**Note to authors of letters:** Letters submitted for publication should not exceed 400 words. 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.

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## Otitis externa

The article on otitis externa in general practice by Rowlands *et al*[1] contains a vast amount of data but perhaps some errors of omission in the overview on suggested management tips for 'sharp end' general practitioners.

1. The old but wise therapeutic adage that it is not what you put in the ear with otitis externa that effects a cure, but what you take out of it, is nowhere considered.
2. The complete failure to admit that one can only diagnose otitis externa in a discharging ear, when a clinical examination has excluded a perforation of the ear drum and thus chronic suppurative otitis media. This is a less frequent clinical problem than a generation ago, but still needs consideration as its sequelae can be disastrous and even fatal.

The skills required for effective aural toilet are no more demanding than, for example, the fitting of intrauterine devices. Ear nose and throat consultants will perhaps use a head mirror and a slightly expensive light fitting to facilitate this procedure, leaving both hands free, so that this gives an impression of special expertise. Any camping or climbing shop will sell a head torch, for perhaps £10, which functions just as adequately and facilitates this procedure, if focused on the narrowest spot beam.

Any general practice could encourage one partner, or nurse, to acquire such skills. The wool holders and the cotton wool are cheap, and the ability to repeatedly make a 'paint brush' of approximate size until the meatus is mopped free is an easily acquired skill. The procedure takes perhaps two or three minutes on average. With the normal external meatus oedema, all of the eardrum cannot usually be seen, but when enough is exposed then asking for a Valsalva manoeuvre to be performed will, if it shows the normal positive 'click', exclude a perforation, and thus chronic suppurative otitis media.

This aural toilet will also allow air to contact the stratified squamous epithelium of the external auditory meatus, which is not designed to cope with the serous discharge of otitis externa.

Three other tips, not backed up by collected data, but perhaps worth quoting:

1. Rather than ask the patient, 'Do you scratch your ear?', ask, 'Show me how you scratch your ear'. The vigorous response of agitated prolonged rotation of the tip of the little finger in the ear is almost diagnostic. Suggest that they avoid this habit, for say, three decades! If they do break this habit, following your effective aural toilet and allowing air in the meatus, many will be cured very rapidly, particularly if they have broken the 'scratch-itch-cycle'. This persuasion may sometimes require a non-fashionable 'Sir Lancelot Spratt approach,' but will help many patients with otitis externa.
2. If you feel the patients do need topical steroid, for what is in effect an active secreting skin atopy in a small cavity (where steroids would be expected to be curative), giving these in an aqueous base will unfortunately cause yet more skin maceration. An alternative prescription is the alcohol-based Betnovate scalp lotion. I believe this to be the only such spirit-based preparation in MIMS. It will sting initially, but be more effective than the steroid or steroid plus antibiotics aqueous-based topical medication mentioned in Rowlands *et al*.
3. Ask the patient if they have cotton buds in the house. Most will have, and again suggest forcefully that they be placed in the dustbin and no more purchased for three decades. This will also cure many a patient. The ear has a most refined self-cleansing mechanism for debris, and its contents will be impacted in the depths of the meatus by these intrusive foreign bodies.

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## Improving access in primary care

The public's top concern about the NHS is waiting for treatment and the NHS plan states that, by 2004, all patients will be able to see a GP within 48 hours. Although the communication revolution has transformed our society, primary care has been slow to make use of these advances for the benefit of the public and many consultations still occur face to face. The exceptions to this have been in the out-of-hours services and NHS Direct, where telephone consultations have revolutionised the provision of care to the public. Previous studies have shown that patients approve of telephone consultations[1-3] and use them as an alternative means to access medical advice.[4] I am a single-handed GP principal with a list size of 2800 and have been 'paperless' for seven years, with all patient consultations recorded on the computer and all important morbidity data Read coded and audited annually. Since August

