LETTERS

Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Repeat prescribing

Sir,

Both investigations into repeat prescribing by Leeds workers (November *Journal*),[1,2] imply that better control and reviews of repeat prescriptions would yield substantial financial savings. Both studies could be carried forward to clarify whether this is the case.

Coincident PACT data will be available for the 50 practices Zermansky visited. The strength of any correlation between practice repeat prescribing control score and practice prescribing cost could therefore be directly assessed. Harris's study is based upon data from practices using AAH Meditel computer software. This system has a reasonable medication reauthorization system, which is considered important in Zermansky's analysis.

The repeat prescription component of the Meditel system intends the reauthorization of medication by general practitioner, for example, but can be overidden to allow reauthorization by receptionists. Such reauthorizations may be identifiable in the IMS database, allowing some analysis of repeat prescription quality control and subsequent prescribing costs.

The practices in these studies, however, are self-selected by the use of a computer in the consulting room, the choice of the Meditel system, and the dependable data entry required for IMS data supply. As such, caution is required before extrapolating this data to the generality of GPs.

In addition, under the Meditel system, intermittently used treatments, even those issued in consultations months or years apart, may be included among repeats.

PAUL THORNTON

Coventry Health Authority
Christchurch House
Greyfriars Lane
Coventry CV1 2GQ

References

1. Harris CM, Dajda R. The scale of repeat prescribing. *Br J Gen Pract* 1996; **46:** 649-653.
2. Zermansky AG. Who controls repeats? *Br J Gen Pract* 1996; **46:** 643-647.

Sir,

I read Arnold Zermansky's paper, 'Who controls repeats' (November *Journal*, p 643) with fascination. It is a paper that is highly relevant to all general practitioners.

As the paper states, many practices do not tackle the problem of the regular reauthorization of repeat prescriptions because they are acutely aware of the workload implications. The solution has to lie in information technology. All it would take is a commitment to annually review all the patients' repeat medication at one time.

This review could be done opportunistically when the patient comes into the surgery with a problem, not necessarily the one that the prescription is for. Whenever the doctor accesses the prescribing screen on his computer, a warning could flash up: 'Annual review of all repeat medication due — would you like to do this now?'

This method has the merit of simplicity and, although it would increase consultation time, it would not generate any more appointments. As far as I am aware, no computer system does this as yet. Perhaps we should lobby the suppliers to provide this facility.

DENNIS COX

Unit of General Practice
University of Forvie Site
Robinson Way
Cambridge CB2 2SR

GMSC's advice on the mentally ill

Sir,

As a member of the current GMSC's Task Group on Mental Health, I read with interest the editorial in the October *Journal*, General practitioners and mentally ill people in the community: The GMSC's advice is over defensive.[1]

Whilst I do not wish to preempt the report on which we are currently working, I feel that this editorial cannot be allowed to pass without comment. The reason why the GMSC established its task group, and also the reason for the recently issued guidance, was the distortion of the mental health services offered to the population at large that has arisen through an overemphasis on the needs of the severely and enduringly mentally ill group of patients. There can be very few practitioners working in normal general practice who do not understand that a very large part of their total workload is to do with the management of the whole range of mental illness problems arising from their practice populations.

Recent high-profile cases and reports are prompting the development of a philosophy that is being encouraged both in health authorities and amongst purchasing general practitioners, and that is producing major distortions.

Whilst not denying the needs and problems of patients with significant psychotic disease, general practitioners with a normal list will be doing harm if they do not recognize the needs of other mentally ill patients for psychiatric treatment, provided by themselves, by the secondary care psychiatric services, and by the whole range of community support services including community psychiatric nursing and counselling services.

It appears to me that we have a problem: where the health needs of a small group of patients can be easily defined, (unlike the rather ill-defined health needs of many of our patients), then the supply of health services is likely to be grossly distorted.

E MALCOLM FOX

South Park Surgery
250 Park Lane
Macclesfield
Cheshire SK11 8AD

References

1. Kendrick T and Burn T. General practitioners and mentally ill people in the community: The GMSC's advise is over defensive. *Br J Gen Pract* 1996; **46:** 568-569.

