GP's attitudes towards drug users

Sir,

General practitioners have long been exhorted to involve themselves in the management of patients with drug problems.1,2 Unfortunately, for the drug user, there is a wealth of research pointing to a poor doctor–drug user relationship.1,2 Sewell warned doctors about deception and manipulation by drug users,3 and more recent research4 depicted drug users as unreliable and unrewarding patients.

A study by McKeganey and Boddy stressed that the lack of established individual and practice policy creates confusion and enables drug users to manipulate the service.5 The authors recommended that strategies be developed which maintained continuity and consistency in treatment. The advent of community drug teams ushered in the era of shared care. This 'integrated model of care'6 implied collaboration between drug workers and general practitioners.

Following a seminar in May 1991 on addiction, attended by doctors in Worthing, 65 West Sussex general practitioners completed a postal questionnaire (81% response rate) canvassing their attitudes to treating drug users, especially the provision of methadone for opiate addicts. Their responses indicated continued distrust of this patient group, 59% of respondents agreeing with the statement that intravenous drug users were a threat to general practice, and 89% of respondents agreeing that given the chance, intravenous drug users exploit doctors. Hardly any general practitioners (6%) favoured injectable methadone, and short term reduction programmes were preferred to longer term maintenance (60% versus 34%, respectively). Harm reduction was seen as a legitimate treatment goal by 81% of respondents, with the vast majority of respondents (90%) favouring needle and syringe exchange schemes and education in safer drug use (72%).

Half of the sample of general practitioners (44%) were aware of intravenous drug users on their lists. One fifth (21%) would not accept a new patient with a known history of addiction, while the remainder would take them on a permanent or temporary basis. Importantly, most general practitioners had no explicit policy on accepting addicted patients (65%) or treating existing patients (66%). The majority (73%) saw the acquired immune deficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) as a greater threat to public health than the individual health issue of drug addiction but only half (51%) had altered their attitude to drug treatment as a consequence.

The data from this attitudinal survey present a more hopeful view of shared care, with 60% of the sample of general practitioners expressing a willingness to engage in the medical management of opiate dependency. This may be an indication of successful partnership between general practitioners and the community drug team.

General practitioners are faced with difficult and challenging decisions. Although many doctors have overcome their reluctance to get involved with treating drug misusers, the effectiveness of this involvement is hampered by the negative attitudes of both doctors and drug misusers and the lack of common, negotiated and explicit policies within and between practices. The sound advice in the government's Guidelines on clinical management7 should encourage improved collaboration between general practitioner and drug abuser.

M George E Martin

Options Service for Drug Misusers
29 Wordsworth Road
Worthing
West Sussex

References

Cost effectiveness of minor surgery in general practice

Sir,

The paper by O'Cathain and colleagues compared the cost effectiveness of minor surgery in general practice.1 We have few doubts about the abilities of properly trained general practitioners to perform technically adequate surgery, though the high incidence of inadequately excised lesions (5%) in this study indicates that the desire to make small excisions often overrides the surgical necessities.

O'Cathain and colleagues list the conditions treated in both settings but it is not clear whether they were all excised. In many cases excision may not have been appropriate. Certainly there are better ways of treating many of these lesions, but choice of an appropriate technique requires an accurate diagnosis. In addition, the cost of a specimen sent for histopathological examination from general practice had an incorrect diagnosis2 and there is no reason to believe that those not sent were diagnosed any more accurately. Other studies have found similar problems.3,4 Many of the lesions mentioned, if accurately diagnosed on clinical grounds, require no treatment at all.

It has been recommended that all lesions removed by non-specialists, or where the diagnosis is uncertain should be sent for histopathological examination,4 and we would agree with this. This obviously has cost implications, but nothing is more expensive than unnecessary treatment. The advantage to patients of the general practitioner performing their minor surgery is of little value if their lesion did not require excision.

Unsightly scarring and poor cosmetic results were reported more frequently in patients who had received treatment in hospital than in general practice, but as the authors point out, the case mix in the two settings was significantly different.1 The removal of more seborrhoeic warts, moles and other lesions would probably lead to a less satisfactory cosmetic result than the treatment of skin tags and warts.