*Table 1. Consultation activity: annual rate (%) per 1000 registered patients.*

| Year | Surgery consultations | Home visits | Telephone consultations | Total |
|---|---|---|---|---|
| 1/4/97–31/3/98 | 2668 (88) | 225 (7.4) | 133 (4.4) | 3026 (100) |
| 1/4/98–31/3/99 | 2580 (81) | 221 (7.0) | 388 (12.0) | 3189 (100) |
| 1/4/99–31/3/00 | 2589 (77.8) | 202 (6.1) | 538 (16.1) | 3329 (100) |
| 1/4/00–31/3/01 | 2494 (74.5) | 194 (5.8) | 658 (19.7) | 3346 (100) |

1996 I have recorded all consultation activity according to location using our EMIS clinical system.

Table 1 shows that the annual consultation rate rose by 10.6%, from 3026 per 1000 registered patients in 1998 to 3346 in 2001. However, a comparison of surgery and visit activity showed a decline of 6.5% and 13.8% respectively. Telephone consultation activity has risen nearly fivefold and now accounts for almost 20% of all consultation activity.

The overall face-to-face consultation rate remained constant at about 2600 for the first three years, which is comparable with the average rate in 1991/92 for England and Wales.[5] In the past year, however, it has dropped to 2500. In comparison, a more recent study involving 23 Sheffield practices between 1996 and 1967 showed that the face-to-face consultation rate was 36% higher, at 3400.[6]

This study shows that telephone consultations increases activity and may help GPs to meet NHS targets of access to primary care.

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## *Chlamydia trachomatis*: opportunistic screening in primary care

Congratulations to staff at the White Rose Surgery for achieving a 78% invitation rate to take part in chlamydia screening.[1] This must reflect considerable effort from all members of their team. However, we would like to raise a cautionary note that this success might not be reproduced if opportunistic chlamydia screening were to be introduced on a larger scale without adequate remuneration and education.

We carried out a study of chlamydia screening in eight general practices in Edinburgh, using urine testing among women aged 20 years or under attending for contraception and among women aged 35 years or under who were attending for cervical screening.[2] The chlamydia tests were paid for by a research grant, but practices received no payments for recruiting patients. Most practices were running 10-minute appointments. The researchers attended practice meetings: recruitment materials were kept in all consulting rooms and reminders about the study were sent monthly to all participating staff. We carried out a check of notes and cervical smear lists at the end of the study and found that only 539/1496 (36%) of eligible women had been invited to take part in the study. Most practice staff cited lack of time as the main barrier to recruitment.

As well as public education, there is a need for professional education about chlamydia screening if primary care is to play a greater role in sexual health.[3] The CMO Expert Advisory Group report on chlamydia screening[4] notes that the introduction of the screening programme must be accompanied by realistic negotiations about fees for extra work. The findings from our study suggest that, unless this is the case, any screening programme will fail to be widely enough offered to commute to health benefits. A structured incentive scheme that does not discriminate against practices in deprived areas may be most likely to produce results.[5]

Evidence of the feasibility of chlamydia screening from individual highly motivated practice teams and well-funded pilot studies is welcome. However, if opportunistic screening were to be introduced more widely then this would risk failing to deliver expected health gains unless adequate resources and training are in place.

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## The end of single-handed practice?

It is most unfortunate and not at all helpful that two non-GPs, one working as an epidemiology lecturer and the other a government paid civil servant should continue to propagate the myth that single-handed practitioners are, in some way, more dangerous than group practice doctors.[1]

Their laughable evidence is an anecdote that one GP self-abused pentazocine. They don't even say whether the GP was single-handed. However, according to Peterkin and Coid this is unlikely to occur in group practices. Where, one wonders, is their evidence for this?

Despite this lack of serious proven evidence the happy two dangerously and, perhaps, sycophantically, go along with the Milburn policy and demand that single-handed doctors be treated more stringently, needing to provide the health authority with a higher burden of proof of competence and, even, regular health checks.

Are readers to assume that their contribution to the journal is part of a new light relief comic section?

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1. Peterkin G, Coid D. The end of single-handed practice? [Viewpoint.] *Br J Gen Pract* 2001; **51:** 769.

