ation in the mass media, based on these findings, was a vital role in lessening the incidence of the epidemic.

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Developing a standard dataset for the NHS

Read codes' primary use is clinical

EDITOR,—N Smith and colleagues identify imperfections in the Read codes.¹ They do not, however, give due consideration to the fact that the codes were developed primarily as a means of entering clinical data into a computer in general practice, facilitating the development of an electronic record of certain aspects of patients' care. The codes were not developed as a tool for delivering health care information to central, academic, public health, or managerial bodies.

The codes have been used successfully in general practice for some years and have helped the foundation of clinical computing in primary care. This success was illustrated by a survey of computing in general practice in 1993, which showed that nearly two thirds of practices actively used the computer to some extent during the consultation and that use of the computer as a clinical record was increasing.² Indeed, this has been recognised to be of such value that a recent report on reducing bureaucracy in general practice called for a speedy legitimisation of computerised records.³ While I have every sympathy for the researchers in finding that the codes did not fit with their definitions, thus requiring them to redefine aspects of their study, they should appreciate that the windfall benefit of access to clinical data through computerisation is not at the core of clinical computing in general practice. Nor is this access likely to become universal without considerable investment in training clinicians to use the codes and in upgrading all systems in general practice to accept them.

Furthermore, some caution is justified. The success of the codes has been partly due to their relative simplicity and ease of use. Subsequent versions of the Read codes will address many of the issues raised by the authors.⁴ A huge thesaurus of clinical terms and qualifiers would almost certainly have overheads in terms of slowing terminals considerably or requiring upgrades to hardware. Slow, unusable systems will be detrimental to the development of clinical computing.

In conclusion, it must be borne in mind that the Read codes were developed to support the maintenance of a computerised clinical record and adopted as such by the joint computing group of the Royal College of General Practitioners and General Medical Services Committee. Any other research, audit, information, or managerial project support is a secondary bonus. The emphasis must remain on clinical use, with any other use being supported as a byproduct.

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Version 3 of Read codes addresses many difficulties

EDITOR,—N Smith and colleagues highlight some weaknesses in the Read codes.¹ Unfortunately, it is not clear to casual readers that the criticism is valid only for the 4 byte and 5 byte sets of version 2. Version 3 has been available for the past 12 months and addresses these limitations.

One of the main structural limitations of a simple coding scheme, such as the International Classification of Diseases, the Symmetrical Nomenclature of Medicine (SNOMED), or earlier Read codes, is that the hierarchy depends on the code itself. This means that (for Read codes) the hierarchy could not be deeper than four or five levels. Version 3's hierarchy is carried in a simple table and does not depend on the code itself. This means that there is no limit to the number of levels and hence no need to "flatten" the hierarchy to make it fit and that the same concept (Read code) can appear in different parts of the hierarchy.

The need for detail has, as Smith and colleagues mention, led to the development of qualifiers—that is, extra pieces of information (laterality, approach, anatomical site, severity, etc) that can be added to the main term. The qualifiers that are relevant to any given main term are presented to the user for selection. Far from complicating use, this allows the main terms to be less complex, simplifying the screen display. The user need add only detail that is relevant to the patient. The use of qualifiers also facilitates much greater consistency across the whole term set—one of the criticisms in the article.

A similar approach, of linking two separate Read codes together, will be adopted for record heading terms such as "family history," "current problem," and "past history." This will, for example, allow any disorder to be tagged as family history.

The content of version 3 will continue to be refined over the next 12 months. The new section on smoking and tobacco consumption has been widely piloted and will be released this month. This topic was addressed by the health related behaviour working group, which consulted widely with public health doctors, general practitioners, and health promotion experts. The group also looked at alcohol consumption, exercise, sexual behaviour, and drug use. These sections make use of qualifiers to allow the exact consumption to be recorded as a number with appropriate units. This avoids constraining the users to predefined bands, which are likely to change over the years.

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Treatment for cancer pain

EDITOR,—Like M Zenz and T Zenz,¹ we appreciate the recent paper by François Larue and colleagues² for opening up a discussion on the undertreatment of cancer pain. Perhaps, however, the topic should be referred to as maltreatment of cancer pain.

Zenz and Zenz make the point that legislation for uniformity in the European Union could threaten the freedom to prescribe strong opioids in Britain. The implicit assumption here is that

regulation keeps opioid prescribing down and that deregulation would increase it. It is also a popular view that patients receiving hospice-type care in Britain are heavily dosed with morphine.

