

Attitudes to the use of health outcome questionnaires <i>S Mowle, A Edwards, N Stott</i>	63	Stop prescribing Temazepam? <i>D Nolan</i>	65	Practice information on audiotape for visually-impaired patients <i>C E Clark, S Bourne</i>	67
Accrediting research practices <i>N Summerton</i>	63	Bereavement care <i>C M Munro</i>	66	Design of asthma inhalers <i>J N H Eisenberg</i>	67
Computer use in Scotland <i>E Wallace, K Chalmers</i>	64	Questionnaire responses and clinical practice in bereavement care – mind the gap <i>R Woolf</i>	66	<b>Note to authors of letters:</b> Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use double spacing and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.	
Home hypertension <i>Y Asai</i>	64	Recruitment of general practitioners to a randomized trial <i>C Heatley, T Ricketts, J Forrest</i>	66		
Concordance for hypertension between spouses <i>J Macleod</i>	64	General practice or primary care? <i>D Church</i>	67		
Association between having a spouse with hypertension and an increased risk of hypertension may not be real <i>W-C Leung</i>	65	Costs are a barrier to GPs performing skin prick testing <i>A Sheikh, M L Levy</i>	67		

### Attitudes to the use of health outcome questionnaires

Sir,  
Meadows *et al* (September *Journal*)<sup>1</sup> report some positive general attitudes among professionals to health outcome assessment. The measures they refer to comprise disease-specific questionnaires. Even when these are available, responders to their survey cited limited knowledge of health outcome literature and not having enough time to discuss such measures with patients as potential difficulties that hinder implementation in routine practice.

The RCGP has argued, correctly, that 'single' performance indicators are 'unlikely to ever have validity as measures to discriminate among the overall quality of general practitioners...' yet the complexity of the composite measures is equally daunting to the average GP.

The Meadows *et al* study is another dimension to the wider search for measures of quality in general practice and the GMC is escalating the specificity of its demands on the medical profession's clinical accountability.<sup>3,4</sup> Clinical governance is being placed at the level of primary care groups/local health groups and this may be the last opportunity for GPs from the grassroots to have a major role in self-regulation.

We suggest that two relatively unsung approaches to quality measurement need serious consideration in general-based primary care.

First, the benchmarking approach that is used quite widely between NHS Trusts. In this, the members each measure one or more dimensions of mutual importance and permit themselves to be ranked. The resulting series of results allows each Trust to 'benchmark' themselves against the performance of their peers. Unlike audit, standards are not set. It is in the range of results that reveal outliers who try to explain their position in relation to the norm. The approach has been used in

biochemistry quality assurance and also in general practice diabetes care where benchmarking over five years in a district has led to remarkable improvements in the process of care.<sup>5</sup>

Secondly, the principle of having an internal rolling audit programme in every NHS Trust is well established as an effective and non-threatening management tool. There is no reason why the same principle should not be developed in every general practice but with a focus on both clinical and administrative functions. This would support quality assurance and provide a happy basis for benchmarking with peers.

Professionals in primary care are unlikely to cope with a profusion of disease-specific measures. What they need is generic measures of outcome that can be developed as benchmarks for a range of clinical situations.

It may be that the advent of clinical governance will provide the imperative to start practice-based rolling audit programmes and even primary care benchmark groups during 1999.

STEPHEN MOWLE  
ADRIAN EDWARDS  
NIGEL STOTT

Division of General Practice  
University of Wales College of Medicine  
Health Centre  
Maelfa  
Llanedeyrn  
Cardiff CF3 7PN

### References

- Meadows KA, Greene T, Rogers D. Attitudes to the use of health outcome questionnaires in the routine care of patients with diabetes: a survey of general practitioners and practice nurses. *Br J Gen Pract* 1998; **48**: 1555-1559.
- RCGP. *Recognizing quality of care in general practice*. London: RCGP, 1998.

- GMC. *Good medical practice*. London: GMC, 1998.
- GMC. *Maintaining good medical practice*. London: GMC, 1998.
- Butler C, Smithers M, Stott N, Peters J. Audit-enhanced district-wide primary care for people with diabetes mellitus. *Eur J Gen Pract* 1997; **3**: 23-27.

