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; please include your postal address). We regret that we cannot notify authors regarding publication.

Primary care in the United States

I read with interest the Discussion paper by Koperski in the April edition of the *Journal*.[1] Unfortunately, I found that his slightly negative tone did not equate with my own experiences when I went to New Mexico last year to look at the provision of primary care to remote rural areas. Instead, I found a Department of Family Medicine (at the University of New Mexico) and a State Government concerned about these issues and actively seeking and implementing solutions.

I also felt his description of physician assistants and nurse practitioners (I assume this is what he meant by the term 'practice nurse') as 'handmaidens' somewhat offensive. The professionals that I encountered were well trained and highly motivated individuals offering a quality of care as good as much of the care I have seen provided by GPs in this country. We have much to learn from these models of primary care, especially when trying to provide quality of care to underserved communities.

There is a somewhat arrogant attitude in the UK that the US has nothing to teach us about the provision of primary care. This is not a contention that I support. The surest way to enhance primary care in both countries is by a healthy level of exchange of ideas.

I have written this letter with a view to alerting you to the fact that there is more than one experience of family medicine in the US.

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Reference

1. Koperski M. The state of primary care in the United States and lessons for primary care groups in the United Kingdom. *Br J Gen Pract* 2000; **50:** 319-322.

Excipient E110: a cause for complaint?

During the recent influenza outbreak, a 53-year-old man consulted because of a persistent productive cough following a flu-like illness. The patient was examined and prescribed Erymax (erythromycin) capsules. He made it very clear that he had a previous history of aspirin allergy and was reassured that there was no known cross-sensitivity between erythromycin and aspirin.

Two days later, the patient's wife came to the surgery quite angry and upset because shortly after taking the Erymax capsules her husband had developed some tingling and swelling of his fingers and feet similar to the symptoms he had previously experienced with aspirin. They were both disturbed to find the warning in the Erymax patient information leaflet that: 'capsules contain the colouring agent E110. This can cause allergic type reactions including asthma. Your are more likely to have a reaction if you are also allergic to aspirin.'

As the patient had highlighted his aspirin allergy he was upset that he had been prescribed a preparation that could cause problems in patients with this history. Despite a home visit to review the patient and make a full apology, the patient's wife went on to make a formal complaint.

The prescribing doctor was unaware both of the presence of E110 in Erymax capsules and of the cross-sensitivity between E110 and aspirin. There is no mention of this reaction in the British National Formulary, the Pharmaceutical Data Sheet Compendium, or the Patient Information Sheet Compendium. The Committee on Safety of Medicines advise that there are one hundred and ninety-four other licensed medicines that contain E110 and that their Adverse Drug Reactions On-line Information Tracking (ADROIT) database identifies several reports associated with E110.[1] This case and the subsequent complaint has highlighted an apparent loophole in the current drug information available to doctors.

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1. Committee on Safety of Medicines. ADROIT Pharmacovigilence Group. (Personal communication.)

Randomised controlled trials in general practice

Curtis Jenkins' concern about the influence of nurse-led recruitment on randomised controlled trials (RCTs) in general practice (April *Journal*[1]) seems misplaced. The single major criticism of RCTs is the selectivity of their recruitment. Anything that encourages recruitment prior to randomisation should not affect the internal validity but will improve the external validity and trial efficiency.

He is concerned that the nurses will have a 'placebo' effect. The influence of the nurse, if any, should be just as effective within each arm of the study. If the intervention of the nurse has affected the patients' 'apparent' response to treatment (possibly by having the time to listen and explain) this can surely address the need for care rather than cure that Curtis Jenkins quotes.

Most importantly, however, the need for nurses to have adequate time to discuss the trial and the patients' concerns should not be seen as an inadequacy but as the ethical *sine qua non*. General practice in particular should not sanction a return to the days when patients arrived at a practice asking their GPs to explain the consent form that they had already signed for inclusion in a hospital study.

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1. Curtis Jenkins G. Randomised controlled trials in general practice. (Letter.) *Br J Gen Pract* 2000; **50:** 326.

Treatment of drug users

Practising in an area well known for its chronic drug problem, I read McGillion *et al*'s survey of GP attitudes to drug misusers with interest (May *Journal*[1]). Like many of the responders, I too began to treat drug users with a certain amount of enthusiasm, although I had no formal training. Now, two-and-a-half years later, I bitterly regret ever becoming involved.

I quickly learned that many of my patients were not looking for reducing doses but wanted maintenance over a long period instead, which could not be offered. Disagreements between myself and these patients became commonplace in the surgery, resulting in verbal abuse and, ultimately, expulsion from my list. I made myself unpopular with my partners, the reception staff, general medical patients, the local pharmacist, and the police. Complaints centred around not seeing enough general patients (partners), putting up with verbal abuse (reception staff), sitting next to abusers who were often unkempt, malodorous, loud, and used offensive language to each other (patients), frequent requests for early prescriptions or scaring members of the public (pharmacist), and the increased sale of prescription drugs on the streets (police). I now no longer treat addiction problems and will not admit drug users to my list. I recognise that my problem was that I tried to treat an area of unmet need in my practice in an *ad hoc* and unsuitable manner — but then so many of us do.

