LETTERS

All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Driving while under the influence of insulin

Dr Ian Hill-Smith's letter (December *BJGP*) raises several issues. Clearly, testing before driving is advisable and it is possible to predict whether blood glucose will rise or fall according to when food was last eaten and the time and dose of insulin. Surely doctors have a duty to advise this, and patients clearly have a duty to themselves and other road users to utilise the advice.

I am interested to know why the diabetes nurse in question believed that to test every time before driving would be foolish. Clearly there may be exceptions, such as when diabetes is very stable and the patient has eaten within the past two hours or performed a test in the past two hours. Was this belief a result of not wanting to be presented with a battery of test results at the next clinic appointment, or concern regarding the cost of testing?

The author commented that 80% of drivers would not have adequate strips prescribed to test before driving. This highlights the lack of adequate self care of many patients with insulin-treated diabetes. It is disconcerting that they are not testing frequently or that healthcare professionals are not encouraging them to do so. I believe this will have to change if we are to attempt to meet National Service Framework targets for glycaemic control, as this will increase the risk of hypoglycaemia and will require increasingly intensive insulin regimens and self-adjustment of insulin. The increased risk of hypoglycaemia from intensive control will of course make testing before driving even more vital. Certainly, testing is expensive but how are patients going to simulate the action of a non-diabetic pancreas without testing at least with moderate frequency?

There was concern regarding upsetting glycaemic control by taking sugar when blood glucose lay between 4 mmol and 6 mmol. I believe that 4 mmol would be too low to commence safely a journey and sensible advice about the amount and type of food to be consumed should be available. A temporary disruption in glycaemic control would be preferable to causing an accident with injuries, loss of life or even unpleasant consequences for the patient, such as loss of driving licence. With trial and error the patient would become aware of how much to eat in order to prevent hypoglycaemic episodes and avoid hyperglycaemia.

ABIGAIL KING

Uplands, Swansea.

Carpal tunnel syndrome

The recently published review by Jordan *et al*[1] concerned with the utility of electrodiagnostic testing for carpal tunnel syndrome (CTS) concludes that testing before surgery is not justified where clinical symptoms are well defined. The authors themselves admit that they were unable to find any good quality evidence in their review and such a concrete conclusion is therefore not appropriate. Since this review was carried out, I have published data on the outcome of 1268 surgical decompressions for CTS, in relation to the preoperative nerve conduction studies.[2] This study reflects ordinary clinical practice in the UK, in an area where nerve conduction studies are routinely used before surgery and shows a very clear, though somewhat complex, relationship between preoperative neurophysiology and surgical outcome. The results imply that surgical decompression should be approached with caution, both in patients with very mild and in patients with very severe neurophysiological abnormalities, though patients with a firm clinical diagnosis of CTS should not be denied effective treatment because their nerve conduction studies are normal.

Jordan *et al* have also failed to address the issue of the usefulness of preoperative results in the assessment of 'failed carpal tunnel decompression'. In my practice, between 6% and 15% (depending on preoperative severity of CTS on nerve conduction studies) of patients emerge from surgery with symptoms more severe than those they presented with, and in such cases the neurophysiologist is often asked to tell the surgeon what went wrong and whether re-operation is appropriate. Such an assessment is much less reliable in the absence of preoperative studies. Would Jordan *et* *al* care to review their conclusions in the light of these observations?

Jeremy D P Bland

Consultant Neurophysiologist, Kent and Canterbury Hospital.

References

1. Jordan R, Carter T, Cummins C. A systematic review of the utility of electrodiagnostic testing in carpal tunnel syndrome. *Br J Gen Pract* 2002; **52:** 670-673.
2. Bland JDP. Do nerve conduction studies predict the outcome of carpal tunnel decompression? *Muscle Nerve* 2001; **24:** 935-940.