Summative assessment

Sir,

Richard West (November *Journal*) raises several issues about summative assessment arising from our paper.[1] West criticizes our use of the Hofstee technique to adjust the pass mark. This procedure is a recongized[2] method of dealing with a situation where assessors overestimate the anticipated performance of a set of candidates. No attempt to set a pass mark is perfect, but we contend that the method described is fairer than failing a fixed percentage of candidates, which is the only real alternative. We are quoted as saying that MCQs are not good predictors of actual performance. This is true, but they are a good test of knowledge, which is why we use the MCQs as the knowledge-assessment element of a four-component system of summative assessment.

The delay in the decision to refuse a certificate as a result of an audit project being judged below minimum competence was a reliability rather than a validity issue. The work being carried out was in a pilot phase allowing full development and testing of the marking schedule and referral system to be completed. This has now been published.[3,4]

We are misquoted as saying that 'assessors showed limited agreement on the individual components of rating scales'. What we said was that '*although* our assessors show limited agreement on the individual components of rating scales and on their rating of individual consultations, they nevertheless show acceptable agreement on the ultimate issue of whether or not the trainees were competent'.

We agree it is inappropriate and totally unnecessary that 'registrars should spend 50% of their tutorial time discussing summative assessment'.

In his penultimate paragraph, West suggests that registrars are developing two consulting styles — one for video sessions and one for normal consultations. Style is not assessed in summative assessment, but leaving that aside we acknowledge that doctors regularly perform at a level below that of which they are capable. We have discussed this in detail elsewhere[5] but the only real solution, using role players pretending to be real patients,[6] is unlikely to be welcomed by many GP registrars. We would hope that the attainment of minimum acceptable competence would not prevent GP registrars from becoming well educated in general practice.

L M CAMPBELL

T S MURRAY

West of Scotland Postgraduate Medical Education Board
1 Horselethill Road
Glasgow G12 9LX

References

1. Campbell LM, Murray TS. Summative assessment of vocational trainees: results of a 3-year study. *Br J Gen Pract* 1996; **46:** 411-414.
2. De Gruijter DNM. Compromise models for establishing examination standards. *J Educational Measurement* 1985; **22:** 263-266.
3. Lough JRM, McKay J, Murray TS. Audit and summative assessment: A criterion-referenced marking schedules. *Br J Gen Pract* 1995; **45:** 607-609.
4. Lough JRM, McKay J, Murray TS. Audit and summative assessment: system development testing. *Med Educ* (in press).
5. Campbell LM, Murray TS. Assessment of competence. *Br J Gen Pract* 1996; **46:** 619-622.
6. Rethans JJ, Sturmans F, Drop R, van der Vleuten C. Assessment of the performance of general practitioners by the use of standardised (simulated) patients. *Br J Gen Pract* 1991; **41:** 97-99.

Sir,

In their letter (November *Journal*), Chris Johnstone and Mairi Scott refer to the six criteria cited by Campbell and Murray.[1] These criteria were used when assessing audit which were in place at a very early stage of summative assessment.[2] The criteria that are referred to in Campbell and Murray's paper therefore have no direct relationship to those being used at present. It was precisely to address the issue of assessing audit that the group of assessors to which they refer was formed. The marking schedule that was eventually to become the national standard for assessing audits for summative assessment took 18 months to develop within this group.

It is interesting, however, that although Johnstone and Scott state that 'audit is being used for assessment, not education', we have found that for 80% of registrars in the west of Scotland this was their first ever practical experience of audit and, moreover, a similar percentage felt more confident about implementing change in future as the result of having carried out such an audit.[4]

As part of the assessment process, a reigstrar whose audit has been identified as being below minimum competence has a second opportunity to submit his or her audit with guidance as to the areas causing concern. Despite this educational advantage, the failure rate after resubmission was 4% in 1995 and 5% in 1996.

It is possible, therefore, for audit to be used for assessment and education — true quality assurance.

