This month • SIDS • psychotropic drugs • privatization • Irish immigrants

Dealing with uncertainty: SIDS

DEALING with uncertainty is seen as an essential skill for general practitioners and although it is much discussed in training circles, there is not much about it in the literature. This study was an attempt to examine the subject directly and the sudden infant death syndrome (SIDS) was seen as a useful model because so little is known about its causes. The study was part of a programme for identifying children at risk from SIDS and providing the families with monitors. Both physicians and families were interviewed to elucidate their explanatory models, and the encounters between physicians and families were observed.

Staff admitted their ignorance, but most favoured a pulmonary model for SIDS, and also mentioned others such as cardiac or neurological abnormalities and child abuse. They disagreed whether SIDS came out of the blue or was the culmination of a series of events, and this was thought to represent a more fundamental disagreement about whether monitors could be effective. Some thought monitors worked only to alleviate parental anxiety but others thought they could be medically useful. Parents' perceptions concentrated mostly on immaturity, for instance that babies got too relaxed and forgot to breathe. Not surprisingly, parents' models showed more variability than those of the staff.

When the clinical encounter was observed the important fact was that uncertainty was not expressed to families. For instance, physicians often did not mention SIDS at all, tending to concentrate more on the children's overall condition, underlying lung disease or apnoea. Not one family was told that the monitor might not prevent their child dying of SIDS. The staff talked a lot about apnoea in order to de-emphasize SIDS but parents continued to associate the two.

The staff acted with certainty by focusing on what was known and sticking to the treatment protocol. This denial of uncertainty was thought to relieve both parental and physician anxiety, and make action possible despite considerable lack of knowledge. The monitor becomes a symbol of this denial and is an important part of therapy, decreasing anxiety in the face of an unpredictable outcome.

One is left wondering how the physicians in this study reacted to the findings, and whether similar conclusions might be found in general practice in the UK for other types of encounters.

(D.J.)

Source: Wright AL. Models of mystery: physician and patient perceptions of sudden infant death syndrome. *Soc Sci Med* 1988; **26:** 587-595.

Long-term psychotropic drugs

THERE have been several recent studies of patients on long-term psychotropic medication. In this study general practice patients on long-term drugs were compared with a group of controls, using the present state examination and Eysenck personality inventory.

The study group comprised 3.6% of the registered patients. Nearly a third had been receiving psychotropic drugs for two to five years, and over half for more than six years. The drugs prescribed were, as expected, anxiolytics, antidepressants and non-barbiturate hypnotics. However, they were thought by the authors to have been prescribed in low doses (particularly the antidepressants), and to have been ineffective in alleviating the symptoms of those of the index patients, slightly less than half, who were unwell at interview. It was suggested that these people might be helped either by increasing the dose of their drugs or by trying a non-pharmacological treatment.

The findings are in line with other studies. Contrary to the current myth portrayed by the media, patients on long-term psychotropic medication are a minority. They are not being inappropriately treated, except that the treatment is not always effective. What we need next is information about how much effort it will take to make the treatment more effective, and whether the patients will welcome it. However, for their own sanity those setting out on this path should decide in advance how many patients on long-term medication, both effective and less so, are acceptable: might 3.6% be low enough?

(D.J.)

Source: Catalan J, Gath DH, Bond A, *et al.* General practice patients on long-term psychotropic drugs. A controlled investigation. *Br J Psychol* 1988; **152:** 399-405.

Is privatization bad for your health?

WHAT is the relationship between outcome of care and the pressures to reduce costs? Death is a fashionable outcome in questions of this sort. One of the authors of this paper is from a school of management, the other is from a medical school. They had a hunch that severe regulatory constraints and strong competition for patients in private hospitals would be associated with poorer outcome for patients than expected. To test this hypothesis they analysed the variation in mortality rates among 981 hospitals in patients from 16 diagnostic categories. Number 16 was 'preventable complications and other misadventures in medical care'. This was chosen because the authors surmised that it might be particularly sensitive to pressures on hospitals to contain costs.

In some states in the USA it appears that a certificate-of-need has to be obtained before a hospital or nursing home can be opened. The criteria in some states are more stringent than in others, with the state being highly regulatory. The authors found that such regulation was associated with significantly poorer mortality rates than expected and also that hospital stay was much longer in such hospitals. This is not what one would have expected. Surely control would have avoided unnecessary operations and demand for beds would have meant that income was assured and turnover rapid? The authors speculate that having to fulfil state regulations may be a barrier to innovation and the upgrading of hospitals. In other words institutions only perform to what is expected from them. Just like individuals. This has enormous implications for the NHS.

Their next finding was that where health maintenance organizations had penetrated the market and were competing with each other mortality rates were significantly higher than expected. The authors found that there was a tendency to cut staff and forgo new programmes that could improve the quality of care.

So what do we make of all this? The authors are guarded in their conclusions. They agree mortality is only one outcome measure of quality of care but they do advise that a closer eye be kept on health maintenance organizations where the competition is fierce and in areas where regulation is strict. These findings will be bittersweet for those who are sold on competition and health maintenance organizations. But those who are sold on that big institution called the NHS also have food for thought.

(T.O'D.)

Source: Shortell SM, Hughes FX. The effects of regulation, competition, and ownership on mortality rates among hospital inpatients. *N Engl J Med* 1988; **317:** 1100-1107.