Although others have found success in treating drug users in general practice, perhaps even with a dedicated drug support worker,[2] I find solace in knowing that there are many GPs out there who have found the exact same problems as I have.[3] Strangely, I now feel that I should not completely desert my drug using patients, primarily as many of them have complex and multiple primary care health problems as well as non-drug-using young children. Rather than advocate either a total general practice setting or a 'specialist settings only' as McGillion *et al* do, I would suggest a half-way house approach, whereby all services (general medical and addiction) are offered by a GP to drug users in dedicated surgeries within the practice but segregated from the general patients. This, of course, is not always practical and would have to be accompanied by training, support, and appropriate recompense.

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References

1. McGillion J, Wanigarante S, Feinmann C, *et al*. GPs' attitudes towards the treatment of drug misusers. *Br J Gen Pract* 2000; **50:** 385-386.
2. Martin E, Canavan A, Butler R. A decade of caring for drug users entirely within general practice. *Br J Gen Pract* 1998; **48:** 1679-1682.
3. Gerada C, Tighe J. A review of shared care protocols for the treatment of problem drug use in England, Scotland, and Wales. *Br J Gen Pract* 1999; **49:** 125-126.

It was interesting to read the conclusions of McGillion *et al* (May *Journal*[1]) regarding the future service provision for drug misusers. To even consider the possibility of reverting back to a 'specialist settings only' policy for the treatment of this client group would seem to be of no benefit to either GPs, specialists or, most importantly, the drug using community themselves. Long waits for treatment are the norm at present and overloading an already overworked secondary care addiction service can only be detrimental.

The issue of clinician workload is central to this problem. I feel that the authors' attitudinal scale could have benefited from direct questioning about GPs' ability to take on yet another area of chronic disease management in the stretched primary care sector; surely what is needed is more resources to support primary and secondary care clinicians. However, to safeguard the cost-effectiveness of such a measure there needs to be genuine co-operation between GP and specialist within a shared care scheme.[2]

This can only be a reality when there is respect for each other's clinical practice and work culture. Without this co-operation, GPs will be vulnerable to professional isolation. Prescribing opiates in a milieu of professional isolation will put the GP at risk of professional incompetence, particularly if a patient dies accidentally, or intentionally, while taking methadone prescribed from their practice.[3] Further research into areas of support for GPs (both personal and professional) undertaking this demanding and complex work is needed to prevent service provision 'ping ponging' between the primary and secondary care sectors.

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References

1. McGillion J, Wanigaratne S, Feinmann C, *et al*. GPs' attitudes towards the treatment of drug misusers. *Br J Gen Pract* 2000; **50:** 385-386.
2. Department of Health. *Drug misuse and dependence. Guidelines on clinical management*. London: Department of Health, 1999.
3. Pringle M. The Shipman inquiry: implications for the public's trust in doctors. *Br J Gen Pract* 2000; **50:** 355-356.

The Shipman inquiry

Mike Pringle (May *Journal*[1]) assumes, probably correctly, that a new post will be created in response to public and professional revulsion from the Shipman case, that of signatory of death certificates. What a responsibility such a person will carry. Most GPs will be interrogated by them most months. They will also need to interview relatives when they are most distressed, most open to the suggestion that the doctor might have done better, might even have acted criminally. Which of us will then gladly care for dying patients, in their own homes where most of them wish to be, when we know that what should be a natural part of life will involve a searching official enquiry, including an examination of all records, when it is over? Once more, the benefits of a new system are assumed to so outweigh the costs that they will never be calculated.

The Shipman inquiry team should know that most of us wish to learn from the deaths of our patients. In the words of Julian Tudor Hart: 'A retrospective search for avoidable factors in individual deaths is probably the most stringent form of self-criticism available to any clinical team'.[2] Whether professional self-criticism in this area can survive must be open to doubt.

The Shipman case casts long shadows and provides ample ammunition for those who wish to extend the current vogue for (spurious) protection by means of ever-increasing bureaucracy. The merit of whichever of the inquiry's proposals are adopted will be able to be tested by examination of the proportions of people dying in their own homes before and after the proposals are adopted.

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References

1. Pringle M. The Shipman inquiry: implications for the public's trust in doctors. *Br J Gen Pract* 2000; **50:** 355-356.

2. Tudor Hart J, Humphreys C. Be your own coroner: an audit of 500 consecutive deaths in general practice. *BMJ* 1987; **294:** 871-874.

GPs' diagnosis of dementia

Van Hout *et al* (April *Journal*[1]) obtained interesting data comparing GPs' diagnosis of dementia with those made by a memory clinic. However, they were marred by inappropriate analysis that failed to address clinically relevant questions and could not be interpreted easily.