Breast cancer prevention

Kefah Mokbel wisely draws attention to the ‘need to individualise chemoprevention strategies in order to improve effectiveness’ at the conclusion of his editorial review of therapeutic strategies aimed at breast cancer prevention.[1] Eligible women considering entry to the IBIS II prevention trial will also need to be enabled to consider the difficult trade-offs they will have to make for the two drugs being compared: Tamoxifen and Arimidex. The difficulties of providing women with a comprehensive profile of the relatively new drug anastrozole (Arimidex) that has so quickly been promoted from use in advanced breast cancer, to adjuvant therapy for post-menopausal women in early breast cancer, to prevention, are considerable.[2] Regrettably, the ‘author's reply’ from the ATAC (Arimidex, Tamoxifen, Alone or in Combination) Trial chairman to letters raising questions about anastrozole for use in early breast cancer and for prevention did not fully satisfy the particular concerns raised.[3]

It should not be forgotten that huge numbers of women who will never get breast cancer will receive these drugs in the IBIS II prevention trial. Decisions about the trade-offs between risks and benefits for both Tamoxifen and Arimidex are more difficult to make for these healthy women than they are for women with invasive breast cancer who will have greater willingness to accept side effects, known and unknown, to set against their potential for gain of disease remission.

Potential IBIS II trial participants should be provided with very clear and full information from a sound evidence base. Their individual decision-making process will require detailed information about side effects, including those on cognition, bone mineral density, and lipid profiles for both drugs. More is known about Tamoxifen, which has been on the market for many years, than Arimidex, which is still in the early phase of long-term follow-up within the ATAC trial, where the pre-planned sub-protocols considered effects of both drugs on the endometrium and on bone, but not cognition. A pilot study is only just now being done to assess an instrument for measuring cognitive function within the ATAC Trial[4] on information gathered from all ATAC patients' self-reported side effects.

The theory of responsibility defines that the person who encourages another to seek a medical intervention, as in screening or prevention, is more responsible than when a decision is made for self or a loved one, or by a physician for patients, and requires a rigorously sound evidence base. Such hasty introduction of a new drug into a potentially vast and healthy population market is ethically dubious.

Hazel Thornton

Honorary Visiting Fellow,
Department of Epidemiology and Public Health, University of Leicester, and Independent Advocate for Quality in Research and Healthcare.

References

1. Mokbel K. Breast cancer prevention. *Br J Gen Pract* 2002; **52:** 972-973.
2. Thornton H. Questions about anastrozole for early breast cancer. *Lancet* 2002; **360:** 1890.
3. Baum M, on behalf of the ATAC Steering Committee. Questions about anastrozole for early breast cancer. *Lancet* 2002; **360:** 1890-1891.
4. The ATAC (Arimidex, Tamoxifen, Alone or in Combination) Trialists Group. Anastrozole alone or in combination with tamoxifen versus tamoxifen alone for adjuvant treatment of postmenopausal women with early breast cancer: first results of the ATAC randomised trial. *Lancet* 2002; **359:** 2131-2139.

One of Professor Mokbel's points in this very comprehensive overview is based on evidence that has been thrown into question by other studies. He quotes the Collaborative Group on Hormonal Factors in Breast Cancer from 1996 as concluding that ‘the oral contraceptive pill (OCP) was associated with a small increase in breast cancer among current users and those who had stopped it in the last 10 years’.[1] This conclusion, based on a meta-analysis, was also published by the same group in the *Lancet* in 1996.[2]

However, a large, population-based case control study by Marchbanks *et al*, published in the *New England Journal of Medicine* earlier this year, found no such association.[3] Their conclusion was that ‘no association between past or present use of oral contraceptives and breast cancer was observed’. This was a well conducted, population-based study of 4575 women with breast cancer and 4682 controls. This study also showed that no subgroup of women who had used oral contraceptives had significantly increased risk of breast cancer. Similar results were reported in the CASH analysis published in 1986.[4]

This point is very important as many unwanted pregnancies are caused by women stopping the OCP in the perhaps misguided belief that it is increasing their risk of developing breast cancer. We need to highlight the fact that the evidence for this assumption is far from clear.

Ray O'Connor

Kileely, Limerick, Ireland.
E-mail: rocthedoc@eircom.net

References

1. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: further results. *Contraception* 1996; **54:** 1S-106S.
2. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast cancer and 100 239 women without breast cancer from 54 epidemiological studies. *Lancet* 1996; **347:** 1713-1727.
3. Marchbanks PA. McDonald JA, *et al*. Oral contraceptives and the risk of breast cancer. *N Engl J Med* 2002; **346:** 2025-2032.
4. The Cancer and Steroid Hormone Study of the Centers for Disease Control and

the National Institute of Child Health and Human Development. Oral-contraceptive use and the risk of breast cancer. *N Engl J Med* 1986; **315:** 405-411.