We have published the results of a survey of 1007 patients (970 with malignancy) receiving specialist palliative care—that is, care under the direction of hospice-type services or community teams—in the Trent region.³ Altogether, 469 patients were already taking an opioid analgesic at the time that they were referred; far from inevitably leading to an increase in opioid consumption, the addition of specialist palliative care led to an increase in only 41% of patients. In 43% the dose remained unchanged during the period they received specialist palliative care (mean 265 days, median 107 days). In 16% the opioid dose was reduced after referral, and in 6% opioids were stopped altogether. Furthermore, only 45% of patients were receiving a strong opioid (morphine or stronger). For those receiving hospice day care and home care from independent Macmillan-type nursing teams (31% and 39%, respectively, of our unselected sample) the mean (median) consumption among those taking opioids was 149 (60) mg and 144 (60) mg morphine equivalent per 24 hours, respectively.

We would encourage greater uniformity of legislation relating to the prescribing of opioids in Europe, preferably in line with the British model. As our data show, freedom of prescribing, when coupled with ready access to specialist palliative care, should not be seen as automatically leading to uncontrollable increases in morphine consumption per patient. The growth of specialist palliative care—which needs an acceptable universal definition—may bring about increased opioid consumption in the population as a whole, but it does so by improving individual patients' access to the drugs and by better pain control as a result. For this reason, we see the problem of cancer pain at the population level as one of maltreatment since both undertreatment and overtreatment with opioids are to be deprecated.

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General practitioners' role in emergencies

EDITOR,—J N Rawlinson's letter about the role of deputising doctors in emergencies is unfairly critical of both general practitioners and their deputies.¹ General practitioners cannot be expected to be available to their patients at all times regardless of the urgency of the situation, and inevitably there will be times when patients are seen by a partner, locum, or deputy. Moreover, there simply are not enough hours in the day to stay to care for someone who is newly bereaved: after offering sympathy, explanation, and advice about necessary formalities there is little else one can do, and other work is always waiting. I would be interested to know how much care and counselling is offered by the doctors in Rawlinson's accident and emergency unit. With the old man's daughter and a concerned neighbour present at the incident that Rawlinson cites, it was not unreasonable for the deputising doctor to leave.

Secondly, Rawlinson comments on the cardio-

pulmonary resuscitation performed. I am sure that Rawlinson, a staff doctor in accident and emergency, gives such resuscitation every day. I cannot remember when I last did. I attend an updating course every two years at our local postgraduate centre, but I have not needed to use advanced cardiopulmonary resuscitation, and the skills that are needed are soon lost.

Thirdly, Rawlinson seems to imply that a general practitioner should be available 24 hours a day for care and counselling about adverse life events. While I accept that a sudden death is different (and I would always offer to visit a bereaved patient as soon as I knew of the bereavement—the deputising services always inform us promptly, but hospitals are rarely so efficient), patients are increasingly “medicalising” adverse events and seem to expect general practitioners to have a means of putting life right for them. I am fed up with being asked to soothe people in tears because their husband has left, they have had a minor car accident, their handbag has been stolen, or their cat has died. The problem is that people seem to have no one else to turn to: there is no real “care in the community,” just general practitioners trying to do their best with minimal back up.

Has Rawlinson ever done any general practice?

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Journals sponsored by single companies

EDITOR,—Martyn Partridge suggests that sponsorship of journals by pharmaceutical companies should be obvious and stated boldly rather than have to be deduced.¹ The code of practice for the pharmaceutical industry of the Association of the British Pharmaceutical Industry, which is operated separately from the association by the Prescription Medicines Code of Practice Authority, was recently amended with this point in mind. It now states, “All material relating to medicines and their uses which is sponsored by a pharmaceutical company must clearly indicate that it has been sponsored by that company.” Anyone who considers that this requirement has not been met in respect of any particular item can complain to the authority about it.

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Videotaping of general practice consultations

EDITOR,—L Malcolm Campbell and colleagues state that the consent rate for videotaped consultations in their study was 91%, which shows the vulnerability of patients to coercion.¹ The method of obtaining consent has an important bearing on this figure and is not described by the authors. When coercion and bias are removed, consent rates in the order of 4-10% are to be expected.^{2,3} Last year the General Medical Council issued guidelines on videotaping consultations to offer patients some protection from exploitation, and Campbell *et al* have noted that adherence to a similar protocol has resulted in falling consent rates.⁴

We also take issue with the authors' unquestioning acceptance of the results of their questionnaire survey on patients' satisfaction. The subjects'

responses are likely to have been influenced by a perception that their doctor's participation in a videotaped consultation renders this an acceptable or desirable exercise, particularly in practices in which consultations are habitually videotaped. In addition, there is the phenomenon of patients who agree with every statement, which was recognised by the designer of the questionnaire used in the study, who warned of the confounding effect of “the acquiescence response set.”⁵

Furthermore, in these days of widespread ownership of and exposure to camcorders it is fatuous to argue that patients who have not previously been asked to take part in a videotaped consultation cannot give a valid opinion about their expected response to such an event. While most of us have never broken a limb, this does not stop us giving an authoritative statement on whether we would expect this to have a beneficial or detrimental effect on our quality of life.

