Letters

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Complementary and alternative medicine

It is regrettable that the *BJGP* should publish obviously wrong medical information. In his paper,[1] Professor Ernst states that a number of alternative treatments are as effective as conventional options. Presumably, Professor Ernst considers his view to be so well accepted and generally held to be true, that he provides no references to support his statements. There are examples below that clearly show that he is wrong.

He states that saw palmetto used for treatment of benign prostatic hyperplasia has similar effectiveness to conventional options. It is not stated if he means conventional medical treatments or conventional surgical treatments or both.

A 2002 Cochrane review of saw palmetto concluded that it may be better than placebo and of similar effectiveness to 5-α reductase inhibitors.[2] In a recent high quality randomised controlled trial it was shown to be no more effective than placebo.[3] To my knowledge, saw palmetto has not been studied in a head-to-head trial with α-blocker and therefore it cannot be assumed that it is of similar effectiveness. Regarding surgical treatment, I am not aware of any randomised controlled trial comparing saw palmetto to surgical treatments or sham operation. So, his statement is untrue whichever conventional options he means.

He also states that treatment of depression with St John's wort has similar effectiveness to conventional treatment. Untrue. In a well-conducted randomised controlled trial in patients with major depression, St John's wort was found to have effectiveness similar to placebo.[4] To my knowledge it has not been tested against most medical treatments for depression, nor against cognitive-behaviour therapy. Certainly, it has never been tested against electro-convulsive treatment, by far the most effective of all conventional treatments for severe depression.

He states that hawthorn for treatment of heart failure has the same effectiveness as conventional options. Let us remind the readers about some conventional options.[5] The proven ones include: diuretics, β-blockers, ACE inhibitors, nitrates, digoxin, bi-ventricular pacing, ventricular assist devices, and heart transplant. His statement seems so outlandish that I feel I need not provide any further references.

Presumably the article[1] was peer-reviewed and approved by the Editor for publication. They singularly have failed in their duties on this occasion.

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Re: Complementary and alternative medicine

The original article was not peer-reviewed, but was approved by the Deputy Editor. We've become aware that this may not be clear, and have recently decided to follow the BMJ*'s example and publish details for each paper so that readers are not left in any doubt — Ed.*

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Author's response

Dr Nick Manassiev accuses me of putting out 'wrong medical information'. He claims that I provide no references. However, my text is quite clear that the information is my attempt to summarise the evidence reviewed in our two books.[1,2] In other words, all the necessary references can be found there because constraints of space would not have allowed me to proceed in any other way.

Is saw palmetto equivalent to conventional drug treatment? (Yes, I did mean to compare only oral treatments.) Even though the data are not entirely uniform (they rarely are), the Cochrane review concluded that it produced similar improvements in urinary symptoms and flow as finasteride and is associated with fewer adverse events.[3]

St John's wort has been tested in more than 30 well-conducted randomised controlled trials. Again, the results are not entirely uniform but collectively the data are positive. In five randomised controlled trials (total sample size = 2251), St John's wort was tested against conventional antidepressants and the meta-analytic risk ratio was 0.96 (95% CI = 0.85 to 1.08).[4]

Hawthorn is backed up by a positive Cochrane review of 14 randomised controlled trials,[5] and a recent randomised controlled trial with 2681 patients showed that, during 18 months of hawthorn treatment, deaths due to cardiac causes were reduced by 20% compared to placebo.[6]

In my article, I do acknowledge that comparing one (complementary) with another (conventional) treatment is by no means straight forward. In fact, I state that: 'This is where things change from complicated to nebulous.' But I do nevertheless insist that the information I provided is based on the best available evidence.[1,2]

While I deplore the aggressive tone of Dr Manassiev's letter, I rejoice in the fact that one commentator found my judgements of complementary therapies unjustifiably negative,[7] while Manassiev believes they are unjustifiably positive. As long as I receive flak from both sides, my position is probably not entirely wrong.

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Emergency Care Summary in Scotland

We would like to correct some inaccuracies in reply to the essay by Dr Gordon Baird in the Back Pages of the February edition of the *BJGP* in which he made comments about the Emergency Care Summary (ECS) in Scotland.[1]

As Dr Baird says in his article, information should only be disclosed in the interest of the patient. That is the sole aim of the Emergency Care Summary. It contains clinical information on current medication, allergies, and any adverse reactions to medications that are recorded on the GP clinical system. Patients can opt out of having their ECS information uploaded from their GP record but, even when it is available, the information can only be accessed with the explicit consent of the patient for that episode of care. This means that the clinician has to obtain consent from the patient before accessing their ECS and this facility is only available for clinicians working in NHS 24, out-of-hours organisations, A&E departments, or other acute receiving units. This consent model has been approved by the BMA, the Scottish Government, the GMC, and EU lawyers.

Dr Baird states that the information in ECS may not be accurate but, by limiting the clinical content to prescriptions that have been prescribed electronically and to adverse reactions that have been recorded, and by updating the uploaded ECS twice daily, the accuracy of the record is high and the likelihood of including erroneous data minimal. In addition, Scottish practices have been paid through an enhanced service in 2007/8 to check the ECS data systematically for their patients.

Dr Baird unfortunately muddles the different consent models and guidance for the Connecting for Health Summary Care Record in England and the Emergency Care Summary in Scotland. This is confusing for readers as the two projects differ significantly in detail of both content and regarding future plans.

Dr Baird states that the audit trail can be over-ridden by the ECS user setting 'no notification to GP'. This facility is used to support patient privacy, not to over-write any audit trail. The whole process, including any accesses from end to end, is regularly audited to a very high standard, for example, failed log ins, excess log-on durations, and user profiling. All of this data are available on request via each practice manager.

Dr Baird asks who is going to gain most from this information sharing. In the 2 years since the ECS has been in use across Scotland, evaluation in NHS 24 and A&E has shown that it has been found to be of strong clinical benefit by the clinicians who are entitled to use it. NHS 24 clinicians have been able to deal with queries about medication and dosage without the need to refer the patient for a face-to-face consultation. ECS has been particularly valuable for clinicians dealing with emergency admissions on public holidays or weekends when there is no access to GP surgeries, and for the 'hospital at night' teams.

Clinicians report that it reduces phone calls to GPs, and that a written list is safer than a receptionist reading a list of medication from a screen. Additionally, clinical pharmacists in acute receiving units for unscheduled care can now take a drug history verified by ECS with consent from patients. The pharmacists even report that some GP practices complain if a phone call is made to check the medication as the GP practices now feel that ECS makes this unnecessary. The outcome of our evaluation is that patient safety is considerably improved by the quality of the information and the amount of time saved.

In summary, in a quote from a clinician: 'this has raised the bar for quality and safety for patients', which reminds us that that is the ultimate goal of the ECS.

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Chair, ECS Programme Board

Stuart Scott
Joint Deputy Chairman, Scottish General Practitioners Committee

Ken Lawton
Chair, RCGP Scotland

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Author's response

Thank you for allowing me the opportunity to respond to the criticism from Dr Morris and her colleagues. Having re-read the essay, I find it difficult to accept that there are any inaccuracies.

It is true that their consent model has been approved by the BMA, the Scottish government, the GMC, and lawyers; nevertheless, the essay points out that a doctor should only transfer information after patients have been informed of the