The authors reported diagnostic agreement and Cohen's kappa for both the presence of dementia and the dementia types among the 'real' dementia cases diagnosed by the memory clinic. These measures are difficult to interpret for two reasons. First, there are two GP categories for the presence of dementia (yes/no) but three categories for the types of dementia (Alzheimer's, other types, no dementia). Hence, the expected diagnostic agreement assuming completely random diagnosis by the GP would be 50% for the presence and 33.3% for the types of dementia. It is not surprising to find the diagnostic agreement to be lower for the types than the presence of dementia.

Secondly, since the GPs' diagnosis of dementia had a higher sensitivity (50/59 = 85%) than specificity (22/34 = 65%), the diagnostic agreement would be expected to increase with the prevalence of dementia in their study sample. A lower threshold for GP referral would increase such prevalence. Furthermore, diagnostic agreement does not address the clinically relevant questions of how accurate the GPs' diagnoses of dementia and non-dementia were. By contrast, the measures of sensitivity, specificity, and likelihood ratios would be independent of the threshold for referral and more amenable to interpretation and application to the clinical practice of other practitioners.

The authors performed χ^2 tests, which showed diagnostic confidence was associated with a statistically significant increase in diagnostic accuracy for the presence of dementia but not for the type of dementia. However, to address the issue on the ability of the GPs to make appropriate selection for referral, it would be more relevant to report the sensitivity, specificity, and likelihood ratios among patients in whom the GPs were confident of their diagnoses.

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1. Van Hout H, Vernooij-Dassen M, Poels P, *et al*. Are general practitioners able to accurately diagnose dementia and identify Alzheimer's disease? A comparison with an outpatient memory clinic. *Br J Gen Pract* 2000; **50:** 311-312.

Who is a frequent attender?

Dowrick *et al* (May *Journal*[1]) add a useful paper to the growing literature on characteristics of frequent attenders. Their analysis is particularly important because by stratifying and controlling their sample they have avoided confounding demographic variables, which have too often confused this body of research.[2] The authors used an arbitrary definition of 'an annual rate at least twice as high as the practice sex- and age-related mean', dividing their practice populations by sex and then into three groups by age. Other authors have used different definitions, some of which are too complex for routine practice data, and few, if any, have presented analyses to justify their definition. Our work[3] in two practices aimed to demonstrate the different patient populations that are identified with and without age–sex correction and the implications for future primary care studies. We found that female frequent attender patients showed a pattern that was consistently higher than males at all ages but varied little with age. Male patients showed a progressive rise with age, only attaining the frequency of female attenders in the same percentile band in old age. Dowrick *et al*'s study shows a similar picture.

Our data also suggest that a simple binary definition of the mean consulting rate for all females and males above and below 45 years of age is adequate to avoid overrepresentation of groups consulting within the 'normal' range for their age and sex. This should be easy to calculate from routine practice data and will allow practitioners attempting to identify their frequently attending population, as a prelude to detection and management of psychological problems, not to spend excessive time screening older females with chronic medical problems.

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References

1. Dowrick CF, Bellón JA, Gómez MJ. GP frequent attendance in Liverpool and Granada: the impact of depressive symptoms. *Br J Gen Pract* 2000; **50:** 361-365.
2. Schrire S. Frequent attenders — a review. *Fam Pract* 1986; **2:** 272-275.
3. Howe A, Parry G, Hockley B, Pickvance D. Defining frequent attendance — evidence for routine age and sex correction in studies from primary care settings. (In preparation.)

I am writing not only to congratulate Dowrick *et al* (May *Journal*[1]) on achieving 100% recruitment of patients in their study of frequent attenders but also to ask how much further their study gets us in discovering why frequent attenders attend as they do.

Their main finding (that frequent attendance was strongly associated with depressive symptoms) seems explainable simply by the inclusion of patients who were known at the time to have psychological symptoms. Though this was not demonstrated in their multivariate analysis, Table 3 appears to show that frequent attenders had significantly more psychological symptoms recorded in their records than the controls ($P<0.001$). It comes as no real surprise to find that the group of patients who were the most depressed (on the Beck inventory) was the same group who had already been noted to have a larger number of similar problems (from their medical records).

It would have been useful to know how many of these extra consultations by frequent attenders could be attributable to the management of depression already identified and how many could be potentially attributed to depression that had not been identified. Differentiating between patient-initiated and doctor-initiated consultations would have been a start towards this and it was a shame this was not incorporated in the study design.

What really would be interesting would be to look at frequent attenders who had not previously been identified as depressed and see how many turn out actually to be depressed. I await the result of Dowrick *et al*'s prospective study with interest.

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Reference

1. Dowrick CF, Bellón JA, Gómez MJ. GP frequent attendance in Liverpool and Granada: the impact of depressive symp-