J M MURRAY LOUGH

West of Scotland Postgraduate Medical Education Board
1 Horselethill Road
Glasgow G12 9LX

References

1. Campbell LM and Murray TS. Summative assessment of vocational trainees: results of a 3-year study. *Br J Gen Pract* 1996; **46:** 411-414.
2. Lough JRM, McKay J and Murray TS. Audit and summative assessment: a criterion-referenced marking schedule. *Br J Gen Pract* 1995; **46:** 607-609.
3. Lough JRM, McKay J and Murray TS. Audit and summative assessment: system developing and testing. *Med Educ* (in press).
4. Lough JRM, McKay J, Murray TS. Audit and summative assessment: two years pilot experience. *Med Educ* 1995; **29:** 101-103.

Evidence-based learning for general practice

Sir,

Ridsdale's editorial on evidence-based learning for general practice (September *Journal*, pp. 503-504) makes a number of important points on the integration of research evidence and patient care. The starting point for the editorial seems to be the assumption that evidence-based learning is a good thing for general practice; a fact not universally recognised by general practitioners themselves.

At the recent Third UK Workshop in Teaching Evidence Based Medicine, a group of interested participants convened a discussion group to explore reasons why committing time and energy to learning the skills for evidence-based practice might actually pay off for general practitioners and their patients. Much of this discussion centred on the empowerment of the general practitioner a) as an knowledgeable and enthusiastic professional, b) as a patients' advocate, and c) as a resource manager and commissioner of services. Not only do the skills required for evidence-based practice provide the patient's personal doctor with

a strategy for keeping up to date on caring and curing, but they also enable the doctor to educate, defend, and negotiate on behalf of patients in a true primary care-led National Health Service.

We thoroughly enjoyed our week in Oxford. We improved our skills for evidence-based learning, but came away feeling that the effective dissemination of evidence-based practice in primary care will depend as much on political and cultural change within the profession as on practical support.

STEPHEN ROGERS

On behalf of the Evidence Based Medicine in Primary Care Participant Active Discussion Group

Third UK Workshop in Teaching Evidence Based Medicine
Centre for Evidence-Based Medicine
The John Radcliffe, Headley Way
Headington, Oxford OX3 9DU.

Chronic disease management system for asthma

Sir,

Neville and colleagues[1] (October *Journal*, p. 583), in a United Kingdom-based study examining an extensive range of measures, found that the present chronic disease management (CDM) system for asthma in general practices was not associated with a number of favourable outcomes, including lower hospital admission rates for asthma. Possible reasons for increased asthma admissions have been the subject of speculation.[2,3] Admission rates as an outcome measure is ill-understood.

The City and East London General Practice Database holds information on all local practices in contract with the health authority. Included in these data are CDM status and asthma admissions data from the district and regional information system (international classification of disease code 493). Between 1992 and 1994, asthma admissions data were available for 135 of the 163 local practices.[4] Our analysis is less prone to participation bias than that of Neville *et al*[1] and confirms no significant relationship between practice asthma admission rates and approval for asthma surveillance in east London practices. The absence of association held good for all asthma admissions, including and excluding readmissions, and for rates broken down by age group. However, we found that the 87 practices in health promotion band 3 had significantly lower mean asthma admission rates (excluding readmissions) than the other 48 practices. The association was strongest in those aged 5-64 years where the coding for asthma is more secure (band 3 rate=0.96, non-band 3 rate=1.30, P=0.001).

If asthma admissions can be regarded as an outcome measure of asthma care, then what are the possible reasons for band 3 practices delivering a more appropriate service? Neville *et al*[1] have suggested that regular practice audit and the employment of a trained asthma nurse may be key factors. In east London, band 3 practices have proportionately more practice nurses than other practices (87% versus 33%) and generally tend to be larger with more resources, and by implication may be more able to undertake audit and deliver better organized care. We have also demonstrated that practices with more practice nursing hours and the employment of a practice manager have higher prophylaxis to bronchodilator ratios,[5] which are in turn associated with lower asthma admission rates.[4]

Although Neville *et al*[1] have considered compliance, they have not listed prophylaxis prescribing as a process measure for asthma care. While we accept that the ratio of prophylaxis to bronchodilator prescribing is a crude indicator of appropriate prescribing,[5] we have shown higher levels of prophylaxis prescribing both in practices approved for asthma surveillance and in band 3.[7]

We agree that the burden of asthma admissions in secondary care may truly lie with the delivery of asthma service in primary care. An investigation into practice and population factors associated with asthma admissions must be a priority.

