They are distinct and important aspects of life. But, if one or both of these words represents the additional meaning implied by 'spiritual', are doctors to be asked to consider a patient's health in sacred or moral terms? What would either imply for practice?

They could imply paying attention to what a patient holds sacred or being aware of a moral dilemma or choice in a patient's life. On the other hand the three more familiar aspects of health are ones to which doctors not only pay attention but which they sometimes influence and change by their active intervention. Would it be right for a doctor to seek to influence the 'spiritual' in either of these senses of the word?

If the College were to endorse this additional term, it must first define it and weigh carefully the possible consequences of its introduction.

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Sir,

I was most interested to read Dr Martin's editorial (January *Journal,* p3). This is a complex subject with refusal to admit evidence of the supernatural on the one hand and excessive credulity on the other. Dr Martin's assessment is helpful in pointing out some of the problems.

I believe that God's healing power is not restricted to supernatural means. Christians have long recognized natural healing processes as a demonstration of God's power. For example Ambroise Paré, the sixteenth century French surgeon, said 'I dressed his wound; God healed him'.

Could I bring to the attention of the working party of the College which is looking into this subject a set of cassette tapes of talks by the late Dr Martyn Lloyd-Jones entitled 'Medicine and the supernatural'? The album of four tapes comes with a book by Dr Lloyd Jones, *The doctor himself and the human condition*.

The album is available from The Martyn Lloyd Jones Recording Trust, Crink House, Barcombe Mills, Nr Lewes, East Sussex BN8 5BJ at £14.50 inclusive of postage and packing. It should be of particular interest to Christian doctors but others could also learn much from it.

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Prevalence of disability in an Oxfordshire practice

Sir,

Drs Sullivan and Murray have criticized the absence of a validated measure of disability in my paper (August *Journal,* pp.368-370). I did not set out to make an objective measurement of the prevalence of disability in my own practice and this is made quite clear in the first paragraph of the paper. The limited objective involved was to see how much disability I identified in the course of routine patient care on known data. Surely this makes it clear that I did not set out to screen patients for disability and to scale the level of disability. I regard my paper as modest, although it was the first that I could trace by a doctor keeping a disability register in general practice.

My own view is that disability and handicap registers will ultimately prove even more valuable than chronic disease registers about which a great deal has already been written. After all, patients consult doctors because they want to be relieved of pain or the disabling effects of a particular disorder and I feel that we are inclined to be too interested in the disease itself and too ready to ignore its social consequences. These are all too often left to others — the occupational therapist, physiotherapist or physician in rehabilitation medicine. The result is a lack of integration of patient care with no one taking overall responsibility except when the patient is severely disabled and even then it is not the general practitioner who is in charge as a rule. Thus I feel that disability in general practice is a neglected field and one which I would like to see greatly developed. I hope to do a study of the prevalence of disability in patients over 75 years of age, which will require me to produce exactly the type of objective measurement to which my critics were referring.

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Out-of-hours visits to children

Sir,

I read with interest Dr Walker's paper on out-of-hours visits to children (September *Journal,* pp. 427-428) and noted his comment on the dearth of direct data on the level of out-of-hours work involving children, especially during the trainee year. While a trainee in a single-handed practice in a semi-rural area I recorded all out-of-hours visits at nights and weekends. The on-call rota involved three single-handed practices with a total population of 6500. Of 169 visits, 36 were for patients in the up to five years age group (21%) and 12 were for patients in the six to 15 years age group (7%).

In the up to five years age group the morbidity pattern was: respiratory 44%, accidents 22%, abdominal (including gastroenteritis) 20%, exanthemata and unspecified fever 11% and genitourinary 3%. None of these cases required hospital admission. In the six to 15 years age group the pattern was: respiratory 57%, accidents 17%, genitourinary 17% and abdominal 9%. Two of these cases required hospital admission.

The figures involved are small, but the morbidity pattern is not dissimilar to the figures from Leicestershire quoted by Dr Walker in his discussion. It might be that more useful information could be obtained by a larger, collaborative study involving all the trainees in one area over a training year. Comparison would then be possible with inpatient statistics from local hospital paediatric units.

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Known epileptic patients brought to the accident and emergency department

Sir,

An epileptic attack appears to many lay people to be a medical emergency that warrants prompt medical treatment. Therefore, the epileptic person may precipitately appear in an accident and emergency department. If prompt first aid is carried out and it is ensured that the epileptic is not in a position to injure himself further and that after the attack he is placed in the semiprone position, it is not necessary to summon an ambulance. However, once the ambulance is called, unless the epileptic has fully recovered, he will be brought to the accident department. We therefore decided to investigate to what extent emergency attendances of known epileptic patients to an accident department were of real benefit to the patient.

During a four-month period all known epileptics who attended St George's Accident and Emergency Department because they had suffered a further convulsion, without an acute precipitating cause, were documented. Eighteen epileptic patients were brought to the depart-

ment over this period during which 9839 new patients were seen. Two epileptic patients were excluded as they were inadequately documented.

