

LETTERS

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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

A path towards self care

Sir,

Non-professional health care is part of the cultural heritage of the community. In western societies, the progressive specialization and technological orientation of medicine have a negative effect on health care resources within the community. We see increasing dependence on formal health care and the abandonment of self care.

It has recently been shown^{1,2} that it is possible to promote self care through health education. We have explored the knowledge, beliefs and attitudes of our patients with respect to a self limiting illness, the common cold. Our survey employed a 30 item questionnaire administered to a random sample of patients attending a primary care centre located in the industrial belt of Barcelona. A total of 162 patients (33% men, 67% women) completed the questionnaire while waiting to see the doctor. Their average age was 42.3 years.

Fifty seven per cent of those surveyed claimed that some of the therapeutic measures they habitually use (drugs and/or home remedies) have healing effects against colds. Home remedies (vapours, gargling, and so on) were used by 62% of respondents and their use was reported more frequently by women. Over the counter medicines, mainly analgesics, were bought by 57% of respondents. Over half of the sample stated that they go to their family doctor when they have a cold; fever and general malaise were the symptoms most likely to lead to a consultation. Eighty seven per cent of respondents thought that a cold may cause more serious illnesses and this view was almost universal in people aged over 45 years.

We agree with other authors^{3,4} that this type of study can be useful for determining groups highly dependent on health services and we hope that they lead to the development of health education pro-

grammes which are effective in increasing the responsibility of patients for their own health.

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Role of practice nurses

Sir,

We would like to report the results of a joint workshop between the Torbay district sub committee of the local medical committee and the Torbay practice nurses group. This arose after the 1989 Exeter trainers course which broke new ground by including practice nurses.

The aims were to increase understanding of the role of practice nurses, and to explore and promote their training. A set of objectives were agreed:

1. The body of knowledge and range of duties of practice nurses should be defined.

2. Practice nurses should be taught by practice nurses.
3. Funding for this education should be made available and time allowed.
4. Prospective practice nurse trainers should learn to teach, have attended a trainers course and have been in post for three years.
5. Practice nurses should work from a suitable environment.
6. Practices with practice nurses should produce agreed practice policies.

In an attempt to define the role of the practice nurse the tasks they performed were listed under the following headings: clinical, immunizations and injections, diagnostic, family planning, counselling, teaching, screening, audit/research, administration/management and management of chronic disease. This list was sent to Torbay practice nurses who were asked to divide the tasks into three groups: those expected of all practice nurses after their initial introductory period, those expected of the average experienced practice nurse and those expected of advanced nurses after further training.

A paper was presented to the local medical committee and the practice nurses group, who endorsed the aims and objectives.

The exercise highlighted the extensive role of the practice nurse. Many duties normally classified as part of an 'extended role' for community nurses are regarded by practice nurses and their general practitioners as within the normal definition of practice nursing. The exercise also illustrated that there were different levels of skills as defined both by nurses themselves, and by what general practitioners will delegate.

It became clear that the training needs of practice nurses are different for different levels of skill and a practice nurse would normally expect a period of practice experience before undertaking further training for advanced tasks. The exercise

reinforced the need for practice nurses to be taught by practice nurses.

We hope this work will further the development of practice nurse education in general practice.

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Books for general practitioners

Sir,

A study of general practitioners' use of postgraduate centre and practice premises libraries has been undertaken in the Vale of Trent faculty area of the Royal College of General Practitioners. A simple questionnaire was sent to all principals via the family practitioner committees in the area. The aim of the survey was to find out how many general practitioners had books on their practice premises and to determine the use made of their own practice libraries and of the postgraduate centre libraries.

Of 893 doctors, only 216 (24%) replied from 136 practices. Less than half of the practices had 50 books or more on their premises. Most of the remainder had 10-50 books. It was interesting to note the general practitioners' choices of the most useful books of reference. The five most frequently chosen books were: Fry's *Illustrated guide to dermatology*; the *British national formulary*; the *Oxford textbook of medicine*; Price's *Textbook of medicine* and Balint's *The doctor, his patient and the illness* (mentioned by 47, 45, 39, 20 and 20 doctors, respectively).