### Accrediting research practices

Sir,  
The editorial by Smith *et al* (August *Journal*)<sup>1</sup> makes some important suggestions for ways of improving the quality of primary care research.

One of the most exciting developments for primary care epidemiological researchers is the advent of practice-based research networks. Such networks serve as laboratories for the study of health and health care events in the real world practice settings that characterize primary care. In the Mant report, 22 primary care research networks were identified; all but one formed in the past 10 years and half since 1995.<sup>2</sup> The total amount of funding received by the 15 networks that provided figures amounted to over £1.5 million in the financial year 1996/7.

In the United States, a recent count identified 28 family practice research networks (only five more than in the UK). Such networks are now producing a great deal of high quality research.<sup>3</sup>

In the UK, funding for all research still remains tight, and it is necessary to demonstrate that any new development has a value-for-money component. The Culyer definition of research is new knowledge that is generalizable, publishable, peer-reviewed, and protocol based. Such a definition should be within the mission statements of all research networks if they are going to be credible. Furthermore, both the Mant report and the MRC report highlight a research agenda for primary care. It is self-evident that the research undertaken by research networks needs to fit in with this agenda.<sup>4</sup>

To deliver value for money in primary care research, I would suggest the following criteria be considered in assessing the quality of research being undertaken by networks:

- Publications by members of the network in peer-reviewed journals
- Percentage of research projects that have written protocol (objective 100%)
- Percentage of research projects that have been peer-reviewed (objective 100%)
- Percentage/number of MREC/LREC approvals obtained (a proxy measure of research quality).

Secondary criteria could be the number of higher research degrees being obtained by members of the network and the numbers of successful research bids submitted.

NICHOLAS SUMMERTON

The Surgery  
Manlake Avenue  
Winterton  
Scunthorpe DN15 9TA

### References

1. Smith LFP, Carter YH, Cox J: Accrediting research practices. *Br J Gen Pract* 1998; **48**: 1464-1465.
2. NHS Executive. *R&D in primary care: 'Mant report'*. London: DoH, 1997.
3. Nutting PA. New knowledge, new tools: a look inside the 'black box' of family practice. *J Fam Pract* 1998; **46**: 361.
4. Medical Research Council. *Topic review on primary health care*. London: MRC, 1997.

### Computer use in Scotland

Sir,

The authors of the report on computer use in Scotland (*August Journal*)<sup>1</sup> draw attention to the lower than expected use of computers by GPs.

In April 1997, a questionnaire was sent to all practices in Fife using the Health Board e-mail requesting details of audit and guideline use by practices. Fife Health Board had connected all practices to a server at the Health Board offices using Microsoft Mail. The system was used as part of the cascade mechanism for distributing urgent information to GPs in Fife (it has largely been superseded by the NHS-net).

The questionnaire was sent to 62 practices in Word 6 format, and instructions were given on how to complete the questionnaire and return it electronically. Overall, there was a 45% response.

Only two practices completed and returned the questionnaire electronically. The average time to access the mail was 48 hours, but seven practices took a month or longer to access their mail. A number of practices contacted the senders within three weeks to request a hard copy, being unable to open the document as they did not have compatible software. Seventeen practices that had not accessed their mail nor returned their questionnaire after three weeks were contacted. Six practices were no longer connected to the system or no longer used it. The practice manager in one practice was on holiday and no one else was allowed to use the computer to access the e-mail. The remaining 10 had been unable to open a Word 6 document.

Ensuring practices are using compatible software, and have staff confident in its use and value, is a challenge for those who advocate the use of computer technology in general practice. In Scotland, all practices that wish to do so have been connected to the NHSnet, and there is an expectation that by the year 2002 general practices will use this to make appointments with hospital consultants prior to the patient leaving the surgery. While this is technically possible, unless staff are encouraged to use the NHSnet as part of their day to day routine, given ongoing training, and are convinced of its usefulness, this goal is unlikely to be achieved.

