unacceptable to us. These patients have tended to be more time consuming and to require additional resources and support, but we have found that many have become manageable in general practice over time, and we have had successes, in terms of both stabilisation of lifestyle, with improved health, and reduced criminal activity. This has led us to define the criteria for monitoring and supervision that some specialist agencies have been so reluctant to provide.

We recognise that methadone is only one of a range of interventions that may be appropriate to manage drug users who are dependent on opiates. In our view, dependence is a long term, relapsing condition, and one of the consistent characteristics of drug users presenting for help is their ambivalence about their drug use. Methadone seems to be more effective at keeping drug users in contact with health services than many other interventions that are proposed. If we acknowledge that drug users who are in contact with health services engage in less risky behaviours than those who are not it seems appropriate to support James L Sorensen² in his reference to Newman's article about the increase in the availability of methadone: "What is needed today is ... a firm commitment to make treatment available on request to every addict willing to accept it."³

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Clinical judgment is important

EDITOR,—As private providers of oral and injectable methadone maintenance, we read John Strang and colleagues' paper about the prescribing of injectable and oral methadone to opiate addicts with concern but also some irritation at its occasional unrealities.¹ Many of our patients have steady and responsible jobs, often in changing locations. For such people, to pick up methadone mixture daily is difficult. Even in the United States, where daily pick up is almost mandatory, some demonstrably stable patients can collect 28 days' supply.²

Furthermore, although 50 mg methadone ampoules retail for as little as £2, private daily dispensing and controlled drug fees can easily reach £25 a week, especially if both oral and injectable methadone are prescribed. In a relatively low cost maintenance programme we have to take this into account. Once patients graduate to less frequent pick up the threat of daily pick up is a useful sanction.

Why is the average NHS oral methadone dose only 44.3 mg/day when a paper from the National Addiction Centre recommended doses of 50-120 mg daily?³ We know that our patients can tolerate the doses we prescribe because we assess their response after they have swallowed or injected the drug under supervision. We test hair for drugs of misuse. This is probably the best technique for monitoring use of non-prescribed drugs,⁴ and we are evaluating its effectiveness for monitoring compliance with methadone treatment. Few NHS clinics take these precautions.

Much could be done to deter and detect diversion of injectable methadone. We introduced 50 mg and 35 mg ampoules. One manufacturer was willing to number ampoules consecutively

and indelibly so that their origin could be traced if they were diverted, but we were officially told that numbering ampoules would undermine the government's policy of reducing bureaucracy. This is dogma gone mad.

Methadone programmes have the highest retention rates of any treatment for dependence on opiates⁵ but need to be flexible. Over the years we get to know our patients fairly well. Inevitably, we are sometimes too suspicious or too trusting, but the alternative is a rigid American-style system of daily supervision, which is sometimes appropriate but "actually hamper[s] the personal and career development of socially rehabilitated patients."² A few irresponsible doctors give private prescribing of methadone a bad name. The Stapleford Centre detoxifies, as inpatients, many more people who are dependent on opiates than it starts on methadone. We hope that the concerns raised by Strang and colleagues will not prevent us from exercising the clinical judgment that is as necessary to the practice of medicine as the research that should inform it.

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Treating hypertension in elderly people

Statistics cannot eliminate weaknesses in study design

EDITOR,—The main question studied by Juan Merlo and colleagues was: Did treatment of hypertension in elderly men (whose blood pressure was measured at one examination in 1982-3 and was classified as being ≤ 90 mm Hg or > 90 mm Hg) lead to more ischaemic cardiac events during follow up of 10 years?¹ In the study hypertension was treated as a point exposure. With a complex health disorder such as hypertension, in which the time from the onset of an increase in blood pressure to diagnosis and treatment varies, such an approach introduces so much insecurity that it cannot be handled by statistical analysis. The treatment of individual patients as well as the effect on blood pressure might have changed several times during follow up, with varying effects on the result.

Table 1—Incidence of ischaemic cardiac events per 1000 person years. Figures on square braces are unadjusted rate ratios (95% confidence intervals)

		Diastolic blood pressure (mm Hg)				
		≤90	>90		All subjects	
Treated	61*	3.9 (2.1 to 7.1)	35*	2.0 (1.1 to 3.6)	42	2.6 (1.7 to 3.9)
Not treated	16		18		17	

*Proposed analysis would determine relative risk in these two groups.