Postgraduate centre libraries appeared to be greatly under-used by general practitioners — a fact which might repay more detailed enquiry. From our survey and from general practitioners and postgraduate centre librarians in Nottinghamshire, Derbyshire and Lincolnshire a fairly comprehensive reading list has been compiled; our thanks go to them, to Margaret Hammond, RCGP librarian, and to Janet Baily, administrative assistant of the Vale of Trent faculty. The list will be kept up to date annually and it could be of value to practices whether they have a library or not. It is available from Mrs Janet Baily, Postgraduate Office, Medical School, Queen's Medical Centre, Nottingham NG7 2UH. Cost £2.50 including postage.

Out of hours workload

Sir,

The paper by McCarthy and Bollam on the use of telephone advice for out of hours calls (*January Journal*, p.19) is an interesting description of the situation in north London. However, two factors may limit the wider applicability of the results they report.

The first is the use of 'practices' as the primary denominator for analysis. A review of out of hours care in my own urban practice with 5800 patients revealed a large variation in the use of telephone advice among established general practitioners during 1989 — from 2.9% to 35.5% of all patient contacts made between 18.00 hours and 08.30 hours (total 802). To quote only the overall mean of 16.3% of out of hours patient contacts managed by telephone advice would lose sight of the importance of inter-doctor

variation. Moreover, further analysis of this data reveals that the time of day at which the patient contact was made exerts an additional influence on the doctors' management of the contact. Figure 1 demonstrates three patterns of doctor response to out of hours patient contact seen among the five trained doctors in the practice. The time of day clearly exerts an influence on whether a doctor will visit in response to a patient contact, but this factor appears to influence different doctors in different ways.

Secondly, it would be more helpful to express the management of out of hours calls as a rate per 1000 patients at risk, rather than the number of calls per general practitioner in the practice. This would allow comparison between individual practices as list sizes vary considerably between practices in any one geographical area. Application of regression statistics to my data suggests a close relationship ($P < 0.01$) between the percentage of calls managed by telephone advice and the total number of calls received.

McCarthy and Bollam observe the potential importance of daytime doctor accessibility on the use of out of hours care, a factor previously noted by Livingstone and colleagues.¹ Data from my practice suggest that when no more routine surgery appointments are available at midday, the doctor on call that evening is twice as likely to be disturbed as on days when appointments are available (Table 1). The data presented represent only 156 of 257 possible weekdays during 1989. It is likely that, given a larger data base, an even closer relationship between accessibility and out of hours workload would be demonstrated.

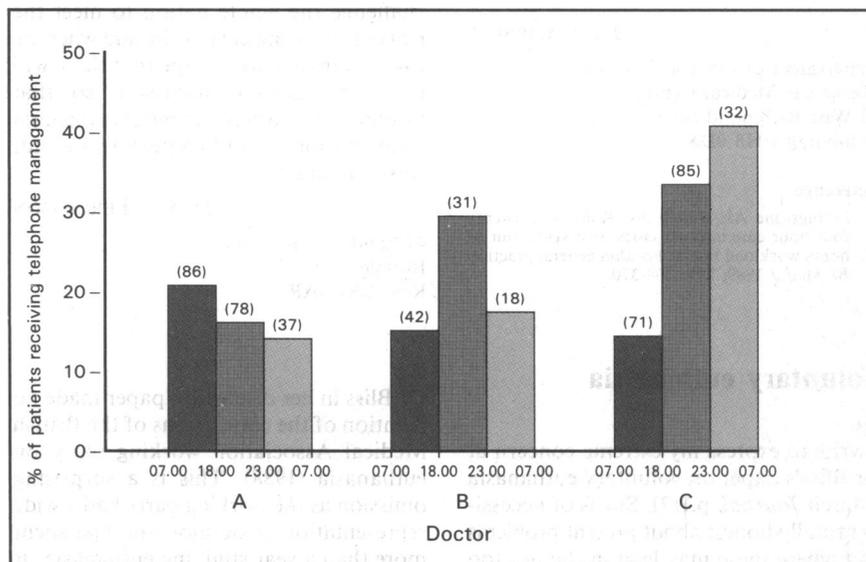


Figure 1. Percentage of patients receiving telephone management by doctor and by time of call. The total number of patients is shown in parentheses at the top of each bar.