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LETTERS



ANTIBIOTICS FOR COUGHS AND COLDS

Goodbye, virus

In 1996 Kai explored the difficulties for parents living in a disadvantaged community of coping with acute illness in their children. They found that doctors' explanations of the illness and its treatment, which involved use of the concept of a "virus," unhelpful and unsatisfactory.¹

They thought that the use of antibiotics should relate not to the cause of the illness, but to its severity. In doing so he anticipated the recommendations of the guidelines from the National Institute for Health and Clinical Excellence (NICE) for respiratory tract infections in primary care by 12 years.^{2,3} The word virus does not feature at all in the guideline's 121 pages; viral appears only five times peripherally.

Given the lack of evidence that we can use these words or concepts in a useful way, either to determine what is the best treatment or to explain the illness to the patient, is it now time to drop the virus from our consulting repertoire for such conditions?

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Competing interests: None declared.

- 1 Kai J. Parents' difficulties and information needs in coping with acute illness in preschool children: a qualitative study. *BMJ* 1996;313:987-90.
- 2 Butler CC, Francis N. Commentary: Controversies in NICE guidance on antibiotic prescribing for self limiting respiratory tract infections in primary care. *BMJ* 2008;337:a656. (23 July.)
- 3 Tan T, Little P, Stokes T. Antibiotic prescribing for self limiting respiratory tract infections in primary care: summary of NICE guidance. *BMJ* 2008;337:a437. (23 July.)

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Hello, virus

The guidelines from the National Institute for Health and Clinical Excellence (NICE) on the treatment of "chest infections" do not adequately tackle these patients' symptoms and the need for the anti-asthma treatment that will

benefit many of them.¹ Furthermore, because of continuing symptoms, such patients will continue to pressurise for antibiotics, given that they have been told they have a "chest infection" but have been given no treatment for the resulting symptoms. May I suggest that the term "chest infection" is unhelpful and misleading, and it is more useful to stick to symptoms. Therefore cough, chest tightness, wheeze, shortness of breath, and light green sputum do not warrant antibiotics and often respond to anti-asthma treatment. Again, fever, once the acute viral infection has passed, being unwell, lack of appetite, require an antibiotic. What do you call these two very different illnesses? What about "viral induced chestiness" for the first and "query pneumonia" the second? Some patients, such as those with chronic obstructive pulmonary disease, with viral induced chestiness, will of course also need antibiotics.

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- 1 Butler CC, Francis N. Commentary: Controversies in NICE guidance on antibiotic prescribing for self limiting respiratory tract infections in primary care. *BMJ* 2008;337:a656. (23 July.)

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SUBCLINICAL HYPOTHYROIDISM

Let's identify research questions

The summary of what is unknown about the management of clinical hypothyroidism by Pham and Shaughnessy seems to have missed a prime opportunity to identify the key research questions that would address the evidence gap—preferably in a PICO (population, intervention, comparison, and outcome) format.^{1,2}

The authors—who have conducted a systematic review on this topic—are best placed to know the evidence gaps and hence identify the research questions which need answering. Even if they themselves had no inclination to do the research, publication here would enable researchers to take those questions, find funding, and answer them.

As is, the recommendations on how to deal with subclinical hypothyroidism constitute a mix of common sense (don't screen for this condition), best guesses (try treating it for a few months), and ignorance of the natural history of subclinical hypothyroidism (check thyroid stimulating hormone every year).

There is a big evidence gap here—amenable to being filled by robust research.

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Competing interests: None declared.

- 1 Pham CB, Shaughnessy AF. Should we treat subclinical hypothyroidism? *BMJ* 2008;337:a834. (16 July.)
- 2 Brown P, Brunnhuber K, Chalkidou K, Chalmers I, Clarke M, Fenton M, et al. How to formulate research recommendations. *BMJ* 2006;333:804-6.

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NICE ON STROKE CARE

Are NICE stroke guidelines scientific or political?

The BBC and other media organisations were provided with additional information from the press conference at which the National Institute for Health and Clinical Excellence (NICE) and the Royal College of Physicians released their joint press statement on their stroke guidelines.¹ The first line was: "Approx 4500 people could be prevented from being disabled through stroke if they were thrombolysed." This figure is unbelievable, given the Department of Health's estimate of a 13.1% absolute benefit of recovery to independence (131 per 1000 treated) as it means that some 34 351 patients would have to be given thrombolysis. The Department of Health's December 2007 impact assessment indicated that 549 would recover to independence, with a range of 307 to 792.

The "extra points" from the conference continued: "Further thousands of lives could be saved if all patients were admitted directly to an acute stroke unit (but we do not have a specific figure as not all the variables are known)." What is the evidence for this claim? Not quantifying the "further thousands" figure is convenient, especially when the impact assessment document makes it clear what the public and primary care trusts can expect from organised stroke care. The "acute unit" refers to the type of hyperacute unit where patients can be assessed and given thrombolysis if need be; as Barer points out,² 90% or more of patients with stroke will be ineligible for the treatment. They need good medical and rehabilitation care pathways for their particular needs.

The final claim—"We do not need any more resources to fulfil the recommendations, just better organisation of what we have already"—

would leave reasonable and informed members of the public, primary care trusts, and politicians rubbing their eyes in disbelief. The Department of Health's impact assessment document and the costing report that accompanied the NICE stroke guidelines make it very clear that the NHS will require more resources to deliver the recommendations.

Such claims, which then escape into the public domain via newspaper reports and online publications, need justification and clarification lest they undermine the credibility and authority of the guidelines.

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Competing interests: None declared.