PATRICIA STURDY

CHRIS GRIFFITHS

JEANNETTE NAISH

YVONNE CARTER

Department of General Practice and Primary Care
St Bartholomew's and the Royal London School of Medicine and Dentistry
Basic Medical Sciences
Mile End Road
London E1 4NS

References

1. Neville R, Hoskins G, Smith B, Clark RA. Observations on the structure, process and clinical outcomes of asthma care in general practice. *Br J Gen Pract* 1996; **46:** 583-587.
2. Identifying R&D priorities for the NHS on management of asthma. Report to the NHS Central Research and Development Committee 1995.
3. Eastwood AJ, Sheldon TA. Organisation of asthma care: what difference does it make? A systematic review of the literature. *Quality in Health Care* 1996; **5:** 134-143.
4. Griffiths C, Naish J, Sturdy P, Pereira F. Prescribing and hospital admissions for asthma in east London. *BMJ* 1996; **312:** 481-482.
5. Sturdy P, Naish J, Pereira F, Griffiths C, Dolan S, Toon P, Chambers M. Characteristics of general practices that prescribe appropriately for asthma. *BMJ* 1995: **311:** 1547-1548.
6. Sturdy P, Naish J, Griffiths C, Setting standards of prescribing performance. *Br J Gen Pract* 1996; **46:** 375-376.
7. Naish J, Sturdy P, Toon P. Appropriate prescribing in asthma and its related cost in east London. *BMJ* 1995; **310:** 97-100.

Diagnosis of asthma and chronic obstructive airway disease

Sir,

In his discussion paper,[1] C P van Schayck remarks on the overlap between the clinical pictures of asthma and chronic obstructive airways disease (COPD), which hampers a clear distinction between the two diseases. One of the objective measurements he advises using is airways reversibility, which he states is 'almost always' present in asthma and is 'almost never' present in COPD. Van Schayck goes on to recommend that if the diagnosis is in doubt it is better to err towards asthma, since treatment options are so much greater, and that patients should not be labelled as having COPD without conclusive proof of irreversibility of airway obstruction, after trials of oral steroids.

Reports in the American literature[2] have suggested that a significant increase in FEV_1 after an inhaled beta-adrenergic agonist has been observed in up to a third of COPD patients in single testing sessions, and in up to two-thirds during serial testing. A review article[3] on the management of COPD has also indicated that over 65% of patients with moderate to severe COPD will show an improvement in FEV_1 after treatment with a bronchodilator drug. It also goes on to say that approximately 20% of patients with moderate to severe COPD exhibit sustained improvements in FEV_1 after oral or inhaled corticosteriods.

Quaternary amine anti-cholinergic broncholdialtors such as ipratropium bromide have been shown[4,5] to be a more effective first-line treatment for COPD than beta-adrenergic bronchodilators such as salbutamol. Following the advice of C P van Schayck, one would therefore risk inappropriately treating up to a third of patients whose diagnosis of COPD or asthma is in doubt. Rather than measure airway reversibility with a beta-adrenergic agonist only, we suggest that results obtained with

standardized salbutamol be compared with an anti-cholinergic agent such as ipratropium, also in a standardized and repeatable dose. These findings, along with history, clinical examination, spirometry and diurnal variability may help to differentiate between asthma and COPD in a greater number of cases. Hence, optimum treatment for COPD could be initiated with appropriate education for patients regarding lifestyle (smoking cessation, occupation, exercise, immunizations) so that they may formulate realistic expectations for themselves within the context of their illness. Treatment for asthma can then be used in those patients most likely to benefit from it, rather than for up to a third of those for whom the diagnosis of COPD was originally uncertain.

