LETTERS

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Teaching old dogs new tricks

The PIER trial[1] looks at a very important area in medicine, namely trying to improve patient care by means of an educational intervention. However, one major opportunity have been missed in this trial, which means that it in fact tells us little more than what we already know; that is, changing physicians' practice is not easy.[2]

Langham *et al* have taken on board the message that '…a doctor's desire to be more competent in the delivery of health care is the most important motivating factor for continuous learning and change',[3] and also allowed a degree of directed self-learning[4] for the practice teams involved. But despite adopting these recognised educational theories in designing their trial, their main conclusion is still that a 'combined intervention of training in both information systems and evidence-based medicine may improve secondary prevention of CVD'.

The problem lies with the interventions (or educational events) designed and used by the practices. By giving such autonomy to each practice, the intervention, as applied by each practice to the problem they faced, is not homogenous. Therefore it is not surprising that the trial's outcome is essentially negative as the trial did not test the four main interventions (information, evidence, information plus evidence or neither) as intended, but a myriad of variations on a theme. Educational events are complex[5] and it is the details within each educational event that count; this was not controlled for in this trial.

What would have told us more is if the results of the trial had moved away from presenting mere mean changes, to exploring in detail what each practice, in each arm of the trial did to try to improve the care of their patients. Within the numbers presented in the results of this trial, some practices will have designed and run successful educational events and will have improved their recording of risk factors and so on; others will not. Understanding why, how, when, and what each practice did is the opportunity missed. In other words, unpacking the 'black-box' of each educational event, both successful and unsuccessful, is what we need to know if we are to teach old dogs new tricks.

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References

1. Langham J, Tucker H, Sloan D, *et al*. Secondary prevention of cardiovascular disease: a randomised trial of training in information management, evidence-based medicine, both or neither: the PIER trial. *Br J Gen Pract* 2002; **52:** 818-824.
2. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA* 1995; **274(9):** 700-705.
3. Holm H. Quality issues in continuing medical education. *BMJ* 1998; **316:** 621-624.
4. Lewkonia R. Medical revalidation and education — directed self-learning. *Med Educ* 2001; **35:** 426-427.
5. Hutchinson L. Evaluating and researching the effectiveness of educational interventions. *BMJ* 1999; **318:** 1267-1269.

Virtue ethics

It was most interesting to read Diane Reeves'[1] reply to Peter Toon's article about virtue ethics.[2] She was right to seize on a weakness of virtue ethics. It is empty of content unless one has an ideal model in mind. For Aristotle this was the citizen of a Greek city state, for Aquinas it was Jesus Christ. Virtue ethics is a way of seeing, but of itself sheds no light. However, the identical criticism can be made of post-enlightenment deontological ethics. If we take the four principles,[3] their choice seems pretty arbitrary, except in so far as they reflect current US culture with its exceptional emphasis on autonomy. Even if we accept the four principles, they come with no mechanism that enables to choose between them.[4] If we take post-enlightenment ethics in general then the most thorough demolition job, as Toon points out, is MacIntyre's *After Virtue*.[5] Essentially, he is arguing that the enlightenment project to establish ethics on reason alone was bound to fail because it excluded a role for meaning and purpose. Moreover, he argues that it actually has failed, in that modern ethicists are more distinguished for their fragmentation into successive schools that successfully criticise each other, than for reaching any general agreement.

So both virtue ethics and deontology can be useful ways of looking at moral problems, but neither can on their own provide a full answer. They are both like torches that can shed light, but only if a battery is provided.

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References

1. Reeves D. Virtue ethics cannot be the answer! [Back Pages.] *Br J Gen Pract* 2002; **52:** 960-961.
2. Toon P. The sovereignty of virtue. [Back Pages.] *Br J Gen Pract* 2002; **52:** 695-695.
3. Beauchamp T, Childress J. *Principles of biomedical ethics*. Oxford: Oxford University Press, 1983.
4. Finnis J, Fisher A. Theology and the four principles: a Roman Catholic view I. In: Gillon R (ed). *Principles of health care ethics*. Chichester: John Wiley & Sons, 1994; pp 31-45.