The review by Kefah Mokbel on breast cancer prevention[1] ignores the single most preventable cause of breast cancer: induced abortion. A 1996 meta-analysis looking at 28 studies showed a 30% increased risk of breast cancer after induced abortion.[2] This 30% figure is already diluted by the existence of studies looking at breast cancer rates in parous aborted women. In nulliparous women, however, the risks are even greater. Carroll compared cumulated cohort abortion rates and cumulated breast cancer rates in both nulliparous and parous women in the UK.[3] He concluded that there is a high correlation between the two and it is particularly evident in nulliparous women. Since the majority of women in the UK undergoing abortion are nulliparous, these findings are of enormous significance. Carroll has estimated an annual UK incidence of breast cancer of 77 000 cases by the year 2023.

Pregnancies that end in miscarriage are not associated with breast cancer because they do not generate increased levels of oestrogen. Healthy pregnancies do expose women to increased oestrogen levels. Nulliparous women who undergo abortion increase their lifetime risk of breast cancer and not just because of foregoing the protective effect of a full-term pregnancy. There is a super-added risk from the abortion, which interrupts the differentiation of breast tissue.[4] The first litigation case has been successfully taken against an abortion provider who failed to warn of such risks.

There is experimental evidence in animals that abortion is associated with mammary cancer.[4] Furthermore, the majority of almost 40 studies since 1957 show an association between abortion and breast cancer. None of this is mentioned in the review.

GREGORY GARDNER

Birmingham.

E-mail: g.gardner@euphony.net

References

1. Mokbel K. Breast cancer prevention. *Br J Gen Pract* 2002; **52:** 972-973.
2. Brind J, Chinchilli VM, Summy-Long J. Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis. *J Epidemiol Community Health* 1996; **50:** 481-496.
3. Carroll P. *Abortion and other pregnancy related risk factors in female breast cancer*. London: Pensions and Population Research Institute, 2001.
4. Russo J, Russo IH. Susceptibility of the mammary gland to carcinogenesis. Pregnancy interruption as a risk factor in tumour incidence. *Am J Path* 1980; **100:** 497-512.

Association between migraine and asthma

Davey *et al*'s large case-control study[1] found an association between migraine and asthma, where the relative risk of asthma was raised in those with a diagnosis of migraine. We recognise the potential importance of this result in relation to aetiological epidemiology.

The authors acknowledged that the lack of information on socioeconomic status was an important limitation of their study — we would question whether they could have analysed their responders in relation to their socioeconomic status using the Jarman, Townsend or other scoring systems. Socioeconomic factors could be a likely confounder, owing to the Inverse Care Law,[2] where people of a higher socioeconomic status would consult with their general practitioner more frequently than people of lower socioeconomic status.

We are also concerned about the ascertainment of migraine cases, since some people with migraine may not present to their GP. They may self-medicate using over-the-counter medicines to treat the migraine, as these are readily available.

We would question whether the authors considered verifying their case ascertainment by having patients diagnosed with asthma as the cases. These patients would need to see their GP to be diagnosed and to have been prescribed medication. These 'cases' could be asked questions to determine if they suffered from any of the symptoms associated with migraine, through a questionnaire. The questionnaire would not use the word 'migraine' but contain questions describing the features of migraine.

In order to take this epidemiological work forward, our suggestion would be to carry out a community survey using the primary care registers. A random sample of people could be chosen and then, through qualitative interviews using semi-structured questionnaires, questioned about whether they would see their GP or self-medicate if they suffered from symptoms characteristic of migraine.

SUELEN SOO

Intercalated BSc medical student

NAOMI GRAYSON

Intercalated BSc medical student

DR IAIN J ROBBÉ

Clinical Senior Lecturer, University of Wales College of Medicine, Heath Park, Cardiff CF14 4XN.

References

1. Davey, G, Sedgwick P, Maier W, *et al*. Association between migraine and asthma: matched case-control study. *Br J Gen Pract* 2002; **52:** 723-727.
2. Hart, JT. The Inverse Care Law. *Lancet* 1971; **1:** 405-412.