EDWIN WALLACE

Centre for Health and Social Research  
Glenrothes House  
North Street  
Glenrothes KY7 5PB.  
E-mail: Edwallace@MSN.com

KIM CHALMERS

Audit Facilitator  
Fife Health Board,  
Springfield House,  
Cupar KY15 5UP

### Reference

1. H M Richards, F M Sullivan, E D Mitchell, S Ross. Computer use by general practitioners in Scotland. *Br J Gen Pract* 1998; **433**: 1473-1476.

### 'Home hypertension'

Sir,

Donner-Banzhoff *et al* (*August Journal*)<sup>1</sup> compared subjects with negative clinic-home blood pressure difference (CHBPD) with those with positive CHBPD and suggested that home blood pressure measurement cause an alerting

reaction. CHBPD may be partly a result of biological variability.

Another explanation for negative CHBPD is that the home blood pressure was not measured in a standardized manner. Specifically, subjects with negative CHBPD, who had a lower mean blood pressure at the office, might be less concerned about their blood pressures and might exhibit shorter waiting times before measurement.

Although there may be some unknown confounders, our findings strongly suggest that self-measurement causes an alerting reaction. We reported a case whose blood pressure, measured at two-minute intervals by an ambulatory blood pressure monitor, rose transiently and reproducibly as a result, but did not rise without self-measurement.<sup>2</sup> On the other hand, Parati *et al* reported that intra-arterial blood pressure in 20 hypertensive inpatients did not rise by self-measurement.<sup>3</sup> The effect of self-measurement on home blood pressure should be compared with controls in future studies in the primary care setting.

YASUHIRO ASAI

Department of Community and Family  
Medicine  
Jichi Medical School  
Yakushiji 3311-1  
Minamikawachi  
Tochigi 329-0498  
Japan

### References

1. Donner-Banzhoff N, Chan Y, Szalai JP, Hilditch J. 'Home hypertension': exploring the inverse white coat response. *Br J Gen Pract* 1998; **48**: 1491-1495.
2. Asai Y, Nago N, Kario K. Home blood pressure elevation by self-measurement. *Blood Pressure Monitoring* 1998; **3**: 9-10.
3. Parati G, Pomidossi G, Casadei R, Mancia G. Lack of alerting reaction to intermittent cuff inflations during non-invasive blood pressure monitoring. *Hypertension* 1985; **7**: 597-601.

### Concordance for hypertension between spouses

Sir,

The case-control study by Hippisley-Cox and Pringle (*September Journal*)<sup>1</sup> suggests that spouses of people with hypertension have a two to three times increased risk of hypertension themselves. This epidemiological association has been demonstrated on many occasions since it was first noted in the early 1960s.<sup>2</sup> Both environmental and constitutional factors are known to be important in the aetiology of hypertension. Married couples will tend to show clustering of many of these factors as a result of

both shared environment and assortative mating.<sup>3</sup> Ascertainment bias, resulting from an increased probability of being diagnosed hypertensive if one's spouse is known to be hypertensive, will also contribute, as the authors acknowledge. The findings of their study are therefore not surprising.

The authors suggest that an important explanatory factor of these findings is shared diet, and that dietary interventions aimed at couples where one partner is known to be hypertensive are indicated. Their results invite other possible interpretations and conclusions. The only important potential confounding variables they control for in their multivariate analyses are age, diabetes, and body-mass index. Other important risk factors for hypertension are likely to cluster in couples. Concordance of partners for physical activity, alcohol consumption, and social position are equally plausible explanations of the association they report.

The results of individual-level behavioural (including dietary) interventions in natural rather than experimental settings are not impressive and do not suggest that investment in this type of strategy is likely to lead to significant improvements in cardiovascular health.<sup>4</sup> In particular, the authors mention the importance of dietary sodium consumption in the aetiology of hypertension. Most dietary salt is 'hidden', and efforts to reduce it should be directed at food processors rather than individual consumers.<sup>5</sup> Primary care doctors would be better employed directing their energies towards improving their delivery of interventions with proven efficacy. This seems particularly true given the scope for improvement in this area.<sup>6</sup>