The authors state that confounding by indication (severity) was handled by the statistical analysis. However, adjustment for cardiovascular disease as investigated in this study does not exclude, for instance, the possibility that patients with initially higher blood pressure or symptoms or with pathological findings on echocardiography were treated more aggressively. It is not surprising that men given antihypertensive treatment who had a normal blood pressure had a higher risk than healthy normotensive untreated men, because hypertension is a risk factor for cardiovascular disease and we know nothing about how well the hypertensive subjects were treated during the follow up.

The important question for clinicians is whether antihypertensive treatment leading to a low diastolic blood pressure increases the risk of ischaemic cardiac events. If the aim of the study was to investigate the possibility that the negative effects of antihypertensive treatment outweigh the benefits then a comparison of the two treated groups would have been more interesting. Table 1 is a modification of the authors' table 3; our proposed analysis would determine the relative risk of ischaemic cardiac events in men receiving antihypertensive treatment in whom a diastolic pressure of ≤ 90 mm Hg was achieved compared with men in whom the diastolic pressure remained > 90 mm Hg. Such an analysis would be expected to yield a relative risk lower than 1. If it does not then we do more harm than good with our treatment. In this case the unadjusted relative risk is approximately 1.7 and probably significant. The most plausible explanation for this, however, is weaknesses in the study's methodology and the problem of confounding.

We agree with the authors that there is much in support of the hypothesis that lowering blood pressure below an optimal level increases the risk of myocardial infarction. We do not, however, fully agree with the authors' conclusions.

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Editorial should have given more pragmatic goals for primary health care teams

EDITOR,—Although the trend towards evidence based medicine and consensus statements is to be commended, the guidelines that are issued can often be divorced from the realities of working in primary care. I would make a plea for pragmatic and robust guidelines that can be implemented in general practice: guidelines that take into account the variability of a non-selected population, problems of patients' compliance

with drug treatment, non-adherence to advice by doctors, and the pressures of limited time and resources.

A point in case is the editorial by Joel A Simon on the control of hypertension in elderly people.¹ Clinicians are instructed to treat all patients with a blood pressure of over 160/90 mm Hg, irrespective of age—but not to lower the pressure too far, for fear of entering the upstroke of the J shaped curve. How practical is this advice, and does it lead to demoralisation among those trying to treat their hypertensive patients?

My group practice covers a population of 14 500, is fully computerised, is a research practice of the Royal College of General Practitioners, and runs specific hypertension clinics. How do we measure up to the standards set in the editorial for lowering blood pressure? Of 771 treated patients attending for surveillance of hypertension, a fifth (160) had diastolic pressures of >90 mm Hg and seven tenths (536) had systolic pressures of >140 mm Hg. Our practice is unlikely to be much different from many in Britain.

Surely it would be more appropriate for achievable targets to be discussed in an editorial, with health gains per mm Hg fall in systolic or diastolic pressure being a more pragmatic (and, indeed, encouraging) goal for primary health care teams genuinely trying their best.

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1 Simon JA. Treating hypertension: the evidence from clinical trials. *BMJ* 1996;313:437-8. (24 August.)

Communicating risk

Use of standard terms is unlikely to result in standard communication

EDITOR,—Kenneth C Calman proposes a language of risk that seeks to introduce standardisation into our communication with patients about risks.¹ The debate that he calls for must address three fundamental issues. Firstly, is it feasible or theoretically justifiable to translate estimates of risk derived from populations to individuals? Secondly, does current communication about risks meet patients' requirements and is it relevant to them? Thirdly, if we continue with a pragmatic approach to communication about risk, developing it in terms of language, how is this best manifested in practice?