Poverty reduction and health

Dorothy Logie's[1] timely reminder of the crippling effects of poverty on health in poor countries makes me wonder how future generations will view our acceptance of this appalling inequality. Just as we look back on earlier generations that accepted slavery and famine in Ireland as normal with incomprehension, so we shall be viewed. Human life developed in Africa but the serendipitous combination of beasts of burden, free-flowing water, reduced disease, sustainable crops, and later cheap energy from coal, led to the economic advantage of Europe. Iron and steel led to ships and guns, which led to empires and exploitation. The empires have gone but the economic exploitation remains. The value of the Nigerian currency is not decided in Nairobi. The value of the world's second most traded commodity — coffee — is decided by four companies, none of which come from Africa or South America, where most is grown. This is not an anti-globalisation argument. We need a pro-global, one-world view. The greatest fear is nationalism; Europe has emerged from a tempestuous adolescence where nationalism led to industrial genocide. Continental co-operation has to be the way forward. Europe could yet be a world model where national boundaries are diminished, where a person's worth is valued equally, and where poor countries are raised up by minimum, not minimal, wages. Perhaps the real answer to global poverty and health inequality will finally come when the economic powers realise that it is in their own interests to diminish, rather than enhance, poverty, to spread wealth rather than to retain it, to release the massive world consumer potential that lies untapped (many times the world's current output), and to provide a world minimum wage in a world currency.

Simon Price
St Julian's Medical Centre, 13a
Stafford Road, Newport NP10 9HW.

Reference

1. Logie D. Poverty reduction and health. [Back Pages.] *Br J Gen Pract* 2002; **52:** 1036.

Symptom attribution after a plane crash

We read with interest the article by Donker *et al*[1] and we congratulate the authors on a novel approach to the complex issue of doctor–patient interaction in general practice following a plane crash. The authors recognise that the self-selection of patients may be the major flaw in this study with no clear criteria for being exposed to the disaster. As a proxy for exposure, proximity to the crash site could have been considered and odds ratios could have been calculated. The crash was in a deprived area and anyone seeking compensation could have attributed symptoms, real or otherwise, to the disaster, particularly during the period of increased attention by the media following the announcement of the parliamentary inquiry.

The six-year delay in the reporting of symptoms could lead to bias as it relies on patient recall, and only symptoms remembered and attributed by the patients to the disaster were included in the study. We would be interested to learn more about the organisation of the call centre and how it was publicised, as the authors refer to a currently unpublished paper for this information.

There appear to be significant differences between the responders and the non-responder group that is lost to the GP part of the study. We would be interested if the authors could further define the 'non-responder' group; for example, their employment status. We agree with the authors that the total symptom score could be shown for comparison as well as information concerning consulting behaviour prior to the disaster.

Finally, symptoms attributable to the plane crash may arise many years after the disaster. We would be interested to find out if the authors intend to carry out a follow-up to the study.

Sarah Sellick
Intercalated BSc medical student

Jenny Hughes
Intercalated BSc medical student

Rachel King
Intercalated BSc medical student

Iain J Robbé
Clinical Senior Lecturer, University of
Wales College of Medicine, Heath
Park, Cardiff CF14 4XN.

References

1. Donker GA, Yzermans CJ, Spreeuwenberg P, van der Zee, J. Symptom attribution after a plane crash: comparison between self-reported symptoms and GP records. *Br J Gen Pract* 2002; **52:** 917-922.

Parental confidence In MMR

I read with interest the paper by Ramsay *et al* in the November issue of the *BJGP*.[1]

As an Associate in Public Health, attached to the Greater Manchester Health Protection Unit, I have recently looked into the age at which four quarterly birth cohorts of children (born between 1 January and 31 March in 1996, 1997, 1998 and 1999) received their first measles, mumps and rubella (MMR) vaccine in Salford, Greater Manchester.

Using data from the Child Health Surveillance System, which is routinely available, I found that, on average, 85% of these children had received their first MMR vaccine by age 18 to 21 months. A further 8% received their first MMR vaccine later than this. Uptake averaging 93% was achieved in all four cohorts by the age of four years. Currently, with 2740 children born in Salford, we could expect 220 children per year to have their first MMR vaccine later than the recommended age.

Ramsay *et al* discuss the adverse publicity surrounding MMR and the fact that 'most mothers seek advice from a health professional before having their children immunised'. All children in Salford are offered a nursery place at three years old and preventing outbreaks of measles in the nursery setting is clearly important. It is essential, therefore, that all health professionals involved in childhood vaccine programmes continue to promote the vaccine to parents of children aged over 15 months, since parents may still be considering the issue up to the point at which their child reaches three or even four years of age.