MINA GOYAL

HELEN CASWELL

JACQUELINE CLELAND

Flat 1807
Kernhill Block B
25-27 Hong Shing Street
Kornhill
Hong Kong

References

1. Van Schayck CP. Diagnosis of asthma and chronic obstructive airways disease in general practice. *Br J Gen Pract* 1996; **46:** 193-197.
2. American Thoracic Society Statement. Standards for the Diagnosis and Care of patients with Chronic Obstructive Airways Disease. *Am J Resp Crit Care Med 1993;* **152:** S77-S120.
3. Calverly PMA. Management of Chronic Obstructive Airways Disease. *Med Int* (Far East Edition) 1995; **9:** 308-312.
4. Friedmann M. Changing Practices in COPD: A new pharmacologic treatment algorithm. *Chest* 1995; **107:** S194-S197.
5. Ziment 1. The Beta-agonist controversy: impact in COPD. *Chest* 1995; **107:** S198-S205.

Breastfeeding

Sir,

Dr Carol Campbell's recent review on breastfeeding and health in the Western World[1] highlights the lack of published research on breastfeeding promotion and management in the primary care setting.

Kilwinning Medical Practice (KMP) has recently completed a Primary Care Development Fund Project based on proposals contained in the document 'Supporting breastfeeding in your primary health care team', written by the Scottish Joint Breastfeeding initiative coordinator, Jenny Warren (now National Breastfeeding adviser). The aim of this project was to increase breastfeeding rates by involving the whole primary care team in breastfeeding support. The project was in the form of a two-group comparative outcome study of an education and awareness regime for breastfeeding mothers. The two groups were samples of those mothers in KMP whose babies were born during 1993–94 and 1995–96. Questionnaires were used to gather data on, amongst other things, duration of breastfeeding, problems with breastfeeding and reasons for stopping.

The project involved the whole of the primary health care team — from receptionists working overtime to blow up 150 balloons and put up banners and posters around the surgery, for the start of Breastfeeding Awareness Week, to health professionals and lay breastfeeding organizations helping a mother successfully relactate.

The results are encouraging. Of the women who started breastfeeding, 59% continued to 6 weeks, while 53% continued to 8 weeks and beyond. We confirmed that the most common reason for giving up breastfeeding was sore nipples,[1,3] recognized as being largely due to poor technique, a problem which should be easily overcome by the provision of practical, readily available, trained support. Other related findings include a positive relationship between breastfeeding duration and the perceived ease of breastfeeding and a strong inverse relationship between smoking and breastfeeding.

We believe we have shown that education and awareness go some way towards increasing breastfeeding duration. However, it would appear that trained readily available practical support is also needed to help women through the crucial first weeks. We feel that a much larger study is now required, one which provides practical support to mothers in the early stages of breastfeeding.

PATRICIA MUIRHEAD

Kilwinning Medical Centre
The Surgery
15 Almswall Road
Kilwinning
Ayrshire KA13 6BL

References

1. Campbell C. Breastfeeding and health in the Western World. *Br J Gen Pract* 1996; **46:** 613-617.
2. Scottish Joint Breastfeeding Initiative. Supporting breastfeeding in your primary health care team. *The Scottish Office,* 1995.
3. Graffy JP. Mothers' attitudes to and experience of breast feeding: a primary care study. *Br J Gen Pract* 1992; **42:** 61-64.

Efficacy of counselling

Sir,

Graham Curtis Jenkins, in his letter (November *Journal*) commending Goldberg and Cater's report in the August *Journal* borrows the expression 'intervention of proven efficacy' and misuses it. Goldberg and Cater were emphasizing the prevalence of mental disorders presenting in primary care, and described a need for training packages for those disorders for which such an intervention was available. Jenkins, who is a firm advocate of the provision of counselling in general practice,[1] describes it in his letter as 'of proven efficacy'.