I was interested in the Viewpoint by Gordon Peterkin and Donald Coid (September *BJGP*, Back Pages). The author's argue that single-handed practice should perhaps end because, among other things: (a) statisticians cannot use death certification to rule out murders; (b) solitary practice can be a formidable burden; and (c) some time ago a GP made a late presentation to hospital with drug addiction.

I find most of these arguments unconvincing in the extreme. Very many single-handed practitioners work in effective teams where all the team members observe each others' practice very closely.

As continuity of care receives increasing attention, there is good evidence that patient satisfaction is higher when consulting the same doctor, and in practices that are 'small, non-training, or have personal lists'.[1-5]

I am not aware of any evidence that partners are good at spotting murderers or drug abusers in their midst. Partnerships undoubtedly have many advantages (for most — but not necessarily all?), yet single-handed practice is the only viable possibility for many remote and rural areas. Would the authors be happy to reduce rural patients' access to health care to ensure that there are no single-handed practitioners?

Many of us actually working in rural practice do not foresee the end of single-handed practice. Certainly these doctors deserve much support; for example, initiatives such as the introduction of associate GPs have enormously improved the lot of single-handed GPs and their patients; one of the (few) outstanding successes of the 1991 Contract. They do *not* deserve extinction.

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### *Authors' response*

I think David Roberts has missed the point of the article. General practice is increasingly a team effort, and where single-handed practice is inevitable or desirable, support mechanisms need to be put in place to ensure the health of the practitioner, quality of care, and peer review in some form.

The world is changing. Brian Keighley's suggested model of a 'penny farthing', where single-handed practitioners are supported by larger practices, sounds creative and worthy of development.

Lastly, although I confess to being a reluctant bureaucrat at this moment, I did spend 26 years in clinical practice.

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## Management of patients with depression

Baker and his colleagues[1] should be commended for their attempt to measure the effects of tailored strategies to implement guidelines.

However, there seem to be many issues that have not been addressed. There are differing beliefs about the nature of the condition named 'depression'. Cultural and religious differences in attitudes to human misery, self-experience of the condition among GPs, and anxiety about workload and the changes required to alter the learned behaviour of GPs who try to control consultation length by not asking open questions, are all likely to have contributed effects that could have altered the outcomes.

Even more concerning is the belief that depression is a stand-alone condition in primary care. Universal experience is that, certainly in general practice, it is often accompanied by anxiety and is associated with a range of physical conditions and affected by social conditions, unemployment, bereavement, homelessness, and so on. Depression seems increasingly to be used as a shorthand description which fails to capture the dimensions of a complex condition. The act of naming certainly doesn't justify treatment.

There appears to be a widening gulf between academic researchers who believe in the existence of a clear-cut condition called 'depression', and their misguided beliefs that: (a) medication is highly effective (which it is not); (b) that cognitive behavioural therapy is a treatment of choice based on highly doubtful premises; and (c) that high (therapeutic) doses must be prescribed and that maintenance of this treatment for many months is required on the one hand, and the beliefs of many who work in the frontline of general practice and their patients, or have time to read the literature (which tells a radically different story), who think differently.

Explaining general practitioners' behaviour in terms of the psychological theory used is unhelpful. Much more fundamental questions need answers: defining the role of the pharmaceutical industry in promoting depression as a diagnosis; inventing a multiplicity of questionnaires to detect depression; and the role of society in seeing a compliant medicated population as an answer to unmet need and for reducing the effects of social exclusion.

I think we need a new way of helping misery, which should allow for appropriate and timely medication for those with what is named as severe major depression. Luckily, the numbers of patients with the condition are small. A new way of caring for what is named 'mild to moderate depression' which, from the evidence available, doesn't respond to medication but is nevertheless frequently treated in this way, would save countless millions of pounds. This money could be put to good use in other ways, including the provision of brief psychological therapy in primary care of proven worth, which would be greatly valued by patients, and perhaps finding measures to alleviate hopelessness and helplessness felt by so many deprived and socially excluded patients and their families — politicians have a responsibility here.

Finally, I am surprised that only two out of the 64 GPs in the study were reported to be depressed. It would have been instructive to have taken the time to find out the status of the psychological health of all the GPs who took part and to measure its impact on their ability to cope with and care for the misery of others.

