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.

Save our soul

During an unusually quiet on-call I picked up the August issue of the *BJGP*, but after an hour or two put it down again feeling a little perplexed. Not perplexed this time that my colleagues seem to embrace technology, appraisal and progress better than I do, or that Holland and Belgium manage to publish so much research, but confused that somehow the journal did not come together.

I do not mean that the staples were missing from my copy, nor that the Editor had failed to employ his usual skill at summarising the contents in Focus, but rather the letters pages were absent. That was it; the soul of the journal was missing. There was no reference to, or comment about recent articles; no jobbing GPs were criticising their academic colleagues for being out of touch; no daft or witty asides; and no healthy debate had been engendered or continued.

I asked myself, why this distinct lack of feedback? Is this the first step on the road to totalitarianism by the Editorial Committee? Had the research papers not been trimmed enough to make room for the dissenters and commentators to move in? Were there so many jobs and courses available that the ads took priority? Or most worryingly had none of us anything useful to contribute? Perhaps all will become clear in the next issue.

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Thank you; thank you for noticing. The straight answer is that there weren't enough letters (of any quality) to fill a sensible space. It's better this month, but not exactly a massive yield. We've said it before and we'll say it again: we value all the feedback we get from the readers, and the more opinionated the better. We know that the *BJGP* goes out to thousands of GPs, that there are thousands of irascible GPs out there, and that some of them read it. So why aren't we flooded with angry letters month after month?

ED.

Does research into epilepsy matter?

I am currently Chairman of the Trustees of the Epilepsy Research Foundation and have been a member of the RCGP for over 40 years.

The Epilepsy Research Foundation is a charity, founded 10 years ago to fund independent epilepsy research, both basic and clinical throughout the UK. We are looking for more trustees to continue the work of those 'slowly ageing current trustees', many who have served since its inception.

I would dearly like to find a GP who has personal experience of just what epilepsy can do to people, and who is interested in continuing the work of the Foundation. Epilepsy is not just a group of symptoms; it carries a stigma even within the medical community. It is poorly understood and most treatments are limited to the suppression of the symptoms, usually at considerable cost to the patient.

The trustees meet three to four times a year, usually in London. They are supported by a scientific advisory committee selected from both active researchers and lay people interested in the disease. The Foundation, in addition, holds select workshops on specific problems in understanding epilepsy with the purpose of producing quality review publications.

If there are members of the RGCP interested in being considered as trustees, please do not hesitate to write to me c/o The Epilepsy Research Foundation, PO Box 3004, London W4 1XT. I will be glad to discuss or meet with those who are interested.

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The ILS course: an answer for MRCGP basic life support?

The RGCP was well ahead of the times in bringing in a test of basic life support, but resuscitation has progressed considerably and a review is necessary. The present certificate claims to be based on the 2000 guidelines but omits several important factors. The phone first or phone fast question is not addressed. This is something that is taught to the lay rescuer. The treatment of a patient undergoing respiratory arrest, or of an unconscious patient with a pulse, is also not assessed. The 'Jaws [sic] thrust' is only mentioned as an acceptable variable whereas the guidelines state that it should be taught to healthcare professionals.

The absence of mention of adjuncts is also worrying. The guidelines state that healthcare workers should use masks with one-way valves or a mechanical device to avoid the need to perform mouth-to-mouth ventilation.[1]

Defibrillation using an automated external defibrillator (AED) is the next link in the chain of survival. Indeed many consider this as part of basic life support and any health professional

trained in basic life support should be trained to use an AED.[2] Many lay people, including police officers, firemen, first aiders, and airline staff, are already trained in the use of these devices. We can see no reason why GPs should not be trained in their use.

The immediate life support (ILS) course is widely available from over 120 Resuscitation Council UK centres. The current fee is approximately £50 for a 1-day course. Our centre trains GPs in ILS and we are convinced that it is the right course for them.

Certificates in advanced life support and pre-hospital emergency care, and the diploma in immediate medical care are already accepted by the RGCP as sufficient for exemption from certification in basic life support. ILS is recommended by the Resuscitation Council UK for training GPs, but is not yet recognised for exemption.

We would suggest that initially ILS is recognised for exemption, and that in due course ILS, including the use of an AED, becomes the standard for the MRCGP and the current test is abolished. The ILS certificate only runs for 1 year. To expect recertification every year is probably unreasonable and every 3 years for general practice is probably a more realistic option.

WDT MOODY-JONES

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The blind alley of decision analysis

Montgomery *et al* argue that decision analysis can inform and clarify patients' decisions.[1] I believe that there are insurmountable problems that have not been fully explored from both theoretical and practical perspectives.