This information will be used in Salford to recommend to GPs, health visitors, and practice nurses the benefits of continuing to offer advice about MMR to parents who have initially refused the vaccine.

Bernadine O'Sullivan

Public Health Associate, Greater Manchester Health Protection Unit, Peel House, Albert Street, Eccles M30 ONJ.

Reference

1. Ramsay ME, Yarwood J, Lewis D, *et al*. Parental confidence in measles mumps and rubella vaccine: evidence from vaccine coverage and attitudinal surveys. *Br J Gen Pract* 2000; **52:** 912-916.

Diabetes care: motivated but not interested?

Hansen and colleagues[1] studied 194 'motivated' Danish GPs to assess whether characteristics, such as sex, years of experience, practice size, ongoing education or a declared special interest in diabetes, could predict glycaemic control in their type 2 diabetic patients. Apparently they do not.

It came as little surprise that a GP's sex made no difference to diabetic control in their patients, but it was surprising that only 16% of these doctors were female.

It is disappointing that no effort was made to include a study of those practices that run dedicated diabetic clinics and those that don't. Few of the doctors studied (6.7%) expressed an 'interest' in diabetes but may have still participated in such clinics. Many GP practices in the UK run regular diabetes clinics, usually with an appointed GP and practice nurse. This often leads to the acquisition of a good working, rather than specialist, knowledge of diabetes care. Less complex diabetic cases are reviewed in these clinics and specialist advice is sought, and referrals made, where appropriate. This concentration of skills and resources is surely worthy of further study and I believe an opportunity was lost here. Hansen's opening comment was that glycaemic control 'varies widely between GPs' but then 'could not identify' any reasons for this. They even considered 'organisational changes', such as having fewer single-handed practices, but ignored the role of GP clinics, which more then likely contributes to this variance.

David Carvel

Biggar Medical Practice, South Croft Road, Biggar ML12 6BE. E-mail: David.Carvel@biggar.lanpct.scot.nhs.uk

Reference

1. Hansen LJ, Olivarius N de F, Siersma V, *et al*. Doctors' characteristics do not predict long-term glycaemic control in type 2 diabetic patients. *Br J Gen Pract* 2002; **53:** 47-49.

Primary care-led NHS

It is encouraging to read the paper by Craig *et al*[1] teasing out the dynamics of a shift from a secondary to a primary care-based NHS. An impressive number of interviews was achieved and the piloting and coding processes appears thorough, but we question whether the validation of the interviews would have been improved by carrying out a full check following the final coding by Dr McGregor. Also it would have been interesting to have read the personal judgements of the investigators regarding the factors identified in the article.

It was not clear exactly how the three conditions of inguinal hernia, stroke, and asthma were integrated into the interviews. In order to fulfil the aim to 'investigate the nature of the barriers to, and the incentives encouraging, the shift towards a primary care-led NHS', we suggest it would be of interest to investigate the user perspective for the three conditions, as their perspectives might provide further information about incentives and barriers to the care shift. Another group that it might be beneficial to include in such an analysis would be health care personnel who currently work in both primary and secondary health care settings, such as physiotherapists.

With a view to seeking some practical information on how to resolve the 'fundamental tension', a further study could perhaps make use of a titre questionnaire — one using a numerical scale to grade answers. This method would enable the investigators to rate each of the five main barriers identified from this first study, and in turn the issues for overcoming these barriers could be prioritised.

Rachel King

Intercalated BSc medical student

Jenny Hughes

Intercalated BSc medical student

Sarah Sellick

Intercalated BSc medical student

Iain J Robbé

Clinical Senior Lecturer, University of Wales College of Medicine, Heath Park, Cardiff CF14 4XN.

Reference

1. Craig N, McGregor S, Drummond N, *et al*. Factors affecting the shift towards a 'primary care-led' NHS: a qualitative study. *Br J Gen Pract* 2002; **52:** 895-900.

Recognising dyslexia

Tim Miles and Richard Huntsman are to be congratulated in pointing out another example in history of an intelligent, articulate and successful person who, nevertheless, demonstrated poor written linguistic skills.[1]

Tim Miles obviously still retains his longstanding fascination with the disability, to the understanding of which he has made an unparalleled contribution. As Professor of Psychology in Bangor he carried out detailed basic research in language learning disorders, influencing many professionals. His books have helped thousands of families with this inherited disorder.