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### *Authors' response*

Jenkins is right to differentiate between patients with major depression and those with mild to moderate depression. There is good evidence to show that those with major depression do respond to medication when it is prescribed in adequate doses for a sufficient period. Despite this evidence, however, patients with mild to moderate depression continue to receive antidepressants. Our guidelines used the ICD-10 or DSM-IV criteria to define cases of major depression justifying treatment. Our intervention did not significantly reduce the proportion of people with mild to moderate depression who were given medication. Thus, it appears to be practitioners, rather than academic researchers, who have a misguided belief in the value of medication.

We agree that better ways are needed to help people with mild to moderate depression. It was striking that a proportion of a GPs in the intervention group expressed reluctance to assess suicide risk because they did not have confidence in their verbal ability to explore this with their patients. If, after all the attention given to communication skills in recent years, some GPs cannot manage this core element of the assessment of psychological state, there must be a long way to go before we can expect all GPs to have the ability to 'capture the dimensions of a complex condition'.

It would indeed have been interesting to investigate the psychological health of all the participating GPs. It is uncommon for a detailed investigation of the obstacles to change to be undertaken prior to selecting implementation strategies for guidelines, and our exploratory study points the way to various obstacles that might be considered in future studies. These include the psychological state of the participating practitioners and also their ability to talk with patients.

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## Proton pump inhibitors: perspectives of patients and their GPs

Grime and colleagues[1] have suggested that adopting more restrictive prescribing protocols and the modification in patients' lifestyles could reduce the prescribing of proton pump inhibitors (PPIs).

Over the years we have addressed the prescribing of PPIs (as they form a significant percentage of our prescribing budget). We have also tried the wholesale switching of patients on one brand to another, which unmasked a range of unacceptable side-effects.

More successful strategies have been to ask individual GPs to review a list of their patients on high dose PPIs and consider whether a switch to a lower maintenance dose would be appropriate. Perhaps more important is to consider a step up and step down approach where the patient's symptoms are reviewed before either a lower maintenance doses is instituted, or a switch to $H_2$RAs or simple antacids, which may control symptoms. Prescribing can be stepped up if symptoms recur or deteriorate. It remains important to address lifestyle issues during all these consultations and this is clearly stated on the opening page of the joint formulary produced by the local NHS trust and all of the local PCGs.[2]

Adopting these measures with PPI prescribing as part of a rolling review process has helped us contain our prescribing costs overall, which converted a 7% overspend to a 5% underspend in two years. In the last quarter of 2000 (the latest data available from PACT) our GI costs have been reduced by 19% from the equivalent quarter in 1999 and was 16% less than the average for the health authority.

It would seem the recommendations of Grime and colleagues have been instituted in some practices and I would commend them as being effective in reducing costs. As we are increasingly feeling the pressure of cost containment and working within budgets, this aspect of our work will assume a greater importance.

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### *Author's response*

I was very alarmed to read Dr Williams' letter which attributes to us recommendations that we did not make concerning strategies to reduce the prescribing of proton pump inhibitors. The purpose of our research was to explore the experiences of patients who were on repeat prescriptions for PPIs. Our findings challenged, for example, the notion that modification of patients' lifestyles would mean that patients could mange without PPIs. It is clearly stated in the discussion that 'Very few responders corresponded to the stereotype of the typical PPI patient widely circulated in the doctors' accounts.' We offer as an explanation (not a recommendation) that the labelling of PPI patients as having a poor lifestyle was a way for doctors to reduce the legitimacy of patient need for PPIs. Raising prescribing thresholds results in covert rationing. Our argument is that rationing decisions for this or any other treatment should be transparent to patients as well as the PCG/PCT.