Campbell and colleagues have failed to address inherent biases that have corrupted other, similar studies. Their results are therefore misleading and do not refute our evidence that patients are vulnerable to coercion into participation in videotaped consultations in which they expect to feel uncomfortable or inhibited.

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Measurement of bone density in osteoporosis

EDITOR,—It is difficult to imagine a more wrong headed approach to osteoporosis than that proposed by E M Tayler.¹ The first major misconception is that a bone density scan rarely influences a decision to start or continue hormone replacement therapy. In many patients this is now the main reason for starting, and often the most important for continuing, such treatment, if necessary life long, to prevent further bone loss. There is currently no more accurate technique of measuring a post-menopausal adverse factor than dual energy x ray absorptiometry. This also emphasises the importance of early screening: I would recommend screening at the age of 40, when peak bone mass is still present, so that advice on lifestyle can be emphasised when osteoporosis is still preventable. Repeat screening at the menopause would then indicate the importance of starting hormone replacement therapy then. Only then will we be able to assess the long term impact on rate of fracture, which, with preservation of peak bone mass, is likely to be considerable.

The indications that Tayler lists for measurement of bone density in Oxfordshire will ensure that no impact on the problem is made there. Throughout the letter Tayler says that such measurement would be worth while only if it would greatly influence the woman's decision, but that decision cannot be made until one knows the state of the skeleton. Nobody would disagree with Tayler's comments about patients taking prednisolone, but

the first line of treatment in high risk patients with established osteoporosis is hormone replacement therapy rather than biphosphonates. Tayler's comment on radiological suspicion of osteopenia is out of date as an x ray film will not show appreciable bone loss until 30-40% has been lost.

Tayler admits that osteoporosis is a major public health issue, but, clearly, no proper guidance about its alleviation will be given by the public health medicine department in Oxfordshire and patients will have to look elsewhere for help.²

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New deal shifts may increase house officers' stress

EDITOR,—The new deal was implemented to improve the working conditions of junior doctors by reducing the total hours worked and, where the intensity of work was high, by changing the pattern of working from a traditional on call rota to full or partial shifts.¹ No research has been carried out, however, to assess whether the change from an on call rota to full or partial shifts in high intensity jobs has achieved the beneficial effect initially predicted.

Two postal surveys of junior doctors were conducted in the west midlands, the first on all preregistration house officers trained in Britain who were working in the region and the second on a random sample of senior house officers working in the region. Both surveys used the occupational stress indicator to determine total job satisfaction and mental ill health (cognitive aspects of strain) and physical ill health (somatic symptoms of anxiety and depression). Details of the system of work (on call rota and partial or full shift) were sought. The survey of preregistration house officers had a response rate of 83.4% (196/235) and that of senior house officers a response rate of 57.8% (292/505).

Senior house officers had significantly higher levels of physical ill health (32.30 (SD 9.14); a high score indicates poor health) than a large group (n=6326) of non-health care workers² (29.60 (9.79), $P<0.001$) and a small group (n=40) of junior doctors at all grades (28.35 (8.29), $P<0.01$).³ Additionally, they had significantly lower levels of job satisfaction (79.47 (17.56); a high score indicates low job satisfaction) than non-health care workers (81.76 (16.64), $P<0.05$). Preregistration house officers had significantly lower levels of job satisfaction (71.86 (12.99)) and significantly higher levels of mental ill health (61.50 (14.31)) and physical ill health (33.87 (10.97)) than non-health care workers (81.76 (16.64), $P<0.01$; 56.54 (12.25), $P<0.01$; and 29.69 (9.79), $P<0.01$, respectively) and junior doctors (83.22 (11.22), $P<0.01$; 55.30 (12.25), $P<0.05$; and 28.35 (8.29), $P<0.01$, respectively). A one way analysis of variance was performed to determine differences in the mean scores for job satisfaction and mental and physical ill health of those working the three different systems of work. Tukey's procedure was used to determine which means differed significantly from each other (reported to be significant at the 5% level of probability; table).

Our work suggests that a partial shift system may lead to better job satisfaction than an on call rota for senior house officers but to decreased job satisfaction and increased physical ill health for preregistration house officers. A possible explanation for this is that partial shifts are more isolating for the individual doctor than an on call