- 1 Swain S, Turner C, Tyrrell P, Rudd A, on behalf of the Guideline Development Group. Diagnosis and initial management of acute stroke and transient ischaemic attack: summary of NICE guidance. *BMJ* 2008;337:a786. (24 July.)
- 2 Barer D. Are NICE stroke guidelines scientific or political? [Electronic response to Swain et al.] *BMJ* 2008. http://www.bmj.com/cgi/eletters/337/jul24_1/a786#200175

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INTIMATE PARTNER VIOLENCE

Violence between intimate partners knows no age limit

The emphasis in Hegarty et al's review of the prevalence of violence between intimate partners is young to middle aged adults.¹ Child abuse and domestic violence have rightly received increasing attention and awareness, but the issue of elder abuse still lags behind in this regard. The US National Academy of Sciences noted recently that there were fewer than 50 empirical studies on elder abuse in the peer reviewed literature, and it is a pity that Hegarty et al did not clarify that intimate partner violence also affects older people.²

Few prevalence studies exist on violence and intimate partner violence among older people, rates of all forms of elder abuse ranging from 3% to 10%; in one study, violence was recorded by 3.2% of older adults surveyed.³ Until recently, there were even fewer data on intimate partner violence among older people. In a study in Kentucky, 2.8% of women over the age of 60 experienced domestic violence over a 12 month period.⁴ In an Irish study reported severe abuse declined with age, but this decline was lower for women than for men, and domestic violence clearly continued into later life.⁵ Future studies must actively eschew arbitrary age limits.

In adult studies, there is no reason to think that domestic violence stops at age 64 (or 49)—no more than there is reason to think that abuse of vulnerable people starts when they become "elder" at age 65. High quality epidemiological data across the adult lifespan are crucial

to understand the patterning of intimate partner violence and to inform prevention and management strategies for all ages.

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- 1 Hegarty K, Taft A, Feder G. Violence between intimate partners: working with the whole family. *BMJ* 2008;337:a839. (4 August.)
- 2 O'Dwyer C, O'Neill D. Developing strategies for the prevention, detection and management of elder abuse: the Irish experience. *J Elder Abuse Neglect* 2008;20:169-80.
- 3 Pillemer K, Finkelhor D. The prevalence of elder abuse: A random survey. *Gerontologist* 1988;28:51-7.
- 4 Fritsch TA, Tarima SS, Caldwell GG, Beaven S. Intimate partner violence against older women in Kentucky. *J Ky Med Assoc* 2005;103:461-3.
- 5 Watson S, Parsons S. *Domestic abuse of women and men in Ireland: report on the national study of domestic abuse*. Dublin: Stationery Office, 2005.

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Honesty is needed when assuring confidentiality

Hegarty et al suggest that the victim of intimate partner violence should be assured of the confidentiality of what she might disclose (box 3), whereas perpetrators of violence who disclose their violence will be offered only limited confidentiality.¹ The review goes on to say that if there is also abuse of children, and the non-offending parent does not improve the situation, a referral should be made to child protection services. What this could mean is "I told the doctor that my husband hit me, so a social worker came and took my children away." While there may be legitimate arguments about the safety of the child being the utmost priority, what doctors are offering in these circumstances is not confidentiality, and it is dishonest to pretend that it is. Abused women say that they want confidentiality, but that is not what we offer to them, and it seems only fair that we should explain the position truthfully.

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- 1 Hegarty K, Taft A, Feder G. Violence between intimate partners: working with the whole family. *BMJ* 2008;337:a839. (4 August.)

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GPs UNDER ATTACK

Minerva perpetuates hearsay

I am sorry that Minerva expressed in print her upset at something she "heard" about what a GP surgery had "apparently" done and that "some in the area" commented that the surgery "had a dreadful reputation".¹

Although in no way wishing to support poor practice, I think Minerva is misguided in perpetuating hearsay. She may be unaware that GPs in the UK now have a proportion of their pay determined by unscientific patient surveys, and that the government intends to increase this proportion in future. If, for example, an already struggling, inner city practice loses more income because of the results of a patient survey, it may well become unviable and patients may indeed lose their local GP service.

My practice stands to lose income of over £7000 this year as a result of such a survey, which led some of our patients to voice the opinion that we do not book appointments more than 48 hours in advance, and that we did not offer them choice of referral hospital. We can prove that these opinions are incorrect, but our primary care trust is under no obligation to pay us the money due for providing the agreed services.

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Competing interests: SG is a general practitioner who finds his income now depends on patient surveys.

- 1 Minerva. *BMJ* 2008;337:a1115. (5 August.)

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More negative spin

So a national survey of 69 000 patients by the Healthcare Commission found patient satisfaction with GPs increased in five tests¹:

- 74% said that the main reason they went to see their GP was dealt with completely to their satisfaction (73% in 2005)
- 93% said they were treated with respect and dignity "all of the time" (92%)
- 83% said their GP "definitely" listened to them carefully (82%)
- 76% said they were "definitely" given enough time to discuss their problem (74%)
- 77% per cent said they "definitely" had trust and confidence in their doctor (76%).

Additionally, 87% were able to see a doctor within 48 hours. I think these figures warrant a little self congratulation—any politician would die for such figures.

Oh no.

The title of your news item in print simply says, "One in seven people in England can't see a GP within two days."

I am used to this spin from the government and the media, but I did not expect the *BMJ* also to be making light of our best efforts. Frankly I wonder these days which side you are battling for.

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Competing interests: None declared.

- 1 Dobson R. One in seven people in England can't get GP appointment within two days, survey shows. *BMJ* 2008;337:a1117. (1 August.)

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