The efficacy of counselling is far from proven, despite several controlled trials.[2,3] Its popularity with some patients has long been known — 'I am no exception to the rule that most people enjoy talking about themselves to a sympathetic listener.'[4] Doctors may also benefit indirectly by offloading time-consuming patients, but this is a considerable distance from 'proven efficacy'. Indeed, Jenkins implies in his letter that the patients who require counselling most are those discharged by psychiatrists 'because they have no effective treatments to offer'. I cannot follow this reasoning.

To thrive, the *Journal* must allow vigorous debate in its correspondence, while remembering that opinions expressed in its pages may be quite influential. It should require authors who make contentious statements to reference them, which Jenkins conspicuously does not.

W T HAMILTON

Surgery
12 Barnfield Hill
Exter EX1 1SR

References

1. Salinsky J, Jenkins GC. Counselling in general practice. *Br J Gen Pract.* 1994; **44:** 194-195.
2. King M, Broster G, Lloyd M, Horder J. Controlled trials in the evaluation of counselling in general practice. *Br J Gen Pract* 1994; **44:** 229-232.
3. Corney R. The effectiveness of counselling in general practice. *Int Rev Psychiatry* 1992; **4:** 331-338.
4. Sassoon S. *Sherston's progress.* London: Faber & Faber, 1936.

Counselling services for general practitioners

Sir,

The most important aspect of Dr Jane Ogden's letter in the October *Journal* is

her closing remark that GPs should be encouraged to use the counselling service provided for them and to acknowledge when there is a need to use it.

A survey of 887 general practitioners (GPs) in Devon and Cornwall carried out in 1991 by a joint working party of Devon and Cornwall LMCs and the Tamar Faculty RCGP showed that 552 doctors were in favour of a confidential counseling service and that 307 doctors said that they might use it.

The Devon and Cornwall General Practitioners Advisory Service was established in June 1995. It is a self-referral telephone service of six GPs and seven psychotherapists. All 990 GPs in Devon and Cornwall have these advisers' home telephone numbers. In the first year of the counselling service (June 1995–June 1996) 15 doctors have used the service. This highlights the view that, although there are numerous advisory counselling services now appearing, doctors still will not recognize their own illness or seek help. We need to know why in order to make these services effective.

BRUCE OSBORNE

The Devon and Cornwall General Practitioners' Advisory Clinic

GP tutors' role

Sir,

Dr Jamie Bahrami promotes a multiactivity role for GP tutors and challenges suggestions that the role of a GP tutor is predominantly bureaucratic. He suggests GP tutors have exerted a powerful influence in encouraging innovation and shaping continuing professional development of general practice (October *Journal* 1996, p.623). The article he criticizes is concerned with one aspect of general practice, namely mental health education, and the results of the RCGP mental health education fellowship illustrate that most tutors were not interested in the activities of regional fellows who were promoting learner-centred activity. If his generalized view of tutors is accurate, then the fellowship raises the question why should mental health education be different from the mainstream.

Despite the promotion of learner-based educational activity, the weekly diet of one hour postgraduate lectures is still dominant[1] and, in providing GPs with their preferred form of education, tutors in the main act as educational managers. The organization of PGEA further necessitates a bureaucratic role. Learner-based teaching is complex, as the fellowship has shown, and specific teaching and facilitation skills are needed. A study of the uptake and use of educational packs designed to support learner-based training by tutors and course organizers in the North West and South West Thames regions found that the GP tutors felt they lacked the skills to use the pack, were more confident in their educational skills, but needed to own the material supplied in the packs. We acknowledge that GP tutors often have difficulty in performing the wide range of tasks expected of them, and the development of practice-based continuing education is important. The mental health education fellowship has illustrated that the participation of tutors as links in a national teaching cascade can not be assumed, and many require training. Until their role is clearly defined, we feel it would be premature to underplay the importance of their role of edcuational manager, and may deflect from addressing their perceived and real training needs.