5. MacIntyre A. *After Virtue*. London: Duckworth, 1985.

New GP contract and European definition

In the November issue,[1] Andrew Williams points out that, at his Portsmouth presentation, Lawrence Buckman made it clear that the concept of holistic, longitudinal family care provided by a named doctor was dead ('The Government is clear that patients want immediate access to a healthcare professional, rather than continuing care with their own doctor').

I agree with Andrew Williams' writing that this seem to be at odds with the preference stated by patients. But I'd add that this strange position is utterly in contrast with The European Definition of General Practice/General Medicine, as studied, prepared and printed by WONCA (Europe), with previous long drafting support of EURACT, and undersigned by European National Colleges.

As the characteristics of the discipline, the definition states in point (c) that 'family medicine develops a person-centred approach, oriented to individual, his/her family'; in point (d) that it 'has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient; and in point (e) that it 'is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient'.

As a specialty of family medicine, the definition states that 'general practitioners are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual'.

For identification of competencies, we can read in point 2 that 'person-centred care includes the ability to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management'.

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Reference

1. William A. Proposed new GP contract. [Letter.] *Br J Gen Pract* 2002; **52:** 941.

Grief counselling and depression

I read Fiona Dowson's article in the November issue[1] with interest.

While I agree we should resist the pressure to medicalise life events such as bereavement and other losses, I believe that as a GP I have some role in supporting people as they come to terms with personal catastrophe.

In the past two weeks I have listened while the widow of a former patient, at a routine appointment, shared how difficult her grief was, more than 12 months after her husband's death; spent half an hour with a woman as she described her confusion of emotions two weeks after the sudden unexpected death of her husband; spoken on the telephone to a couple whose fit and successful student teenage son had died from overwhelming infection a week before; shared the disappointment and tears of a woman who believed she was about to have a second miscarriage.

In each case our conversation was in the context of my knowledge of the patient and his or her previous experiences. None of these was labelled as depressed, although one patient will return so that together we can reassess this possibility later; none was referred for counselling and in each instance the importance of the support of friends and family was emphasised.

However, as a GP I do have some familiarity with loss and grief and am familiar with the confusing and overwhelming emotions that people may experience at this time. My role may only be to acknowledge the hurt, confusion, and anger and to reassure that these are appropriate and natural reactions to the life-shattering event. Although I can do little more than listen, some people find this useful as they start to come to terms with the loss and rebuild their lives. There is a time where advice to get a puppy, grow vegetables or start an evening class would be inappropriate and unhelpful.

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Reference

1. Dowson F. Depressed? You must be joking! [Back Pages.] *Br J Gen Pract* 2002; **53:** 959.

Thank God for Fiona Dowson!

In her article[1] she has had the courage to say publicly what many of us — myself included — have said privately, but have not had the bottle to publicise our views in case we are labelled as being heretical against an increasingly accepted, if incorrect, orthodoxy.

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Inaccurate, leaky sphygmomanometers are still common

A recent series in the *BMJ* (ABC of Hypertension[1]) has highlighted the importance of accurate blood pressure measurement. Studies around the world and in UK secondary care[2] and primary care,[3,4] have pointed to ongoing problems with inaccurate sphygmomanometers. We were also concerned about cuff size (a standard cuff bladder should be 26 cm ± 1 cm long[1]) and the increasing use of electronic devices. We set out to survey all the sphygmomanometers in use in a single Primary Care Group (PCG). There were 16 practices in South Islington PCG, including 45.5 GP principals and 32.2 district nurses in five teams. We approached practice or team managers and arranged for them to complete a questionnaire and for their machines to be collected together for calibration at their premises. We checked machines used both in surgery and from visiting bags. Each machine was checked for general condition, leakiness (declared leaky

Table 1. Sphygmomanometer survey.

South Islington PCG	GP			Aneroid (District Nurse)
	Mercury	Aneroid	Electronic	
Number of machines found	67	66	22	25
Needing cuff/tube/bulb repair	13	2	0	2
Remaining leaky, >2mm Hg/sec	0/67	5/66	0	2/22
Machine calibratable	67	60	0	22
Inaccurate by >2 mmHg	3/67	32/60	–	11/22
Inaccurate by >4 mmHg	0/67 1	6/60	–	2/22
Inaccurate by >10mmHg	0/67	4/60	–	0/22
Small cuff, bladder <25cm	32/67	57/66	12/20	22/25
Standard cuff bladder 25–27 cm	5/67	3/66	6/20	1/25
Large cuff bladder >27cm	30/67	6/66	2/20	2/25
No cuff found	–	–	2	–

if leak rate was greater than 2 mmHg/second — the recommended deflation rate for general use). Simple leaks were repaired and then the machine was calibrated against a new and calibrated Erka 3000 mercury sphygmomanometer).