JOHN MACLEOD

Department of General Practice  
University of Birmingham  
Edgbaston  
Birmingham B15 2TT

#### References

- Hippisley-Cox J, Pringle M. Are spouses of patients with hypertension at increased risk of having hypertension? A population-based case-control study. *Br J Gen Pract* 1998; **46**: 1580-1584.
- Chazan JA, Winkelstein W. Household aggregation of hypertension: report of a preliminary study. *J Chron Dis* 1964; **17**: 9-18.
- Sackett DL, Anderson GD, Milner R, *et al*. Concordance for coronary risk factors amongst spouses. *Circulation* 1975; **52**: 589-595.
- Ebrahim S, Davey Smith G. Systematic review of randomised controlled trials of multiple risk factor interventions for preventing coronary heart disease. *BMJ* 1997; **314**: 1666-1674.
- Watt G, Hart JT. Slow decremental change in dietary sodium load in whole populations is needed. [Letter.] *BMJ* 1997; **315**: 486.
- Fahey T, Peters TJ. Clinical guidelines and the management of hypertension: a between-practice and guideline comparison. *Br J Gen Pract* 1997; **47**: 729-730.

#### Association between having a spouse with hypertension and an increased risk of hypertension may not be real

Sir,

Hippisley-Cox and Pringle (September *Journal*)<sup>1</sup> found an apparent association between having a spouse with hypertension and an increased risk of hypertension for both men and women, and a reduced risk of hypertension for women who are part of a couple compared with single women, and concluded that there are significant environmental factors in the aetiology of hypertension.

There are at least two explanations for the observed association between having a spouse with hypertension and an increased risk of the disease. First, as a result of increased awareness by both patients and health professionals, those whose spouse had a diagnosis of hypertension may be more likely to have their blood pressure monitored and are hence more likely to have their condition uncovered. As most patients had a blood pressure reading within the past 24 months, in both cases and controls, the adjustment for this binary variable in the multivariate analysis is unlikely to correct fully for this effect. The number of blood pressure readings in the past 24 months may be a more appropriate and sensitive variable for this purpose. Secondly, as doctors usually look after both members of the couple, those whose spouse had a diagnosis of hypertension may be more likely to have their diagnosis recorded on computer. Indeed, Pringle *et al* previously found a wide range of hypertension prevalence amongst the four general practices in the Trent Region, and commented that hypertension was less consistently recorded than other diagnoses such as diabetes mellitus or glaucoma.<sup>2</sup> A cohort study may be needed to overcome these methodological difficulties.

The reduced risk of hypertension for women who are a member a couple compared with single women found on univariate analysis may be simply because 'single' women within the study population were older than those who were a member of a couple. The study population were those over the age of 30, and single women were likely to be widowed. The

fact that women are more likely to be widowed than men in older people may explain the authors' observation that the risk of hypertension for men who were a member of a couple was not significantly lower than 'single' men.

The authors called for the costs and benefits of intense surveillance among spouses of hypertensive patients to be determined. Even if there were significant environmental factors in the aetiology of hypertension, hypertensive patients' genetically-related household members would have a higher risk of developing hypertension than their spouses. Our surveillance efforts should initially be targeted on this higher risk group.

WAI-CHING LEUNG

Department of Public Health Medicine  
Sunderland Health Authority  
Durham Road  
Sunderland SR3 4AF  
E-mail: W.C.Leung@ncl.ac.uk

#### References

- Hippisley-Cox J, Pringle M. Are spouses of patients with hypertension at increased risk of having hypertension? A population-based case-control study. *Br J Gen Pract* 1998; **46**: 1580-1584.
- Pringle M, Ward P, Chilvers C. Assessment of the completeness and accuracy of computer medical records in four practices committed to recording data on computer. *Br J Gen Pract* 1995; **45**: 537-541.

#### Stop prescribing Temazepam?

Sir

The recent article concerning the stopping of Temazepam (September *Journal*)<sup>1</sup> was very interesting. We are all too aware of the bad press that many GPs have come in for regarding the supply of these tablets on the black market. However, I feel that rather than just stopping these medications without patient involvement, it may be more useful to review why these patients were prescribed them in the first place. It may be that an underlying depression was overlooked.

