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. . . if used within its limits

EDITOR,—In our recent paper we presented normative data on the short form 36 (SF 36) health survey questionnaire.[1] We intended these data to be of use to people considering using this instrument. Trevor Sheldon subsequently suggested, however, that data from the Oxford study should not be taken as typical of responses from Britain as a whole and that our data should be interpreted with caution.[2] We have sympathy with this view but would point out that the comparison between, for example, the data from Oxfordshire and the data from Sheffield is more striking for its similarities than its differences. Furthermore, the designers of the SF 36 suggest mean differences which might be regarded as significant,[3] and the differences reported from Sheffield and Oxford are far less than the benchmarks offered by the designers.

Sonja M Hunt and Stephen P McKenna suggest that we imply that the SF 36 can be used for the evaluation of outcomes of anything from health promotion activities to hip replacement operations and exercise programmes. No such claims were made or, we believe, implied in our paper. We emphasised that the questionnaire should be used carefully and with considerations to its limitations. Hunt and McKenna, for example, note that the SF 36 lacks a dimension concerning sleep; this point was clearly made in our paper, and we further advocated careful choice of instruments that measure dimensions appropriate to specific illnesses.

Hunt and McKenna also suggest that questionnaires age and that their items may become less appropriate with time. This is true, but the SF 36 is relatively new and has not yet been fully documented for use in England. Papers on the questionnaire that have been published in the *BMJ* are attempts to validate it for use in Britain and are not, as Hunt and McKenna suggest, attempts to renovate an old instrument. We find it ironic that the designers of the Nottingham health profile claim that we should not be renovating old instruments: after all, it was these designers who recently published a paper on an amended version of their own—and, on their own admission, old—questionnaire so it could be used to derive a single index figure.[5] The papers on the SF 36 that have been published are attempts to validate the measure to ensure that its operating characteristics are documented: once these have been established the measure can be used appropriately with full understanding of its strengths and weaknesses.

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Unanswered questions remain

EDITOR,—As John E Ware notes in his editorial, the arguments for including measures of patients' subjective perceptions in the assessment of the outcomes of health care interventions are now widely accepted.[1] The challenge, he argues, is to find reliable, valid, acceptable, and feasible tools to collect such information. According to narrow technical definitions of these criteria, the short form 36 (SF 36) health survey questionnaire seems to be moving ahead of other such instruments. Before definitive judgments are made on the utility of particular measures, however, different and perhaps more intractable questions about validity, acceptability, and feasibility must be resolved.

Firstly, standardised measures of the outcomes of discrete elements of care will never measure the full complexity of the experience of health and illness. But we have examples from interviews with older patients with cataract of the SF 36 failing to pick up important aspects of this experience. Secondly, the fact that patients respond to a questionnaire obviously means that in some sense the questionnaire is "acceptable." This does not, however, mean that administering it by post or any other means is ethical. The SF 36 caused considerable distress to some patients in our study. Both these problems could have been magnified by the age of our patients. Structured measures may, however, result in similar problems with any group with multiple or complex health problems, regardless of age.

Thirdly, as Andrew M Garratt and colleagues argue, purchasers need to measure outcomes to allocate resources cost effectively and humanely and providers need to show the quality of services to survive in the market.[2] Our experience suggests, however, that in the real world of the NHS the divisions between purchasers and providers can engender distrust, which may make it more difficult to collect the information on outcomes that is needed.

There is undoubtedly a role for standardised measures of outcomes as assessed by patients and for more methodological work testing such measures. It is too early, however, to focus all energies on the SF 36. In particular, routine in depth qualitative research is needed to listen directly to what patients have to say rather than their voices always being channelled through templates of the experts' making.

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Questionnaire does detect poor sleep

EDITOR,—The two recent papers on the use of the short form 36 (SF 36) health survey questionnaire[1 2] prompted several letters, one of which criticised the validity of the instrument on the grounds that it does not contain questions referring to sleep.[3] Though we agree with the authors that sleep disturbance is commonly associated with ill health, a health status instrument should not be disease specific but should be able to differentiate between people with and without specific disorders that affect health.

We recently carried out a study of health status in which a random sample of adults (n = 827, response rate 82%) in West Glamorgan were interviewed by health visitors in their own home. The SF 36 was used, and several questions on self reported morbidity were asked, including one on whether the person had been treated by a doctor for "problems sleeping" during the previous 12 months. Eighty five people reported having received such treatment in the previous year.

Multiple linear regression was used to determine whether the people who had been treated for a sleeping disorder had lower scores for the SF 36 variables than the other people when allowances were made for differences in age and sex. The table gives the mean scores for all the people interviewed (the group means) and the difference between the mean scores for the people who had been treated and the group means. These results clearly indicate

Mean score for eight variables of SF 36 for all 827 people interviewed (group mean) and difference between mean score for the 85 people who reported having been treated for sleeping problems in previous year and group mean

Variable	Group mean	Difference (95% confidence interval) between mean score for those treated and group mean
Physical functioning	76·2	−18·3 (−12·8 to −23·8)
Role limitations:		
Emotional	82·9	−27·8 (−20·1 to −35·5)
Physical	72·5	−19·4 (−10·9 to −27·9)
Social functioning	80·6	−21·6 (−15·4 to −27·8)
Mental health	75·3	−19·2 (−15·0 to −23·6)
Bodily pain	70·9	−21·0 (−14·5 to −27·5)
Vitality	58·4	−18·6 (−13·4 to −23·7)
General health perceptions	66·6	−22·2 (−16·9 to −27·5)

that the people who had been treated for sleeping disorders had significantly lower scores for each of the eight variables of the SF 36. As the question asked is clearly not 100% specific or sensitive in detecting current sleep disorders and as some misclassification would have occurred, which should have biased the results against showing any association, the true magnitude of the association between sleep disorders and health status must be larger than that shown. Nevertheless, the size of the differences between the people who had and had not been treated for sleeping disorders indicates that the SF 36 does distinguish well between these groups; the lack of a question on sleep does not seem to detract from its validity.

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Regulation of locum staff

EDITOR,—The report of the hearing of the General Medical Council at which Dr Behrooz Irani was found guilty of serious professional misconduct is disturbing.[1] The most worrying aspect of the affair is that Dr Irani was able to put other patients at risk after the incident at Castle Hill Hospital. How could this have been prevented?

Even if doctors are seen to be unsafe and are dismissed, as was the case with Dr Irani, they can apply for other posts by using referees from