FRANK SMITH

ANDREW SINGLETON

St George's Hospital Medical School
University of London
Hunter Wing
Cranmer Terrace
London SW17 0RE

References

1. Difford F and Hughes RCW. General practitioners' attendance at courses accredited for the postgraduate education allowance. *Br J Gen Pract* 1992; **42:** 290-293.
2. Singleton A, Smith F and Lewis B. The perception and use of mental health educational packs by GP teachers. Is training necessary? *Educ for Gen Pract* 1997 (in press).

Blaming primary care teams: omitted or just poorly committed?

Sir,

In their paper, Foss *et al* (October *Journal*) used data obtained from a questionnaire completed by patients to assert that 'primary care teams … have failed to provide relevant counselling on risk factor reduction to important sub-groups of patients…' Unfortunately their method has not tested whether or not primary care teams counselled patients about risk factors. Instead it has tested the patients perceptions of the counselling that primary care teams have provided. Maybe this counselling was never given, but there are other explanations. Patients may not have remembered it taking place because the counselling had insufficient impact, or they may have chosen not to recall it because they did not wish to, or because they did not share the same perspectives as primary team members.

In a small, practice-based study of patients with epilepsy, there was no correlation between the advice the patient recalled receiving and the advice recorded in the notes.[1] Mayou's editorial[2] stresses how health beliefs and behaviour influence the success of screening and how didactic advice is often unsuccessful.

The authors are right to call for better targeting of lifestyle interventions, but these interventions need to be made more effective and to take in to account the beliefs, behaviour and expectations of patients. There is much work still to do to establish successful lifestyle interventions. Glib exhortations to do better are likely to be unsuccessful and to alienate primary care teams.

WILLIAM W HALL

Division of General Practice and
Public Health Medicine
School of Medicine
University of Leeds
20 Hyde Terrace
Leeds LS2 9LN

References

1. Hall WW, Ross D. General practice study of the care of epileptic patients. *Practitioner* 1986; **230:** 661-665.
2. Mayou R. Screening in primary care: pointers for further research. *Br J Gen Pract* 1996; **46:** 567-568.

Unrecognized psychiatric illness in general practice

Sir,

There has been recent concern about unrecognized psychiatric illness in general practice[1] and this seems to be a particular problem in elderly patients.[2] Educational packages have recently been developed for general practitioners[3] but we wish to report on another means of psychiatric education for GPs which already exists but is rarely used as orginally intended — the joint dominciliary visit with psychiatrists.

Under the terms and conditions of

service of hospital medical and dental staff, a domiciliary consultation is defined as 'a visit to a patient's home by a specialist, normally a consultant, at the request of a GP and normally in his company, to advise on the diagnosis or treatment of a patient who, on medical grounds, cannot attend hospital. Such visits are frequently requested in psychiatry, particularly in old age psychiatry, and provide an invaluable educational opportunity for GPs since, unlike in educational packages, a real patient is present. However, a recent retrospective study of 100 consecutive domiciliary visits in old age psychiatry, within the catchment area of one consultant, confirmed our suspicion that the visits were rarely joint in nature. Attendance by the GPs was only 15% overall (27% in urgent cases and 13% in non-urgent visits). This is despite 70% of GPs saying in a parallel questionnaire about domiciliary visits that they tried to attend, with only 24% saying they did not try to.

It is likely that both GPs and psychiatrists could do more when planning domiciliary visits to make them joint in nature. Such efforts would be beneficial educationally as well as directly for patients.

D C TULLETT

Lewisham and Guy's Mental Health Trust
London

M W ORRELL

UCL Medical School, London

C L E KATONA

Department of Psychiatry
UCL Medical School, London

References

1. Wright AF. Unrecognized psychiatric illness in general practice. *Br J Gen Pract* 1996; **46:** 327-328.
2. Tylee A, Katona CLE. Detecting and managing depression in older people. *Br J Gen Pract* 1996; **46:** 207-208.
3. Hannaford PC, Thompson C, Simpson M. Evaluation of an educational programme to improve the recognition of psychological illness by general practitioners. *Br J Gen Pract* 1996; **46:** 333-337.

Heart failure — who should we investigate and treat?