Patients have a right to be involved in their treatment, and creating patient dissatisfaction in stopping regular medications, which many patients rely on, is not ideal. Indeed, it may well make it increasingly difficult to develop a healthy therapeutic relationship in the future.

Although the results in the study seem impressive, it must be remembered that other studies have shown that chronic benzodiazepine use can be reduced by almost one-third simply by mailing information



to patients.<sup>2</sup>

There have been many reports of withdrawal syndromes in long-term users of short-acting benzodiazepines when switched to long-acting benzodiazepines;<sup>3</sup> I wonder if patients were informed of this possible reaction before being 'enrolled' into this study?

We are living in a time when patients must become part of the prescribing contract, and the notion that patients attend to collect their prescription, but instead find themselves given something totally different that doesn't work in most cases, is not acceptable.

The way forward is through education, not 'doctor knows best'.

DERMOT NOLAN

Department of General Practice  
Guy's, King's and St Thomas' Medical  
School  
Weston Education Centre  
Bessemer Road  
London SE5 9PJ

## References

1. Gilhooly T, Webster M, Poole N, Ross S. What happens when doctors stop prescribing Temazepam? Use of alternative therapies. *Br J Gen Pract* 1998; **48**:1601-1602.
2. Tiller J. Reducing the use of benzodiazepines in general practice. *BMJ* 1994; **309**: 3-4.
3. Conell LJ, Berlin RM. Withdrawal after substitution of a short-acting for a long-acting benzodiazepine. *JAMA* 1983; **250**: 2838-2840.

## Bereavement care

Sir,

I was interested to read the survey of bereavement care by Harris and Kendrick (September *Journal*).<sup>1</sup>

The keeping of a death register is, of course, important,<sup>2</sup> but is only half the story. Many patients requiring bereavement support have lost relatives who were not our patients. Their needs are equally valid, but as a group they are harder to identify. Many will, however, present to us soon after bereavement with physical or grief-related problems.

In my practice, we keep a bereavement register. Any team member who knows of someone who is bereaved, enters the details in this record. Relatives' names are included, and we mark the notes and computer records. We send a simple practice sympathy card soon after the bereavement notification whenever possible. A home visit occurs if appropriate. The card serves the dual purpose of indicating to the bereaved that the practice team is aware of

their loss and that they are also offering an open-ended invitation to the patient to come and talk when the time is right for them. Later we send an invitation to our bereavement group — an hour-long meeting fortnightly for six sessions. Our counsellor and myself run the group. Patients can share experiences, question a doctor on medical queries about the deceased's last illness, get practical advice about sorting out the deceased affairs, and make social contacts that may lead to longer-term mutual support. For those who dislike groups, our local bereavement service offers trained bereavement visitors who can visit at home with the frequency of visits varying according to need.

We have found the leaflet entitled *Bereavement*<sup>3</sup> helpful, and have a small patient library of books on grief and loss.

The bereaved are wounded, vulnerable, and often exhausted. I certainly agree that bereavement care must not be imposed, but, unless the support services available are visible and easily accessible, the chance to provide simple, yet invaluable help may be missed. The grief journeys of our patients may then be needlessly prolonged.

C M MUNRO

Highview Medical Centre  
20 Southgate Road  
Potters Bar  
Herts EN6 5DZ

## References

1. Harris T, Kendrick T. Bereavement Care in General Practice: a survey in South Thames Health Region. *Br J Gen Pract* 1998; **48**: 1560-1564.
2. Charlton R, Dolman E. Bereavement: a protocol for primary care. *Br J Gen Pract* 1995; **45**: 427-430.
3. Royal College of Psychiatrists. *Bereavement*. London: Royal College of Psychiatrists, 1998.

## Questionnaire responses and clinical practice in bereavement care — mind the gap

Sir,

Harris and Kendrick's paper on bereavement care in South Thames (September *Journal*)<sup>1</sup> provides a useful description of existing practice. At a time when the traditional personal style of general practice is thought to be under threat,<sup>2-4</sup> it is important for the profession to debate how best to support the bereaved. Indeed, their paper appears to reveal differing views among GPs toward the practice of bereavement care.