Most GPs will have more dyslexics than diagnosed diabetics in their patient populations, but how many would have any idea about where to obtain help for a condition which can cause lifelong misery, underachievement and frustration? The prison population, for example, is particularly over-represented with language-disordered people.

While recognising that 'there is possibly some malfunctioning of the cerebellum' in dyslexia, the authors might, in my experience, have underestimated its significance.

At Dyslexia, Dyspraxia, Attention Deficit Treatment (DDAT) centres throughout the United Kingdom and Australia, doctors involved in the assessment of thousands of children and adults self-referred because of reading and spelling failure (and dyspraxia and attention deficit disorder, which so commonly co-exist) have found consistently high levels of posture immaturity, eye movement abnormalities, and clinically abnormal cerebellar signs. Between 60% and 80% show abnormal computerised dynamic posturography and electronystagmography. There is now strong evidence that the cerebellum is involved in language acquisition and reading.[2]

The DDAT programme of twice-daily neuro-developmental exercises directed at specifically improving balance, trunk, head, and eye movement coordination, and which is carried out in an increasingly complex and integrated fashion, has been shown by independent academic researchers to substantially improve cerebellar function, cognitive skills underlying literacy, and language acquisition over a six-month period.[3]

Miles and Huntsman are absolutely right in their assertion that the dyslexic child should be encouraged by examples of famous poor spellers and parents should consider referral to an educational psychologist and specialist teachers. However, GPs might also be wise to introduce families affected by dyslexia to the work of doctors at DDAT centres throughout the UK which, by an enjoyable programme of remediation exercises, significantly enhances literacy skills compared with that of a literacy scheme alone.

CHRISTOPHER WALES

Burley-in-Wharfedale, Ilkley, West Yorkshire.

References

1. Miles TR, Huntsman R. The stupidity of Elizabeth Fry — was it dyslexia? *Br J Gen Pract* 2002; **52:** 1042-1043.
2. Fulbright RK, Jenner AR, Mencl WE, *et al*. The cerebellum's role in reading: a functional MR imaging study. *Am J Neuroradiol* 1999; **20:** 1925-1930.
3. Reynolds D, Hambly H, Nicholson R. The cerebellum and dyslexia: evaluation of an exercise-based treatment. *Dyslexia* (in press).

Parents' expectations of symptom relief for their children

While preparing to work a January weekend co-op shift, I was very interested to read Kallestrup and Bro's brief report on parents' expectations when bringing their febrile children to out-of-hours clinics.[1] The summary indicates that 34% of parents expected symptom relief, while only 13% expected a prescription. Intrigued to discover quite how the parents were expecting the out-of-hours doctor to relieve symptoms without a prescription, I carefully read the remaining article.

The number of parents expecting relief of symptoms for their child is not mentioned at any point in the remainder of the article, so my confusion remained unresolved. Where does this figure come from?

Is it possible that some people stated their expectation for relief of symptoms as an indirect way of indicating their expectation for a prescription? This may explain the unexpectedly low figures for people expecting prescriptions.

RICHARD SWEENEY

Dr Moss and Partners, 30 Kings Road, Harrogate, North Yorkshire HG1 5JP.

Reference

1. Kallestrup P, Bro F. Parents' beliefs and expectations when presenting with a febrile child at an out-of-hours general practice clinic. *Br J Gen Pract* 2003; **53:** 43-44.

A survey of diabetes care in general practice in Northern Ireland

We report the outcome of a survey of the organisation of diabetes care in general practice in Northern Ireland, which used a similar method to a survey reported in 2000 in England and Wales, which had shown a large proportion of diabetes care was being done in the community, much of it delivered by practice nurses.[1] A previous study in Northern Ireland in the late 1980s had shown that care for people with diabetes was shifting from hospital clinics to general practice.[2]

The aim of this survey was to detail the degree of involvement in diabetes care reported by general practice, and to identify the prevalence of the following key features of GP service provision in Northern Ireland: protected time for diabetes care; disease registers; practice nurses with some knowledge of diabetes; and written protocols agreed with local diabetologists.

Seventy per cent of practices (252/358) responded. These practices were similar in list size and numbers of practices to those of Northern Ireland as a whole. Of these, 92% of practices have active registers of people with diabetes, identifying 1.9% of their population as having diabetes and 85% of practices use these registers for call/recall visits.