The following information was recorded. Fifteen patients had a tonic-clonic fit and one patient had a partial fit (simple right-sided motor). The age range of the patients was 14–74 years. Twelve patients had had one or more convulsions in the past year, nine of whom had had one or more in the previous month. Six patients were receiving a single drug for epilepsy, eight patients were receiving more than one drug and two patients were not receiving any medication. The convulsion occurred at home for eight patients, at their work place for two patients and in a public place for six patients. Fourteen patients arrived at the accident and emergency department in an ambulance, one in a taxi (on the driver's initiative) and one in a private car. The transport was organized by a relative in seven cases, a friend in four, a passer-by in three, the police in one and a general practitioner in one. Eleven patients were discharged after a period of rest of two hours or less with no treatment. Two patients were treated for injury and discharged (suture of lacerations), two patients were admitted (neither were in status epilepticus) and one patient was treated with the anticonvulsant drugs which he had recently omitted to take.

None of the epileptics carried a British Epilepsy Association Card. One patient wore a bracelet identifying him as an epileptic.

When a patient suffers a convulsion in a public place it is understandable for the emergency services to be contacted as there may be no one capable of supervising the patient and nowhere for him to recover. However, this was not the case for the majority of patients in this study.

Unnecessary admission to hospital accident departments is a waste of resources. Furthermore, far from doing the patient a service, the patients' realization that their convulsion resulted in their being taken to hospital serves only to heighten their self-awareness of their epilepsy. This may be partially responsible for the increased rate of suicide among epileptics which is four times that of the general population.[1]

However, a proportion of convulsions are a result of poor patient compliance with their treatment[2,3] and precipitate hospitalization may serve to reinforce compliance with prescribed medication. Where poor compliance is suspected we recommend that a blood sample for anticonvulsant drug levels is taken in the accident department.[4] The result of this test can then be considered during the necessary follow-up outpatient review.

The family and workmates of patients with epilepsy could be instructed in how to manage convulsions, with the knowledge that for known epileptics in the majority of cases only simple first aid is required. Useful guidelines for the layman are contained in pamphlets which are available from the National Society for Epilepsy and the British Epilepsy Association. In the event of a known epileptic having a convulsion the following criteria to call an ambulance should be applied by layment:

1. Unduly prolonged fit with slow recovery of more than 15 minutes.
2. Injury (especially head injury).
3. Inhalation of vomit.
4. Series of fits or the first fit in a patient in whom a fit usually presages a series.
5. Unusual precipitating factor or unusual circumstances for a fit, for example hypoglycaemia.
6. Difficulty with breathing after a fit.

Doctors are in a good position to help remove some of the fear and stigma of epilepsy by publicizing the appropriate management of epileptic convulsions. Unnecessary hospitalization of epileptic patients could then be avoided.

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Benzodiazepines as a major danger in overdosage in drug abusers

Sir,

There is pronounced regional variation in prescribing for drug abusers despite the recent DHSS guidelines for good clinical practice.[1] For this reason there are marked differences in black market trade in prescribed drugs and therefore in the experience of drug users in different centres. The prevalence of HTLV III infection also varies, presumably reflecting a high level of needle sharing in those areas of high seropositivity.[2] In regions of high seropositivity to the HTLV III virus[3] we support the provision of clean equipment as advocated recently.[4] However, we wish to draw attention to the dangers of introducing an unfamiliar drug into the illicit market in a well-meaning attempt to prevent the spread of HTLV III virus. In our own area there has been little or no prescribing of methadone and heavy reliance has been placed on non-opiate drugs as a substitution therapy or a withdrawal agent for heroin users. This is clearly reflected in the behaviour of the local black market where benzodiazepines are readily available and heavily used and abused.

Two recent cases have increased our awareness of the potential dangers of this situation. Both patients were heavy heroin abusers and both had antibodies to the HTLV III virus. In an attempt to stabilize their self-confessed chaotic opiate abuse, both were prescribed methadone as recommended by the DHSS.[1] Both continued to take prescribed diazepam but were warned that they should reduce the dose considerably if taking oral methadone (although they had previously taken illicit heroin in addition to diazepam). Both were admitted to hospital in the early hours of the morning, *in extremis,* two days after commencing therapy. One was seen by the doctor on call and given naloxone (0.4 mg intravenously) prior to admission and he survived. The other died of respiratory failure shortly after admission to the accident and emergency department of the hospital.

Although the dangers of opiate overdosage are well known and the potentiation with other drugs has been previously described, it is important that the prescribing doctor is aware of the experience of the drug users in his area and the substances available on the black market. Both of the patients described here had taken over 100 mg of diazepam and 80 mg of methadone on the day prior to admission.

The dangers of introducing a powerful opiate which is new to the local illicit market is considerable. The precise risks of large doses of opiates in combination with benzodiazepines in patients compromised by HTLV III infection is unknown.

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