However, I feel it is important to rec-

ognize the potential for bias when asking the senior partner about their particular practice's approach to bereavement; I feel this needs more emphasis. Most readers will recognize that senior partners do not always speak for their partners. More importantly, it is essential to appreciate the discrepancy between what GPs say they do and what actually happens in practice. Cartwright's study of bereavement revealed that 51% of patients whose GP had stated that all bereaved patients should receive a visit did not see their doctor within seven months of their loss.<sup>5</sup> Although we have no way of knowing if a similar recall bias is at work in the paper being reviewed here, equally we have no reason to presume that its sample population will be responding differently. The gap between perceived levels of care and actual practice observed by Cartwright may have curious explanations. We can only speculate as to what these might be, but it is probable that, whether a bereaved patient receives a visit or not, is not down to chance alone and that certain groups are being cared for differently to others.

When considering the future of general practice bereavement care, it is important to have informed debate and also appreciate GPs may not always deliver the quality of care they believe they provide.

RICHARD WOOLF

Department of General Practice  
The Medical School  
University of Birmingham  
Edgbaston  
Birmingham B15 2TT

## References

1. Harris T, Kendrick T. Bereavement care in general practice: a survey in South Thames Health Region. *Br J Gen Pract* 1998; **48**: 1560-1564.
2. McCormick J. Death of a personal doctor. *Lancet* 1996; **348**: 667-668.
3. Baker R. Will the future GP remain a personal doctor? *Br J Gen Pract* 1997; **47**: 831-834.
4. Taylor MB. Compassion: its neglect and importance. *Br J Gen Pract* 1997; **47**: 521-523.
5. Cartwright A. The role of the general practitioner in helping the elderly bereaved. *Br J Gen Pract* 1982; **32**: 215-227.

## Recruitment of general practitioners to a randomized trial

Sir,

FC Taylor *et al* (October *Journal*)<sup>1</sup> are sanguine in their experience of recruiting GPs for research. We have recently commenced a smaller scale randomized controlled trial/training programme in

Cognitive Behavioural Therapy for Panic Disorder in primary care using Culyer funding. Our successful bid included a substantial proportion dedicated to paying the participating GPs' expenses for day-time training and assessment sessions, as well as offering 18 hours PGEA. These inducements resulted in recruitment of 20 out of the 300 GPs in Sheffield with just one flier distributed through the Health Authority's internal mailing system. There is no question about the GPs' enthusiasm for the content of the study having been appropriately rewarded for the time spent learning something new and useful. Hopefully this is the pattern for future bids involving GP time and commitment to research and development in primary care.

CHARLES HEATLEY  
TOM RICKETTS  
JULIE FORREST

Panic Disorder in Primary Care  
Birley Health Centre  
120 Birley Lane  
Sheffield S12 3BP

#### Reference

1. Taylor FC, Davidson O, King M, *et al.* Recruitment of general practitioners to a randomized trial. [Letter.] *Br J Gen Pract* 1998; **48**: 1704.

#### General practice or primary care?

Sir,

There seems to be some confusion in the viewpoint (Back Pages, August *Journal*)<sup>1</sup> as to what is a 'general practitioner' and what is 'primary care'. They are not the same.

The Royal College of General Practitioners should continue to promote excellence in general medical practice, encourage professionalism and the ideals of integrity and expertise, and the continued personal learning and development it stands for. 'Primary care' includes first aid, ambulance and paramedic services, accident and emergency departments, and now the NHS Direct helpline. These are separate and diverse areas, although often working together in development, and benefiting from good working relationships on the ground to help patients. Any attempt by any section to take control of the others would quite likely cause divisions and a lack of cooperation among camps competing for 'power'.

The work and training of GPs is unique. Contrary to the view expressed in the article, many GPs see their role as helping patients and others to gain access to the health information they need, rather than

keeping it secret. Giving just anyone, regardless of their training and knowledge, the mandate to hand out what information they think appropriate and put the College's name to it, would demean the College and its reputation for excellence among patients. If this is just another attempt by nurses to edge into what they see as a bastion of medical power, then it would show up the low morale in nursing and suggest lack of confidence in the esteem of the College of Nursing. Perhaps the RCN has indeed lost its way, and is more interested in cutting in on the success of others than in promoting excellence and professionalism in real clinical nursing?