The organisation of diabetes care is outlined in Table 1. Seventy five per cent of practices held diabetes clinics run by the general practitioner and nurse (63%), or a nurse alone (32%). Only 47% of practices felt they received adequate support from an acute diabetes team, with 29% meeting with this team regularly and only 19% having a shared care protocol. Overall, practices provided most of the routine care for 60% of their diabetic patients. The majority of GPs and practice nurses had received some diabetes education in the previous year, although GPs should also be aware their practice nurses' educational needs may not be met fully.

There was a difference in our study to the England and Wales study in the amount of professional contact with secondary care. In England and Wales, 80% of practices received adequate support from secondary care; in Northern Ireland only 29% had such support. This may reflect either the relative dispersal of diabetes teams, or very poor relationships between primary and secondary care. Such a primary–secondary divide is an inefficient way of delivering seamless care to patients.

Table 1. The organisation of diabetes care

	Yes (%)	*n*
Would you describe your practice as having a special interest in diabetes?	169 (71%)	242
What is the total number of people with diabetes in the whole practice?	108 (mean)	252
What percentage of these patients are having most or all of their routine diabetes care in general practice?	151 (60%)	252
Do you have an active register of patients with diabetes in your practice?	232 (92%)	252
Is it used for call/recall?	214 (85%)	252
Is it fully computerised?	166 (66%)	252
Do you have dedicated time for diabetes-only clinics in the practice?	141 (75%)	188
How frequently are these held?		185
Weekly	35 (19%)	
Fortnightly	55 (30%)	
Monthly	75 (41%)	
Other	20 (10%)	
Who runs the clinic?		186
GP and nurse	117 (63%)	
Nurse alone	59 (32%)	
GP alone	10 (5%)	
Median number of patients seen per clinic	8	

Colin Kenny

Dromore, Co. Down, Republic of Ireland

Mary Pierce

Warwick Diabetes Care, University of Warwick

References

1. Pierce M, Agarwal G, Ridout D. A survey of diabetes care in general practice in England and Wales. *Br J Gen Pract* 2000, **50:** 542-545.
2. Hegan MC, Mills KA, Gilliland AEW, Bell PM. Diabetes care by general practitioners in Northern Ireland: present state and future trends. *Ulster Med J* 1991; **60(2):** 199-204.

Disadvantages of chronic disease templates in primary care consultations

Computer templates for the management of chronic diseases are being increasingly used in general practice. There is an automatic assumption that they are good for patient care. While they have obvious advantages, they also have disadvantages.

Templates may have an adverse effect on the consultation. Pendleton[1] encourages us to ask open questions and to address the patient's agenda. Templates encourage us to ask closed questions and to address the clinician's agenda. The danger is that consultations may become dysfunctional because they become so clinician centred.

It can be argued that templates will make no difference because some doctors conduct doctor-centred consultations and others patient-centred. In reality there is a spectrum of consultation styles and doctors can vary from patient to patient and from problem to problem, as to whether they are doctor or patient centred.

It is quite straightforward to add patient-centred questions to a chronic disease template. For instance, in a patient with type 2 diabetes, a standard first question could be: 'What are your main concerns about your diabetes at the moment?'. Admittedly, this will not usually generate a simple tick box/Read code-friendly response, but it may push the consultation a little way towards the patient-centred end of the spectrum.

In our practice we have attempted to assess the influence of adding open questions on a template by video consultation analysis using the RCGP examination check list. Although this has acted as a salutory reminder about the difficulties of using template structure in a consultation, we have not been able to reliably assess the validity of any additional questions.

If we feel as a profession that there is merit in patient-centred consultations, then this should be true in all consultations. Effective communication should occur with the assistance of the template rather than despite the template.

J N H Eisenberg

Macklin Street Surgery, Derby

Reference

1. Pendleton D, Schofield T, Tate P, Havelock P *The Consultation: An approach to learning and teaching*. Oxford: Oxford University Press, 1984. .

New GP contract and European definition

I agree with Francesco Carelli (*BJGP*, January 2003) and with Andrew Williams (*BJGP*, November 2002) that, at his Portsmouth presentation, Lawrence Buckman made it clear — 'that the concept of holistic longitudinal care provided by a named doctor was dead'. This is indeed a very strange position and one that needs to be clarified by the College.