Understanding of risk differs among epidemiologists, clinicians, and lay people. In epidemiology, risk expresses as a statistical measure the association between a characteristic and a disease in a defined population. Tension exists, however, between this perspective, which derives most closely from the "frequentist" interpretation of probability, and the lay perspective.² The lay perspective corresponds with the "subjectivist" interpretation of probability, reflecting the context and our expectations and observations of events.²

Clinicians may view themselves as trying to mediate between these two, using epidemiological data about groups to help individual decision making in practice. But communication about clinical risks is not straightforward, which perhaps suggests that estimates of risk derived from populations are unhelpful in the individual setting (as the subjectivist perspective holds) and that current practice in communicating risks fails to meet patients' needs. People often have an "all or nothing" perspective of harm or risk (and may therefore, for example, continue to smoke, or not take any risk with a new drug or an operation), showing that epidemiologically derived estimates of risk are often irrelevant to them.³

We still need to know more about what information about risks patients require. Perhaps our language for communicating risks should not be complicated by the uncertainty of applying population estimates to individuals, or perhaps we should continue to bridge this gap from population to individual. This is where a consistent and standardised language could help, but we must address other aspects too. Use of standard terms in the assessment of risk is unlikely to result in standard communication because the interpretation of the language of risks by patients and doctors varies^{4,5} and because of other contributions to the communication process: non-verbal elements, mental images, past experiences, and discussion about the meaning of risk to individuals. Standard terms would have to be sufficiently flexible to accommodate these contributions. Research to improve communication about risks may need to consider innovation in all these areas and identify whether patient oriented outcome measures are improved by the new processes.

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Risks can also be categorised as normal or abnormal

EDITOR,—Kenneth C Calman's article on science and society and the communication of risk opens a much needed debate on the public perception of risk.¹ It defines many of the words used in the assessment of risk, but I would suggest that a further factor that is implicit might be added, though maybe it should be more explicit. To Calman's concept of pairs of terms (avoidable/unavoidable, justifiable/unjustifiable, etc) I would add another pair—normal/abnormal. This is close to the acceptable/non-acceptable pair but not identical.

As a community, we accept some risks as normal even when their values are quite high. Examples include accidents on the road (1 in 8000), falling off a ladder while painting the bedroom, and cutting off a thumb with a hedge trimmer. These are accepted, albeit with some grumbling, as "part of life." Other risks, such as being infected with a virus in the course of treatment, being exposed to natural radiation, or becoming infected by a virus while swimming, are often perceived as not being part of normal life; though in the range of very low to negligible risks, they are regarded as unacceptable. Some others, such as the risk of being mugged in the street, lie somewhere between and are usually ignored except after a particularly well publicised event.

Whether a particular risk is regarded as normal or abnormal varies greatly over time. For example, we no longer expect a man with a red flag to walk in front of a car, and this reflects how

well the general public comes to terms with different examples. Assessment of risks has to go closely with education if we are to manage risk sensibly, and, because it takes time to come to terms with new factors, such education takes longer than we would prefer. Without it, perception is uninformed and the response volatile. As a result, as Calman says, we face spending undue amounts of money on abating negligible risks.

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Prescribing incentive scheme for non-fundholding general practices

Tailoring a scheme to individual practices is more effective

EDITOR,—D N Bateman and colleagues' paper adds to the evidence that incentives to general practitioners are an important component of a strategy to change doctors' prescribing patterns.¹ It is interesting to compare the results of the scheme in the Northern region in England, described by Bateman and colleagues, with those of the rational prescribing payment scheme in Lothian, Scotland. Both schemes contained financial incentives for non-fundholding practices and led to savings in prescribing. The Lothian scheme consisted of three targets for practices: to be within budget, to achieve a rate of prescribing of generic drugs of over 56%, and to achieve a quality target.

Table 1—Comparison of main features of schemes in Northern region and Lothian. Figures are numbers (percentages) except where stated otherwise

	Northern region	Lothian
No of practices eligible	459	93
Entry to scheme	Automatic	Voluntary
% Of practices participating	Automatic	75
No of targets	1	3
Practices achieving financial target	106 (23)	39 (42)
Practices achieving generic target	NA	90 (97)
Practices achieving quality target	NA	60 (64)

NA = Not applicable.

The main difference between the schemes was the way they were applied. In Lothian methods that have been shown to be effective in changing doctors' behaviour were used. These have been described by Grol.² He recommends the use of face to face education, assessment, and feedback by well respected peers, combined with practical support (including financial stimuli), as a particularly effective means of improving the quality of care. He has shown that coercive controlling methods can have a negative effect at one end of the spectrum and facilitating educational methods a positive effect at the other. An essential part of Lothian's scheme included a practice meeting with the health board's medical prescribing adviser to set the targets and allow discussion.

The success of these schemes could be measured by looking at the number of practices taking part (uptake) or the number achieving their targets, or both. Interestingly, the results are