A decision model aims to capture the essence of reality, simplifying relevant issues to a minimum level while retaining their principal components. From a theoretical perspective, the derivation of expected utility, which forms the basis of this technique requires a utility (or wellbeing) function to be quantified and combined with the probability of achieving that state. However, the derivation and application of utility values remains highly contested.[2] Can the complexities of life really be condensed into a scale between 0 and 1? There are also problems from a psychological perspective with the derivation of probability values.[3] The probabilities that we allocate to different health states vary with time and are dependent on the way in which the questions are framed.

From a practical perspective there are also concerns. Firstly, the analysis takes 45–60 minutes to complete, which severely limits its application in the real world of primary care. Secondly, as the accompanying commentary by Dowie points out, the exercise is only of relevance if the patient requests this level of analysis within the context of the patient–practitioner relationship. Apart from a handful of university lecturers, I can't imagine anyone on my list and the majority of my colleagues being anything other than baffled.

Limited resources would be more appropriately directed into research on how solutions emerge from within the existing healthcare environment rather than the development of models that reduce the reality of the healthcare environment to such a point that their practical value is extinguished.

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Author's response

Kernick suggests that problems in using decision analysis in primary care are insurmountable. While we acknowledge that further development of decision-analysis based decision aids is required, we do not agree that theoretical and practical problems extinguish their value.

Kernick criticises the derivation and use of probabilities and utilities, but offers no alternative apart from seeming to support the paternalistic approach of 'doctor knows best'. Patients and health professionals have been shown to have different preferences for accepting blood pressure lowering drugs.[1] By explicitly quantifying probabilistic and utility information, decision analysis addresses the lack of transparency in how patients' views regarding potential outcomes (if indeed such views are even sought) are combined with the likelihood of these outcomes happening.[2] Probabilities in decision analyses are generally obtained from the best current research evidence. Is this not the same source of evidence upon which clinicians base their (non-decision analytical) treatment decisions?

Framing of probabilities is not a problem exclusive to decision analysis. And while it is true that a patient's preferences may change over time, so decision analysis, or at least a formal review, may be repeated to allow the patient and GP to discuss whether treatment should be started, maintained or stopped.

While the decision tree in our study was relatively simple, decision models can be as complex as the clinician, patient or analyst wishes. For example, Markov models for treatment of atrial fibrillation or hypertension have been developed to model outcomes over a patient's lifetime with much greater complexity.[3,4]

Regarding practical concerns, patients will differ in the degree to which they wish to be actively involved in decision making, as we clearly stated in our paper. A patient who does want a role in decision making could undertake a decision analysis via the internet before meeting with the GP. This could facilitate discussion and shared decision making during the consultation. Furthermore, users do not necessarily

need to see the structure and workings of the underlying decision tree in order to benefit from the process. As for the baffling nature of decision analysis, the vast majority of the patients in our study were able to complete the process. Although we did not collect data regarding occupation or educational level attained, this was not a highly select group of individuals.

By explicitly and transparently specifying the components involved in any decision, decision analysis makes clear what is regarded as important by patients — something that the implicit and opaque processes currently in use in the existing healthcare environment do not.

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Editorial freedom in Focus

Dear Editor,

You seem a little confused about the editorial position of the *BJGP*.[1] The RCGP has given editorial freedom, but there are many points of evidence that remain to indicate that the *BJGP is* the mouthpiece of the RCGP. Firstly, the RCGP is the publisher, and financial accounts are linked. Secondly, subscription to the *BJGP* is linked inseparably to membership of the RCGP. Thirdly, the journal is known throughout the world by its previous name, the *Journal of the Royal College of General Practice (of Great Britain)*, which of course it is, since receipt is linked to membership! Fourth, the *JRCGP (of GB)* is known throughout the world as the mouthpiece of British GPs, leave alone their College. Fifth, the *BJGP* still carries the official notices of the RCGP (and I don't think it matters whether they pay for them or not!).

So, please note, that you have *only* been given 'editorial freedom'. As editor of a college journal, you have an ethical and moral obligation to the College and to the people that you represent, which by historical implication, is all British GPs. In fact, you have further ethical and moral restraints than that, in that the journal is health related, and gives you 'undue influence' over health matters affecting the public (further than just of Britain, too). This means you have a duty to uphold the interests of British GPs and their patients, which takes precedence over your freedom as editor. That is the way it is; if you don't like it, then perhaps there is something else you would rather edit than a linked membership journal?

I know that in recent years there has been a lot of work to make the *JRCGP* more readable and useful. Although I do not agree that all the changes are as I would have liked, the majority I feel are certainly great improvements. I do not think, however, that there is any chance of severing the moral link to the RCGP. Name changes mean nothing for many years, and while the RCGP still insists that all of its members must subscribe to the journal, the *BJGP* will continue to be known everywhere as the *JRCGP*, and the restrictions on the editor's freedom, due to it being the mouthpiece of the RCGP, will remain.

Best wishes, and do carry on with the improvements.

