the main business of almost any residential or nursing home for older people—improving dementia awareness and care skills in all care home staff, inspection and registration staff, hospitals, purchasers and politicians is urgent. We should develop specialist homes for people without significant dementia, in which their autonomy and self fulfilment can be more easily safeguarded. The term elderly mentally infirm should disappear. Prevarication and dishonesty must be stripped away from policy and the decisions being made about the fate of individual patients. Restricting the recognition of dementia to a minority of homes is a dangerous fiction which does little for people in residential and nursing care.

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