I am reminded of the parable of the sower (from the Bible), where some seed falls on good ground and has space to put down good roots, but other seed has only shallow roots, and so withers and dies in the heat of the sun. The Royal College of General Practitioners has developed good roots and a sturdy and trustworthy trunk, even if it has some work to do in improving its yearly output of fresh growth and fruition in the new Millennium. There is a fashion for cutting off one's roots and eschewing tradition that has been evident in the '80s and '90s, but this fad is now ending as people find they are 'rootless' and start looking for their origins again. Roots are the basis of identity.

A Royal College that throws away too much of the assets of the years and tries to enter the new Millennium with a faddy but unrecognizable face, will fall by the wayside just like last year's clothes fashions.

DAVID CHURCH

Mid-Wales  
E-mail: churchs@geocities.com

#### Reference

1. Kernick D. From the Royal College of General Practitioners to the College of Primary Care? [Back Pages.] *Br J Gen Pract* 1998; **48**: 1537.

#### Costs are a barrier to GPs performing skin prick testing

Sir,

There is increasing evidence to support the use of allergen avoidance measures in the management of atopic patients with allergic conditions such as asthma, rhinitis, and eczema.<sup>1-4</sup> The accurate identification of the allergic trigger involves taking a detailed allergy history and confirming one's clinical suspicion with a skin prick test (SPT).<sup>5,6</sup> This test is safe and has the potential to deliver considerable improvements in patient care; however, there are

very few GPs offering SPT and allergen avoidance advice to their atopic patients.

Skin prick tests are currently available from specialist allergy centres, necessitating a referral (with costs thereof), or from GPs prepared to buy the test reagents themselves. The latter is an obvious barrier that may be removed by paying trained GPs an item-of-service fee and adding these items to the drug tariff.

AZIZ SHEIKH

Department of General Practice  
Imperial College School of Medicine  
Norfolk Place  
London W2 1PG

MARK L LEVY

The Kenton Bridge Medical Centre  
155-175 Kenton Road  
Kenton  
Harrow  
Middlesex HA3 0YX

#### References

1. Sporik R, Holgate ST, Platts-Mills TAE, Cogswell JJ. Exposure to house dust mite allergen and the development of asthma in childhood. *N Engl J Med* 1990; **323**: 502-507.
2. Ehnert B, Lau-Schadendorf S, Weber A, *et al.* Reducing domestic exposure to dust mite allergen reduces bronchial hyperreactivity in sensitive children with asthma. *J Allergy Clin Immunol* 1993; **90**: 135-138.
3. Hide DW, Matthews S, Tariq S, Arshad SH. Allergen avoidance in infancy and allergy at 4 years of age. *Allergy* 1996; **51**: 89-95.
4. Durham SR. Allergen avoidance measures. *Resp Med* 1996; **90**: 441-445.
5. Cross S, Buck S, Hubbard J. Allergy in general practice. *BMJ* 1998; **316**: 1584-1587.
6. Rusznak C, Davies RJ. Diagnosing allergy. *BMJ* 1998; **316**: 686-689.

#### Practice information on audiotape for visually-impaired patients

Sir

General practitioners are obliged to provide information about their practice in a leaflet.<sup>1</sup> Since one in sixty people are registered blind or partially-sighted, a number of patients in each practice will not be able to gain access to this information. To overcome this we have developed an audiotape of the leaflet for one rural dispensing practice.

