interventions that are not cost-effective.

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Glycaemic control and mortality

The last sentence of the article by Landman *et al*[1] states, 'for patients with moderate glycaemic control and longstanding diabetes, it may be better to focus on other risk factors, such as smoking, high blood pressure, and lipid profile disturbances, than to aim for increasingly lower therapeutic values for HbA_{1c}'.

However, this observational cohort study showed no significant difference in baseline characteristics between the survivors and the deceased in blood pressure, lipids, and smoking characteristics.

Surely an implication of this study is that the benefits of interventions noted in other studies do not necessarily translate to improvements in the wider context of general practice.

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Authors' response

In our article, published in the March edition of this journal, we state that 'it may be better to focus on other risk factors, such as smoking, high blood pressure, and lipid profile disturbances, than to aim for increasingly lower therapeutic values for HbA_{1c}.'[1] The validity of our conclusions was confirmed by a recently published large retrospective study.[2] Although the design was different, it emphasised the absence of benefit of strict glycaemic control in patients with longer diabetes duration. In fact, this study even showed an increased mortality in patients with HbA_{1c} under 7.5% who underwent treatment intensification with insulin.

In his comment to our article, Searle points out that there are no baseline differences in these risk factors between the survivors and the deceased in our study.[3] Although this observation is correct, we respectfully disagree that it contradicts our statement. Absence of differences in baseline characteristics, for example smoking, does not mean that smoking is not an independent risk factor for mortality. To answer the question whether smoking, blood pressure, and cholesterol levels are related to mortality, Cox regression analyses, including correction for confounders, are an option in order to better interpret a (possible) effect of, in this case, HbA_{1c} on mortality. For example, in the same study cohort, we studied the relationship between mortality and lipid profile in different age groups.[4] In this study, higher cholesterol levels did relate to mortality.

We agree with Searle that the benefits of interventions, as studied in randomised controlled trials, do not necessarily translate to improvements in daily practice. Many trials include a selected population and are, therefore, not representative of the general population. However, our results more or less confirm the results of these trials, like the UKPDS, that we discussed in our article.

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Dementia: the deception is broken; naked truth looks OK

We are warmed and encouraged by the supportive responses,[1–3] to our challenge to the National Dementia Strategy in its current form.[4]

Professor Iliffe wonderfully caricatures the four flattering tailors who would weave the magic suit of clothes to bedeck the Emperor. 'But look' says he, and professor Manthorpe, and doctors Vahabzadeh, Abbas, and Boyle say 'aye'. This is an important but well-recognised variant of the human condition, don't make it more than that. Enfold it as such among people at home and in their care homes and help these individuals live their lives as fully as possible — specialist skills welded within primary care can play a useful, humble part in this.

The Gnosall model has recently been visited by Professor Burns in full Tsar regalia. Shrewd Scot that he is, he knows true value when he sees it. This may be a further step toward wide adoption, the approach that offers better care for people with dementia, their families, and people who devote their working lives to their support. Its economics may just save the NHS from administration.

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Do general practice patients who are prescribed Tamiflu® actually take it?

Caley and colleagues found that West Midlands GPs thought oseltamivir (Tamiflu®) was easy for patients to obtain.[1] But it is unclear how many patients actually complete the course. Between December 2009 and March 2010 we conducted an audit of patients with suspected swine flu at an inner London practice to see how many actually took a course of oseltamivir and reasons behind their decisions to take or not to take the drugs.

Using Population Manager in EMIS and key words 'swine flu' or 'suspected swine flu', we identified 72 registered patients who may have been prescribed oseltamivir between August and October 2009. Attempts were then made to contact these patients by telephone.

The response rate was 50% (36/72). Thirty-three of the 36 patients (92%) said they had been prescribed oseltamivir: 20 by the practice, 12 via the pandemic flu line, and one through the local out-of-hours service. The mean age of these 33 patients was 27 years (range 1 to 79 years), 45% were female, and 25% were from ethnic minority groups. The majority — 27 patients (82%) said they had completed the full 5-day course. Four patients took oseltamivir for less than 5 days, and two patients did not take any medication, one because of clinical improvement and one because of fear of side effects. In total, eight patients (24%) experienced symptoms that they attributed to oseltamivir, mainly gastrointestinal symptoms and listlessness or drowsiness.

Caley *et al* identified ease of obtaining antiviral medication as one of the strengths in the 'professional to professional' H1N1 response. Our small audit found this was matched by a high (82%) compliance rate in patients at one general practice, suggesting that many patients seem to have trusted the information they received.

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PHQ-9: sensitivity to change over time

Malpass *et al*, in a mixed methods study assessing PHQ-9 scores and patients' experiences, report that patients found the PHQ-9 to be helpful,[1] concurring with other recent qualitative work that suggested that patients viewed such measures as an 'objective adjunct to medical judgement'.[2] Unfortunately, the value of these observations rests entirely on the assumption that the PHQ-9 is a valid measure of depression severity. Considerable doubt attends this premature notion.[3,4] Indeed, the most recent of these findings is reported by Reddy and colleagues on the pages following Malpass *et al*'s piece.[5] We should not be comforted by the observation that patients' believe their depression is being better assessed by this process until it is shown that this belief matches the evidence.

A further finding of Malpass *et al* was of discord between symptom frequency and intensity in relation to the PHQ-9 and patients' accounts.[1] This raises an important consideration for the use of the PHQ-9 in assessing depression severity and treatment responsiveness. If depression severity measures are intended to facilitate the alignment of clinical decision making to evidence-based interventions, consideration should be given to how severity of depression was measured in that evidence base. Guidelines indicate[6] that largely this has been in studies where depression severity has been measured with the Hamilton Depression Rating Scale.[7] With regard to how to administer this measure, Hamilton states that 'no distinction is made between intensity and frequency of symptom, the rater having to give due