The cost of excision by the general practitioner was 25% cheaper than in hospital (£33.53 versus £45.54).1 Most of the additional cost in hospital was explained by the initial outpatient visit and the higher cost of follow up, which may not be re-
quired. We believe that this cost is relatively small and is good value for money, if a clear diagnosis is made, and appropriate management is initiated. That after all, is what specialist departments are for.

We accept the convenience of general practice management, but until diagnostic ability improves, we suggest that many patients are being badly and unnecessarily treated. Training in minor surgical technique is only a small part of the necessary education — diagnosis and application of technique is equally important. The costs may make treatment in general practice appear attractive but the person who bears the expense, in the form of inappropriate treatment, is inevitably the patient.

JULIA STAINPORTH
M J D GOODFIELD
Department of Dermatology
The General Infirmary at Leeds
Great George Street
Leeds
West Yorkshire LS1 3EX

References

Coronary heart disease
Sir,
We read with interest the editorial by the chairman of the International Task Force for the Prevention of Coronary Heart Disease (February Journal, p.47) and share his concern that the mortality rates in the United Kingdom from coronary heart disease are among the world's highest. We too are anxious that all appropriate measures are used to help normalize cholesterol levels. However, Professor Lewis' comment that 'after 20 years of research there is no persuasive evidence that reducing plasma cholesterol to 4.9-5.0 mmol l-1 causes any untoward effect' is directly contradicted by a recent editorial in the British Medical Journal in which it was suggested that multiple interventions in middle aged men with a moderate risk for coronary heart disease may do more harm than good. In the same issue there was also a call for a moratorium on the use of cholesterol lowering drugs. In 1991, an overview of 16 published controlled trials of diet designed to lower serum cholesterol levels suggested that they were much less effective than once supposed.

If our interpretation of the various studies is correct, only the Oslo study has shown that the level of serum cholesterol and the risk of fatal coronary events can be definitely reduced without an associated increase in overall mortality. However, this study was carried out on a select population with very high cholesterol levels (7.5-9.8 mmol l-1) and very high dietary fat intake (average 44% of total energy, compared with an average of 35-37% in British men). In addition, the diet was remarkably strict and there was also a concurrent reduction in cigarette smoking in the intervention group. As Ramsay and colleagues point out, the study's results cannot be extrapolated to those with less severe hyperlipidaemia, to those with a more typical dietary fat intake, to women, or to the outcome with a standard cholesterol reducing diet. This latter diet, in which total fat accounts for less than 30% of total calories, where the ratio of polyunsaturated fat to saturated fat is 1.0, where cholesterol intake is less than 300 mg daily and where calorific intake is reduced to achieve a desirable weight, has little effect on serum cholesterol concentration in subjects not living in institutions (mean reduction in cholesterol level of 2%, range 0% to 4%, over six months to six years). At this level of efficacy the cost per life year gained through the use of such a diet would be about £62 000 for men and £310 000 for women; the use of effective lipid lowering agents would apparently increase costs approximately 10-fold.

But it is over the safety of these drugs that there is most controversy. Although most of the available lipid lowering drugs are known to influence lipid levels favourably, there is a lack of long term data showing them to reduce overall mortality rates. The increased overall mortality associated with clofibrate in the World Health Organization study is well known and consequently this group of drugs is regarded with caution. On the other hand, the newest group of drugs, the 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, such as lovastatin and simvastatin, would appear to be more hopeful, having a satisfactory side effect profile and showing up to 32% reductions in cholesterol levels within weeks (data on file, Merck Sharp and Dohme Limited). Up to 25% of the UK population may be eligible to commence treatment with these drugs (Monthly index of medical specialties, January 1992). However, in the first year of a study clinically evaluating lovastatin, a worrying trend has appeared: it would seem that there is already an excess mortality rate in the treatment group.

In summary, the evidence suggesting that general practitioners may usefully reduce the cholesterol levels of those at moderate risk of coronary heart disease is conflicting and inadequate. The resulting confusion has been compounded by the many sets of guidelines for the management of hypercholesterolaemia, published by national and international advisory

Care of patients with psychiatric problems
Sir,
I read with interest the editorial by Elizabeth Horder on care for patients discharged from psychiatric hospital.