I am puzzled as to why Dr Williams has misunderstood the arguments put forward. The paper never set out to develop strategies to reduce the prescribing of PPIs but to improve patient care. However, by portraying the experience of 82 patients on long-term PPIs, some of whom were subject to switching brand or, more problematically, the simultaneous change of brand and dose, the impact on patients of such strategies can be seen and the likely success evaluated. Interestingly, one strategy that Dr Williams does not refer to is that of patient self-regulation of PPIs where one-third of patients had experimented with their regime of taking PPIs at some time, often without their doctor's knowledge.[1] Patients and NHS managers share a common concern to minimise medicine taking. We argue that promoting patient autonomy and involving patients in treatment decisions is desirable in its own right but also has the spin-off that it can potentially reduce PPI prescribing and the associated cost.

I hope I have set the record straight.

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## Repeat prescribing realignment project

Drug expenditure in primary care, mainly resulting from repeat rather than acute prescribing, is large and growing[1] and some patients have large stocks of drugs, as revealed by 'brown bag schemes'.[2] We used prescribing savings allocated to us by North West Edinburgh Local Health Care Cooperative's to 'realign' patients' prescriptions (so that all their drugs ran out at the same time) without wasting these stocks of drugs. We selected patients whose prescriptions over the previous six months had cost at least £800, who were on any individual expensive drugs, who were on multiple drugs or who were perceived as problematic by staff or pharmacists, and visited them at home to count their stocks of drugs and realign their prescriptions.

We visited 32 patients (median age = 57, range = 37–76, 7 (22%) male) and realigned the drugs for 15 of these (Table 1).

Since our repeat prescriptions are generally for 56 days we would expect the optimum mean stock of drugs to be 28 days' supply. The mean and median stocks in this study were only slightly greater than this, so intervening simply to defer the next prescription would not have lead to much saving. The degree of misalignment, however, was considerable and we were able to begin correcting this. We were interested to discover that it was hard to predict which patients would have large stocks or misalignment problems. Incidentally, we also found that, while we use interval dispensing to prevent waste, one of our local pharmacies packaged such drugs in advance and claimed payment whether or not the drugs were collected.

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*Table 1. Stocks held by the study group (*n *= 32).*

| | Median | Range | Quartiles |
|---|---|---|---|
| Number of drugs per patient | 7 | 2–10 | 6, 8 |
| Number of days' drugs in stock for group as a whole | 28 | 0–473 | 13, 55 |
| Mean number of days' drugs in stock per patient | 37 | 10–113 | 22, 47 |
| Misalignment (defined as the discrepancy in days between the patient's stock of the most plentiful drug and stock of the least plentiful drug) | 56 | 15–459 | 44, 75 |

## What does patient-centredness really mean?

In masterly fashion, Steve Iliffe's editorial[1] transforms a simple, but important problem with simple, though demanding answers, into a scholarly but insoluble puzzle. By replacing the apparently simple idea of 'patient-centredness' by his hideous neologism 'deontological', he may hope to elevate his argument to some higher plane, but if ever there was a subject needing its feet firmly on the ground, it is this.

Like most of his contemporaries, he thinks GPs are being squeezed between the rising expectations of consumers and the diminishing readiness of undecided voters to pay for them. I say 'undecided voters' rather than government, because their desires and feelings now lead what passes for thought in our elected dictatorship. As he says, 'Being caught between the hammer of deontology and the anvil of utilitarianism is painful'. He goes on to ask, 'What options are open to us in general practice to resolve these conflicting and sometimes contradictory demands?'.

To avoid a simple answer, he misquotes the critically important evidence of David Tuckett's classic study.[2] Tuckett observed practice just as it was in the 1980s and found no objective difference between Balint-trained GPs and a random sample of matched non-Balint peers in the extent to which they actually listened to what patients thought, or involved them in decisions about their care. In other words, to proclaim patient-centredness is not enough. We have actually to stop being doctor-centred. Steve claims that 'recasting consultations as "meetings between experts" did not shift the professional concern with diagnosis and staying in control'. None of the consultations Tuckett observed had been thus recast — that was the whole point of his study. We have a wealth of evidence that, if patients are helped to develop as active co-producers rather than passive consumers,[3] and if doctors accept them as allies rather than adversaries, consultations do become more productive of health gain.[4,5] The 'two experts' scenario has huge potential for reducing the huge gap between what doctors and patients think is important[6,7] and expanding productivity in real terms of health gain.[8] However, this does entail redefinition of the evidence we use to reach a diagnosis, and it also entails sharing of control with our patients. It is a difficult, necessary, but relatively simple shift in power, with huge and complex consequences.