Sir,

I have followed the correspondence following Mair *et al*'s original paper in the February issue of the *Journal* with interest.[1] Heart failure is a common malignant condition that has not received the attention it deserves from the medical profession and the media.[2] We are all regularly informed of the seriousness of breast cancer and diabetes mellitus and of the chronic disability from degenerative arthritis, yet heart failure has been shown to be more malignant and to lead to a worse quality of life than those other disorders.[2,3] General practitioners' (GPs') diagnosis of heart failure has been shown to be subject to significant error.[5,6] We need guidance on ensuring we are making the correct diagnosis, not just of 'heart failure' itself, but also of the underlying cause. In so doing we will be targeting those patients who will most benefit from effective therapy and avoiding expensive and potentially harmful therapy where it is not indicated.

There is a huge economic burden on the state from the current management of heart failure with the greatest costs due to in-patient stay.[4] An effective coordinated community-based heart failure service is urgently needed. Who should have echocardiography? Research has shown correlation between abnormalities on resting ECG and left ventricular systolic dysfunction that could help to target those who would benefit most from investigation and modern mortality-lowering management.

On Wirral, we have proposed a heart failure service based in a community hospital with on-site echocardiography which will be run by an experienced GP with a background in hospital clinical cardiology. This locality-based pilot will be extensively audited after an initial period of 12 months.

A word of warning to fellow practitioners — heart failure is not in itself a diagnosis but a mixture of symptoms and signs that may be brought about by a large number of disorders. An elderly lady came to see me recently with exertional dyspoea and fatigue, but the history was short and even a brief examination confirmed she was anaemic (haemoglobin of 6 g/dl). Clearly any attempt to coordinate heart failure care must exclude confounding conditions to avoid unnecessary and harmful investigation and treatment that, at the very least, may delay the diagnosis of the real cause of the 'heart failure'.

ANTHONY CUMMINS

Egremont Medical Centre
9 King Street
Wallasey
L44 8AT
Merseyside

References

1. Mair FS, Crowley TS, Bundred PE. Prevalence, aetiology and management of heart failure in general practice. *Br J Gen Pract* 1996; **46:** 77-79.
2. Dargie H, McMurray JJ. *Heart Failure.* Martin Dunitz & Co. London, 1993.
3. McMurray JJ, Dargie H. Trends in hospitalisation for chronic heart failure in the United Kingdom. *Eur Heart J* 1992; **13:** 350.
4. McMurray JJ, Hart W. The economic impact of heart failure on the NHS. *Br Heart J* 1993; **69:** 19.
5. Wheeldon NM, MacDonald TM, Flucker CJ, *et al.* Echocardiography in chronic heart failure in the community. *Quart J Med* 1993; **86:** 17-23.
6. Remes J, Miettinen H, Reunanen A, Pyorala K. Validity of clinical diagnosis of heart failure in primary care. *Eur Heart J* 1991; **12:** 315-321.
7. McMurray JJ, *et al.* Value of the electrocardiogram in identifying heart failure due to left ventricular systolic dysfunction. *BMJ* 1996; February 1996.

Database items for chronic disease management

Sir,

In my district there are three local databases for chronic disease management either operational or soon to be operational. It will not be too long before many more are set up. I am uncomfortable about their design, feeling that much that is included is redundant. Such redundancy is a tax upon GP activity.

I propose that, for the purpose of clinical management of patients suffering from chronic disease, GPs should be asked to record:

- Minimal patient identification (and, on first presentation, address, telephone number etc.)
- Clinical data that satisfy the following three criteria:
  (1) There is a known causal association between the data item recorded and morbidity/mortality.
  (2) The data item is known to be a modifiable surrogate outcome measure.
  (3) To modify the data item the numbers of patients needed to treat (NNT) for one year is not greater than 10 000 in the case or mortality, or 100-1000 depending upon the severity of morbidity to be prevented.

M B TAYLOR

Heywood Association of Small Practices
York Street Surgery
19 York Street
Heywood
Lancashire OL10 4NN