The essential message to come out of the editorial was the importance of communication between general practitioners and psychiatric services. At present, care is often fragmented and information is not exchanged between the general practitioner and psychiatric services concerning their roles and the provision of ongoing care.

Continuity of care is important when dealing with patients who have chronic psychiatric problems. This continuity can be provided by close links between community psychiatric teams and the general practitioners in their area. Link workers can telephone or visit general practitioners on a regular basis. They can then receive information or referrals at an early stage and give an appropriate response.

Shared care has worked well in obstetrics for many years. The differing roles of the obstetrician, midwife and general practitioner have been utilized to the benefit of the patient. By cooperation, we can also provide broader and better care for chronic psychiatric patients.

AMANDA KIRBY

References

Coronary heart disease
Sir,
We read with interest the editorial by the chairman of the International Task Force for the Prevention of Coronary Heart Disease (February Journal, p.47) and share his concern that the mortality rates in the United Kingdom from coronary heart disease are among the world's highest. We too are anxious that all appropriate measures are used to help normalize cholesterol levels. However, Professor Lewis' comment that 'after 20 years of research there is no persuasive evidence that reducing plasma cholesterol to 4.9-5.0 mmol l-1 causes any untoward effect' is directly contradicted by a recent editorial in the British Medical Journal in which it was suggested that multiple interventions in middle aged men with a moderate risk for coronary heart disease may do more harm than good. In the same issue there was also a call for a moratorium on the use of cholesterol lowering drugs. In 1991, an overview of 16 published controlled trials of diet designed to lower serum cholesterol levels suggested that they were much less effective than once supposed.

If our interpretation of the various studies is correct, only the Oslo study has shown that the level of serum cholesterol and the risk of fatal coronary events can be definitely reduced without an associated increase in overall mortality. However, this study was carried out on a select population with very high cholesterol levels (7.5-9.8 mmol l-1) and very high dietary fat intake (average 44% of total energy, compared with an average of 35-37% in British men). In addition, the diet was remarkably strict and there was also a concurrent reduction in cigarette smoking in the intervention group. As Ramsay and colleagues point out, the study's results cannot be extrapolated to those with less severe hyperlipidaemia, to those with a more typical dietary fat intake, to women, or to the outcome with a standard cholesterol reducing diet. This latter diet, in which total fat accounts for less than 30% of total calories, where the ratio of polyunsaturated fat to saturated fat is 1.0, where cholesterol intake is less than 300 mg daily and where calorific intake is reduced to achieve a desirable weight, has little effect on serum cholesterol concentration in subjects not living in institutions (mean reduction in cholesterol level of 2%, range 0% to 4%, over six months to six years). At this level of efficacy the cost per life year gained through the use of such a diet would be about £62 000 for men and £310 000 for women; the use of effective lipid lowering agents would apparently increase costs approximately 10-fold.

But it is over the safety of these drugs that there is most controversy. Although most of the available lipid lowering drugs are known to influence lipid levels favourably, there is a lack of long term data showing them to reduce overall mortality rates. The increased overall mortality associated with clofibrate in the World Health Organization study is well known and consequently this group of drugs is regarded with caution. On the other hand, the newest group of drugs, the 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, such as lovastatin and simvastatin, would appear to be more hopeful, having a satisfactory side effect profile and showing up to 32% reductions in cholesterol levels within weeks (data on file, Merck Sharp and Dohme Limited). Up to 25% of the UK population may be eligible to commence treatment with these drugs (Monthly index of medical specialties, January 1992). However, in the first year of a study clinically evaluating lovastatin, a worrying trend has appeared: it would seem that there is already an excess mortality rate in the treatment group.

In summary, the evidence suggesting that general practitioners may usefully reduce the cholesterol levels of those at moderate risk of coronary heart disease is conflicting and inadequate. The resulting confusion has been compounded by the many sets of guidelines for the management of hypercholesterolaemia, published by national and international advisory