Irish immigrants have their problems too

BECAUSE of longstanding free access between both countries, there is an established pattern of Irish emigration to Britain, especially in times of economic depression such as during the great famine of 1845–49, the 1930s, the 1950s and most recently in the mid-1980s. In 1971 1.8% of the population of England and Wales had been born in both parts of Ireland.

While Irish immigrants do not generally share the linguistic, racial and broad cultural disadvantages of other immigrants, they tend to be from the lower social classes and have predictable mortality patterns. The standard mortality ratio of male Irish immigrants to England and Wales between 1970–72 was higher than that of the male population in Ireland and the general population in England and Wales. In contrast, female immigrants had a standardized mortality ratio a little lower than the female population in Ireland and a little higher than the total female population in England and Wales. Mortality in both sexes was highest, relative to Ireland, in conditions with a behavioural background, such as smoking-related cancers, obstructive airways disease, peptic ulcer, cirrhosis, accidents, poisoning and violence, and in tuberculosis as well.

Ease of migration may mean that ill health and economic and social disadvantage, rather than acting as a barrier, may act as a spur to migration. A change from the rural Irish environment to the industrial environment of England, and heavy smoking habits, may explain the higher lung cancer rates among immigrant men. Doctors practising in areas such as London, the Midlands, Liverpool and Glasgow — traditional destinations for Irish immigrants — should be aware of these trends as large-scale Irish immigration is likely to continue.

(C.D.)

Source: Adelstein AM, Marmot MG, Dean G, Bradshaw JS. Comparison of mortality of Irish immigrants in England and Wales with that of Irish and British nationals. *Ir Med J* 1986; **79:** 185-189.

Contributors: D. Jewell, T. O'Dowd, C. Daly.

FILL THIS SPACE

Contributions to the Digest pages are welcome from all readers. These should be from recent papers in research journals which general practitioners might not normally read. Send to: The Editor, Journal of the Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE. Please quote the full reference to the article (authors, title, journal, year, volume, page range).

INFECTIOUS DISEASES UPDATE

Advice for travellers

The Department of Health and Social Security has in 1988 brought out a new and colourful edition of a travellers guide for health entitled *Before you go.* This pamphlet SA40 replaces the previous SA30 and 35. It is free of charge and can be obtained by telephoning 0800-555777 or in bulk from DHSS Leaflets Unit, PO Box 21, Stanmore HA7 1AY. The information given includes a country by country listing of recommended vaccinations and whether or not malaria is present. Additional comments on immunoglobulin against hepatitis A and on bacille Calmette-Guérin (BCG) are made and advice given on rabies and the acquired immune deficiency syndrome. The advice is concise and therefore is not able to take into account to any great extent the traveller's intended lifestyle — for example, administering cholera vaccine to the businessman staying two nights in a four star hotel in Kuala Lumpa may be considered excessive — but this can be allowed for during consultations. The booklet gives advice on malaria prevention and general measures such as avoiding mosquito bites. It does not go into detail about regional differences in prevalence within a country or describe which prophylactic tablets may be appropriate.

The book updated annually by the World Health Organization, *Vaccine certificate requirements and health advice for international travel* (available through Her Majesty's stationery offices, price Sw fr 14, approximately £8), gives regions within countries where the greatest risk exists and whether or not there is drug resistance. This further information can help avoid the unnecessary use of prophylactic tablets with their occasional side effects and indicate when two drugs taken in combination may be preferred because of resistance problems.

Further information for advising travellers is available in a variety of books: *Travellers health* by Richard Daywood (Oxford University Press, 496 pages, price £6.95) gives a comprehensive look at prevention. *Well away: a health guide for travellers* by E. Walker and G. Williams (British Medical Journal, 56 pages, price £5.00) gives a briefer account for the lay public or the general practitioner needing an occasional source of reference.

Meningococcal infection in Africa

This year has seen a large outbreak of meningococcal septicaemia and meningitis especially in the eastern parts of the 'meningococcal belt' of sub-Saharan Africa. Countries affected included Sudan, Ethiopia and Chad. Several thousands of cases were reported to the World Health Organization with a mortality of approximately 10%. In 1987 this annual epidemic spread across into the Arabian peninsular. A single dose of vaccine which gives protection for about two years against the 'C strain' normally responsible for epidemics can be obtained on a named patient basis from Merieux UK Ltd in single dose or from Smith, Kline and French Ltd in 10 dose vials.

Measles, mumps and rubella vaccine

This combined vaccine will soon be introduced throughout the UK and it should replace monovalent measles vaccine, normally given to children at around 15 months of age. It is hoped that the publicity surrounding its introduction and the advantages of a three-in-one injection will encourage a high uptake which has never been achieved with the measles vaccine alone. The combined vaccine has for some years been used successfully in the USA and rubella vaccine alone should still be offered to girls at secondary school both to cover children who missed out on the vaccine as infants and to ensure good antibody levels as girls reach the childbearing age. As with monovalent measles vaccine, when the combined vaccine is given to infants aged under one year (for example prior to travel to highly measles endemic areas or to children with fibrocystic disease) then a further dose during the second year of life is advisable.

Suggestions for topics to include in future updates are welcomed and should be passed to the contributor, Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (041-946-7120), from whom further information about the current topics can be obtained.