1. It is totally at odds with the stated preference of patients.
2. It is also at odds with the European Definition of General Practice/ General Medicine as prepared by WONCA (Europe) and undersigned by European National Colleges.
3. The Specialty of Family Medicine states that general practitioners are personal doctors providing comprehensive and continuing care to their patients.
4. The Secretary of State (Alan Milburn MP) recently confirmed that small practices were an essential part of the NHS.

We need a firm statement from the College exactly what the position is as regards the relationship of the family doctor and his patient. There is an obvious desire by patients that they should be able to identify themselves with one doctor as a general rule.

T D RICHARDS

South Gloucestershire

Measuring consultation skills

Although we fully agree with Robinson *et al*[1] that 'consultation skills are essential for general practice', it is misleading of them to claim that either the MASS History-taking and Advice Checklist GP (MASS-GP) tool, or its revised version, has face/content validity as a measure of consultation skills. This is because the MASS-GP tool, as its name suggests, contains only a limited, although important, range of the required consultation skills of a GP.

The MASS-GP tool is restricted to interviewing, behavioural, and some management skills and omits such key consultation skills as the ability to make the correct diagnosis, to elicit abnormal physical signs, to make discriminating use of investigations and referral, to recognise limits of competence, and to recognise and act on appropriate opportunities for health promotion and disease prevention. These more inclusive aspects of required consultation skills were identified from two studies[2,3] involving much larger numbers of GPs than used by Robinson *et al* and also incorporated the views of patients.[3]

Furthermore, it is inaccurate for Robinson *et al* to assert that 'until now there have not been any tools to measure consultation skills that have been shown to be valid and reliable in real patient encounters in general practice settings'. The Leicester Assessment Package has been demonstrated to be not only valid and reliable, but also feasible, acceptable, and possessing educational impact.[4,5] in that very context. How did such an unsustainable assertion escape the scrutiny of the review process?

ROBIN C FRASER

Professor of General Practice,
Leicester Warwick Medical School

ROBERT K MCKINLEY

Senior Lecturer in General Practice,
Leicester Warwick Medical School

References

1. Robinson J, Walley T, Pearson M, *et al*. Measuring consultation skills in primary care in England: evaluation and development of content of the MASS scale. *Br J Gen Pract* 2002; **52:** 889-894.
2. Fraser RC, McKinley RK, Mulholland H. Consultation competence in general practice: establishing the face validity of prioritised criteria in the Leicester Assessment Package. *Br J Gen Pract* 1994; **44:** 109-113.
3. Patterson F, Ferguson E, Lane P, *et al*. A competency model for general practice: implications for selection, training and development. *Br J Gen Pract* 2000; **50:** 188-193.
4. McKinley RK, Fraser RC, Baker R. Model for directly assessing and improving clinical competence and performance in revalidation of clinicians. *BMJ* 2001; **322:** 712-715.
5. McKinley RK, Fraser RC, van der Vleuten C, Hastings AM. Formative assessment of the consultation performance of medical students in the setting of general practice using a modified version of the Leicester Assessment Package. *Med Educ* 2000; **34:** 573-579.

Editor's note

Regarding the scrutiny of the peer review process, *mea culpa*. But as we state, quite openly, in the Information for Authors document (published with updates in *BJGP* January 2003), 'The peer review process is widely acknowledged to be imperfect'.

The role of GPs in medical student education

I am a newly qualified pre-registration house officer who is writing to question the training some fifth-year students receive at GP practices across the country. As part of the University of Manchester Medical School curriculum, I spent two months of my final year at a GP practice. I was given my own clinic of approximately five to six patients, spending 30 minutes with each patient. After taking a history and examining the patients, I would subsequently discuss their management with the GP. By doing this, I vastly improved my communication skills, as well as my history and examination technique. Some of my fellow doctors, however, were not so fortunate. They had to sit in with their GP's normal clinic for the majority of the time, just like we had done for the previous two years. Ultimately they didn't get to see their own patients and as a result they didn't achieve the same experience from their attachment as I did. This has subsequently led them to question the use of the GP attachment.

I realise that not all practices have the resources and facilities to enable final-year students to have their own clinic. However, I feel that sitting in with doctors is fine for the initial clinical years, but is of no benefit for final year students. As a result, I think surgeries should either accommodate students in a way that would be beneficial for both parties, or should not accept final-year students at all.

AVANT KAPOOR

Hope Hospital, Salford.