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Appraisal of family doctors

We read with interest the article by Lewis *et al* on GP appraisal, which raises important issues about the implementation of GP appraisal.[1] We have run a similar, though smaller, project here in south-east Scotland.

In the first instance we looked at GPs' expectations of the appraisal process through a questionnaire (McKinstry *et al*).[2] The second part of the project explored, through questionnaire and semi-structured interviews, GPs' actual experiences of the implementation of two kinds of appraisal; appraisal by peer partners and appraisal by centrally appointed GPs. Our findings are broadly analogous to Lewis *et al*'s and our respondents were generally positive about the whole process of appraisal.

However, there is a notable exception: a number of our interviewees noted collusion as being of importance, an issue not mentioned by Lewis *et al*. Analysis of our interviews of appraisers and appraisees shows that there is a level of concern about collusion between those involved in the appraisal, which takes a number of forms. There are those who view the whole process of appraisal as just a hoop to jump through, particularly with appraisal being linked to revalidation, and a perceived political agenda:

> '… you must be appraised you might find because GPs are very good at jumping hurdles, that they all rush and jump that hurdle, "here we go, here's my piece of paper, I've been appraised", and then it will be useless and it might upset people because it has been done improperly'.

Furthermore, there are those who identified the possibility of the appraisal turning into a cosy chat between two colleagues, neither providing a challenge nor motivation for development. One third of our respondents did not deal with difficult issues during their appraisal:

> '… there's nothing major but I suppose in an appraisal there are certain issues that we should have touched upon which you can avoid …'

This is particularly relevant when a difficult issue is raised that the appraisee does not wish to discuss or address, as happened to one of our appraiser interviewees:

> '… it came out in the appraisal … an issue and the doctor did not want to discuss it in any detail but it seemed as if there may be some relevance to the doctor's actual problems … I felt it was important to respect his wishes and at no time did I try and push him on to it.'

Generally, our research, like Lewis *et al*'s, shows that GPs are ready and willing to undertake appraisal with a few provisos. Implementation of the appraisal process for GPs in Scotland is now underway and has addressed many of the issues raised by our research.[3] It will be interesting to review the process in the not too distant future. We look forward to comparing appraisal implementation around the country.

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Primary care during the SARS outbreak

Severe Acute Respiratory Syndrome (SARS) is a global health challenge. By 17 June 2003, 8460 people had been infected resulting in 799 deaths worldwide.[1] As this disease outbreak was so swift and the treatment so controversial,[2,3] hospitals in Hong Kong were put under huge pressure for managing SARS cases as well as all other suspected cases. In turn, this led to serious strains on the current health resources with disruptions in services other than for 'life-threatening' cases.

The primary care system in Hong Kong is poorly developed and works independently from the rest of healthcare system, the latter dominated by the Hospital Authority (HA): 70% of primary medical care is provided by the private sector whereas 90% of the hospital care is carried out in public institutions.[4] There is little interface between primary and secondary care, let alone collaborations between the private and public sectors.[5]

The clinical manifestation of SARS is not so dissimilar to the other causes of respiratory tract infections. GPs have no immediate and rapid access to the investigation facilities of the HA hospitals. This led to too many referrals of patients to secondary care for screening or admission, and the secondary effect was to increase the risk of hospital cross infection (including SARS).

In May 2003, 183 GP tutors affiliated to our department were approached, and 137 responded to our questionnaire, of which 119 (86.9%) worked in the private sector:

- 83.2% of them wanted more involvement in the management of SARS in the community: 74.6% as educators and 68.4% as gatekeepers.
- 68.4% wanted rapid diagnostic tests whereas 84.2% were happy to administer vaccines when available.
- Nearly one-third (31.6%) would like to be involved in SARS research in the community.
- About two-thirds (65.2%) suggested transferring non-urgent procedures to the private sector, in a shared-cost scheme between the patients and the government, during the SARS crisis to ease the burden on government hospitals.
- Three doctors expressed their wish to 'share the government's outpatient burden and/or outreach services at elderly homes' and another doctor had volunteered in a SARS screening clinic.

In an unexpected infectious outbreak, any health system will be put under stress and even more so in Hong Kong where there is no partnership between the two sectors. The government should review the whole healthcare system. As one of our respondents put it, this is 'a golden opportunity for integrating the public–private interface not to be missed'.

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Corrections

We published a letter in the March issue of the *BJGP* signed by Mireia Marsa Carretero, Cristina Alos Manrique and Joan-Antoni Valles Callol. Their names should be cited as Marsa M, Alos C and Valles JA.

In the August issue, we gave the incorrect name for the author of the book review on page 667. The correct author's name is Jane Roberts, not Jane Gordon. This mistake was repeated on the front cover and on page 672, where her job description was also incorrectly cited as a GP near Durham. Her correct job title is a lecturer in medical education at the University of Durham and a GP on Teesside.