Steve knows this. Why does he, along with most other GPs, still choose to ignore it? In a public service, doctors and patients should work optimally as co-workers. Both doctors and patients bring with them a great deal of traditional baggage that they both need to lose, but we've made much progress in this over the past century.

With goodwill on both sides, this will continue. Provider–consumer relationships are inherently adversarial (although mutually dependent). Co-producer relationships may not, at first, be easier, but they will be more efficient and more satisfying to both parties. So why do so many doctors hesitate to follow this obviously attractive path?

Steve poses only two alternatives: 'Can we rely on any professional or academic strategy to make patient expectation harmonise with available provision, or are we forced to demonise one or other source of demand?' As once he knew, as advocates for our patients and our communities, it is not our job to reduce patients' generally reasonable expectations to the abysmal provision our government wants to provide, through a stealthy retreat into marketed care. This does not demonise government, but simply describes our actual position in relation to other countries in Europe. Ours is a rich country, whose health services should match the rest of its wealth. The civilised way to do this is through social solidarity and graduated income tax. The barbaric way is through every man for himself, an expanding market in fee-paid care, and some barebones service for those left outside. Though a few doctors will join the barbarians, most will eventually side with their patients, most of them people with little to spare after paying their mortgage. Most doctors will join their patients politically, and they will join them clinically, by making 'meetings between experts' a reality. This requires courage and imagination, and a break with craven professional traditions reaching back to the middle 19th century, but come it will.

Times are a-changin'. If Steve tried leading the advance instead of rationalising retreat, he might find it easier than he has led himself to expect.

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## *Author's response*

Julian Tudor Hart agrees with me that GPs can try to escape from the dilemmas of currently unmet need by putting personal and clinical problems into their policy context. He also agrees that few GPs will escape through market relationships, which he conflates idiosyncratically with barbarism. I agree with him that *some* of our discomfort between the hammer and the anvil will be relieved if there is a renewal of vertical social integration (solidarity), expressed tangibly in progressive taxation. So far, so good. He tells me that I am just like most of my contemporaries, which is comforting, but qualifies this by saying that most of us misunderstand our everyday experience, ignore the wealth of evidence about the beneficial effects of sharing control with patients, and lack the courage and imagination to become the advocates of our patients and our communities. However salvation is at hand, for although most of us are contemptible, we will eventually leave our traditional baggage by the wayside and sit down to 'win–win' consultations with our expert patients — in a hundred years or so, if I read his letter correctly. Julian Tudor Hart does not describe the process of our enlightenment ; perhaps it will be an epiphany.

Others can decide what all this has to do with stereotyping patients who want proton pump inhibitors. I suspect the real argument hinges on a passing criticism of producerism in the editorial. Producerism is the antithesis of consumerism, simplifying the relationship between doctor and patient to a positive and collaborative bond in exactly the same way that consumerism reduces the relationship to a challenge to physician authority. Both types of activity do occur in (among other situations) teamplaying, resignation, and avoidance, and both are elevated to heroic status by naïve and simplistic idealisation of model forms of behaviour. Unfortunately complexity clutters grand visions. What matters to me is not what I *should* do with my co-producers of health (many of whom may not know their true status and simply believe that they are ill) but what I *can* do with real people in real situations. Here I find applied sociology, for all its unfamiliar language, methods and theory, more helpful than evangelical zeal and utopian politics. For example, I do want to know about different responses to disability and their relationships to knowledge exchange, shared decision-making, and enablement, so that I can play my part to the best of my ability using psychology and sociology alongside clinical medicine. That seems to me to be the scientific way, and it is tough enough to absorb all my energy. I do not want to know that, given enough simple faith, I can face hard times, see off the barbarians, and produce 'huge and complex consequences', as if general practice were some never-ending Wagnerian opera. The concrete analysis of concrete situations and the development of less grandiose objectives may be dull, but they are down to earth and surely good enough pursuits.

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