We had 100% cooperation from GP practices and district nursing teams, and were able to check all but two of the 182 known machines in use. Disappointingly, only two of the 22 electronic machines in use were from the British Hypertension Society approved list (www.hyp.ac.uk/bhs/bp_monitors_resources.htm). For technical reasons, we were unable to calibrate any of the 22 electronic machines (six different models in nine practices).

We found that 19% of mercury machines were leaky, but easy to repair and then very accurate. Aneroid machines, usually in the GPs' or district nurses' visiting bag, were a different story. They were often inaccurate (52%) and commonly had only a small cuff attached (85%). We were not able to gather any evidence that larger cuffs were also carried in the visiting bags, but these were usually stated to be available at the surgeries.

Of the 30 aneroid machines where the needle was not at zero with the cuff deflated, 24/30 (80%) were inaccurate at 2 mmHg. Four out of five (80%) of the persistently leaky aneroid machines were also inaccurate at 2 mmHg.

These results have highlighted a problem at the heart of patient care, with little evidence of improvement in the quality of the machines in use since 1982.[5] Given the relative cheapness of sphygmomanometers, and the simple methods needed to check them, there is no reason why this should continue, especially with increased funding for the management of CHD in primary care linked to the Coronary Heart Disease National Service Framework (www.nelh.nhs.uk/nsf/chd).

We believe that the very high participation rate was due to user awareness of a widespread need for sphygmomanometer calibration. PCTs need to develop policies for the purchasing, maintenance, and calibration of sphygmomanometers. This should be the responsibility of clinical governance or CHD leads, and should include standards regarding cuff sizes available for use with each machine. Particular care should be taken with the devices in visiting bags, and there is an argument for 35–40 cm cuffs to be typically attached to these devices to make sure that most arms are adequately covered.

Any user can make some simple checks: measure the bladder, check the leak rate if any and replace any faulty bladders/cuffs/tubes/bulbs. Then look at the position of the meniscus or needle with the cuff deflated — if the reading is not at zero, it is wise to consider calibration or replacement.

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References

1. O'Brien E, Beevers DG, Marshall H. *ABC of Hypertension*. London: BMJ Books, 2001.
2. Rouse A. How reliable are sphygmomanometers? *Nursing Times* 12 September 2000.
3. Ashworth M, Gordon K, Baker G, Deshmukh A. Sphygmomanometer calibration: a survey of one inner-city primary care group. *J Hum Hypertens* 2001; **15(4):** 259-262.
4. Markandu ND, Whitcher F, Arnold A, Carney C. The mercury sphygmomanometer should be abandoned before it is proscribed. *J Hum Hypertens* 2000; **14(1):** 31-36
5. Burke MJ, Towers HM, O'Malley K, *et al*. Sphygmomanometers in hospital and family practice: problems and recommendations. *BMJ* 1982; **285**: 469-471.

Preventing falls in primary care

In their editorial, Hampton and her colleagues[1] mentioned several cardiovascular disorders that cause falls in the elderly, but not the long QT syndrome. Acquired long QT syndrome is often induced by drugs prolonging myocardial repolarisation, so in older people it is largely an iatrogenic disease.[2,3] Non-antiarrhythmic drugs that can prolong the QT interval are widely used in many European countries.[4] Also, medical conditions associated with acquired long QT syndrome have a high prevalence in older people; the association with type I diabetes, coronary heart disease and aortic stenosis is well known, and it has recently been shown that about a quarter of patients with type 2 diabetes also have increased QT duration.[5]

In the *BJGP*'s Quality supplement, Avery *et al*[6] point out the frequency of medication-related morbidity in primary care, and the need to revise the underlying systems-based problems that cause it; it would be prudent, therefore, when reviewing older people (especially those who have fallen), to routinely check for medicines that prolong the QT interval: some patients may be on more than one drug, and have predisposing medical conditions too.