A recording was made from a transcript of the printed practice leaflet. It was broken up into sections covering emergency and out-of-hours telephone numbers, the appointment and repeat prescribing systems, consultation times and opening hours, visiting arrangements, health pro-

**Table 1.** Responses to questionnaire.

Question	Yes	No
If you were a patient joining the practice, would you find the tape helpful?	25	0
Is it of more use than the usual printed leaflet?	24	1
Was important information, such as our emergency telephone number, easy to find on the leaflet?	0	25
Was it easier to find this information on the tape?	25	0
Do you think that your own practice should be encouraged to produce such a tape?	25	0
Could you give the tape a score out of 10? (0 - of no use; 10 - couldn't be better)	Mean score	9.0 <sup>a</sup>
Could you give the leaflet a score out of 10? (0 - of no use; 10 - couldn't be better)	Mean score	0.1 <sup>a</sup>

<sup>a</sup>Difference between means = 8.88; t-test for difference; t = 32.67, P < 0.001.

motion, supplementary services, training, and staff. It also included telephone numbers for hospitals, social services, and community mental health teams. One male and one female voice were used on the tape to break up headings and sections of information.

To pilot the tape, it was sent to volunteers from blind and partially-sighted groups around Devon, who were asked to assess the tape as though they were joining the practice; the usual printed version was also made available. They were also asked to reply to a short questionnaire, which was included on the tape (Table 1).

The tape was very positively received, with useful suggestions for additions, such as details of disabled access, whether the staff had received disability awareness training, how a patient would know when the doctor was ready to see them, and adding the doctors' voices to the tape to aid recognition.

Following this pilot, we produced, with the aid of the Royal National Institute for the Blind (RNIB) transcription service, a tape for use in the practice, with Braille on the cassette for identification and audible tone cues that allow fast-forwarding between sections for rapid access.

This project has demonstrated a need for recorded information for visually-impaired patients, many of whom are elderly<sup>2</sup> and are therefore likely to need access to their general practitioner.

Audio cassettes are a popular medium for information.<sup>3</sup> Production of the tape was straightforward and inexpensive, but the recording must be of good quality. The RNIB can produce tapes for a modest charge and publish a fact sheet on production of audiotapes.<sup>4</sup>

Visually-impaired people are disadvantaged in their access to medical information.<sup>5</sup> Participants commented on this tape's potential for increasing the confidence of visually-impaired patients in using the surgery independently. This may benefit the practice if their services are then used more appropriately.

CHRISTOPHER E CLARK

The Mid Devon Medical Practice  
School Surgery  
Fore Street  
Witheridge  
Tiverton  
Devon EX16 8AH

SALLY BOURNE

Living Options Devon  
Ashclyst Centre  
Hospital Lane  
Whipton  
Exeter  
Devon EX1 3RB

#### References

1. *Statutory Instruments* 1992 No 635. The NHS (GMS) Regulations. London: HMSO, 1992.
2. Royal National Institute for the Blind. *Blind and partially sighted people in Britain*. London: HMSO, 1991.
3. Marsland D, Leoussi AS, Norcross P. Disability abated: Audio cassettes for the visually impaired. *J R Soc Health*. 1994; **114**: 29-32.
4. Royal National Institute for the Blind. *See it right - An introduction to tape*. London: RNIB, 1998. Also available on the Internet at <http://www.rnib.org.uk/wesupply/fct-sheet/sirtape.htm>
5. Raynor DK, Yerassimou N. Medicines information - Leaving blind people behind? *BMJ* 1997; **315**: 268.

#### Design of asthma inhalers

Sir,

The manufacturers of inhaled bronchodilators are currently involved in the extremely important job of redesigning them to be chlorofluorocarbon (CFC) free. There is another factor that should be taken into consideration at the same time: a generic Salbutamol inhaler has gaps on either side of the canister. This gap allows debris to drop down the barrel to the bottom of the inhaler, from there it can be inhaled, particularly with the vigorous

inspiration that asthmatic patients use with their inhalers. Other inhalers; for example, generic breath-activated inhalers or some non-generic devices such as AIROMIR, do not have gaps around the canister and are less likely to allow objects to be inhaled.

A decision to change the design can be made on the grounds of common sense, without the need to resort to prospective trials. A change may save future patients from the transient unpleasantness of inhaling foreign bodies and, on occasions, from significant morbidity caused by localized patches of bronchiectasis.

J N H EISENBERG

Macklin Street Surgery  
90 Macklin Street  
Derby DE1 1JX