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References

1. Hampton JL, Kenny RA, Newton JL. Effective interventions to prevent falls in older people. *Br J Gen Pract* 2002; **52:** 884-886.
2. Haverkamp W, Monnig G, Schulze-Bahr E, *et al*. Physician-induced Torsade de Pointes — therapeutic implications. *Cardiovasc Drugs Ther* 2002; **16(2):** 101-109.
3. Futterman LG, Lemberg L. The long QT syndrome: when syncope is common to the young and the elderly. *Am J Crit Care* 1995; **5:** 405-412.
4. De Ponti F, Poluzzi E, Vaccheri A, *et al*. Non-antiarrhythmic drugs prolonging the QT interval: considerable use in seven countries. *Br J Clin Pharmacol* 2002; **54(2):** 171-177.
5. Veglio M, Bruno G, Borra M, *et al*. Prevalence of increased QT interval duration and dispersion in type 2 diabetic patients and its relationship with coronary heart disease: a population-based cohort. *J Intern Med* 2002; **251(4):** 317-324.
6. Avery AJ, Sheikh A, Hurwitz B, Smeaton L, *et al*. Safer medicines management in primary care. *Br J Gen Pract* 2002; **52(Suppl):** S17-S21.

Using local authority data

With reference to the paper on using local authority data for action on health inequalities in the October issue of the BJGP,[1] I wish to comment as follows.

In 1995 I was granted a period of extended study leave in which I studied and linked the health and social needs of central Southampton. It was of course no surprise to find a direct link between deprivation and morbidity, mortality, and use of GP services. I referred and relied heavily on the local authority data at the time. I realised, as did the FHSA and Health Authority, how relevant and informative was the information to both strands of the public services. The paper I produced and later submitted to the *BJGP* was used in helping to define and delineate the formation of the infant Primary Care Groups. Of course now because we use different and reorganised bureaucratic organisations we assume we are breaking new ground in every direction. The premise and findings of Fone *et al*'s paper say nothing startling or new. Please let us give some respect for the past and stop writing about what seems to me to be standard school knowledge

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Advanced access

Anthony Lamb is right to challenge not only the practicability, but also the advisability of offering advanced access to patients in primary care.[1] The workload stakes are indeed very high. Nine tenths of health care is self-care,[2] so even a small trend towards increasing demand would have an enormous impact on health services.

Advanced access is not instant access. It is not even 'doing today's work today', at least not for the patient who decides at five minutes to midnight that he wants to see a doctor. There are still practical constraints that are not based just on patient wishes. Not even GPs can be in consultation with more than one patient at a time. What is missing is information about what is the optimum time that patients should wait to see a doctor.

Advanced access may encourage self-reliance by providing a prompt back-up when a patient's confidence in their self-care is wavering, but delays actually enforce self-reliance. If advanced access causes a decline in patient self-confidence and independence, then it is a backward step.

Doctor–patient consultations rely to some degree on status differences. If the doctor knew no more than the patient, there would be little point in consulting at all. People are more likely to be convinced by advice offered by someone who they believe to be of higher status.[3] Inaccessible people are, like rare animals (particularly endangered species), more of a prize when finally spotted. I am currently much more accessible to my patients than my hairdresser or my dental hygienist are to me. A reduction in GP status has a cost, and not only to GPs. Such a reduction also means that GPs are seen as less important than hospital doctors, which will surely have an impact on demand for referrals.

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References

1. Lamb A. Why 'advanced access' is a retrograde step. [Back Pages] *Br J Gen Pract* 2002; **52:** 1035.
2. Hannay DR. *The symptom iceberg*. London: Routledge and Kegan Paul, 1979.
3. Johnstone K. *Impro*. London: Methuen, 1981.

Corrections

In the October *BJGP* (pages 838–843), the article 'General practitioners with a special clinical interest: a model for improving respiratory disease management' by Williams *et al* had incorrectly stated the lead author's affiliation as the Occupational Health and Safety Unit, Royal Free Hampstead NHS Trust. Ms Williams' affiliation should have read as follows:

Siân Williams, MA, MSc, DLSHTM, AHSM, DipHSM, health development consultant. E-mail: sianandhahn@blueyonder.co.uk.

We apologise for the error and for any confusion this may have caused.