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Health promotion under the new contract

Sir,

To assess how the health promotion department in greater Glasgow health board could more effectively support local general practitioners, and to foster stronger personal links between general practitioners and health promotion officers, a questionnaire survey was carried out by health promotion officers in February 1990. Representatives from 202 practices (91% of all practices in greater Glasgow) participated.

Almost all general practitioners (96%) expressed the view that they had a role in health promotion although only 43% had made any previous use of the services of the health promotion department. This reflected the fact that most health education carried out by general practitioners was directed towards individuals and carried out opportunistically in the context of the consultation. Structured, formal health promotion sessions were uncommon at the time of the survey. However, there was a clear indication that most practices were intending to establish or develop health promotion sessions — sessions for well women, well men, heart disease prevention, dietary advice and smoking cessation were the most commonly cited. The practices will need considerable support if health promotion sessions are to increase to these levels. The provision of additional staff, training for staff, adequate premises and support materials were identified as the main needs.

This survey has highlighted three main areas for concern. First, it has revealed that the health promotion department is seen primarily as a resource of leaflets and posters yet most health promotion professionals would argue that they have a much more active role to play as trainers, advisors and active participants. Clearly, much more needs to be done through joint working and collaboration to foster stronger links between general practitioners and health education/promotion officers. A second concern is that the establishment of formal, structured health

promotion sessions might diminish the general practitioner's long established role as an opportunistic health promoter. This would be a backward step which we need to guard against. Thirdly, it is difficult to see how health education/promotion departments will be able to meet the increase in demand for support materials which will inevitably accompany the current growth in health promotion sessions. It is therefore important to establish clear and agreed priorities so that the most important resource needs are identified and potentially constructive relationships are not compromised over disputes about resource provision.

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A simple ophthalmic diagnostic aid

Sir,

I wish to report the use of a metal tea strainer as an inexpensive and easily managed pin hole device. Some referrals to overcrowded eye outpatient departments could be avoided or redirected to opticians if a pin hole test were available in general practice. After recording distance vision, a pin hole in an opaque disc is held in front of the patient's eye allowing a small pencil of light to enter the eye unaffected by the eye's focusing system, creating a smaller blurred circle on the retina. If the vision is improved, this indicates that it is the focusing system which is at fault and this can usually be corrected by spectacles. If the vision is not improved, a pathological state is more probable.^{1,2}

The pin hole can be difficult to manipulate, especially for patients with less dexterity and comprehension, and discs with multiple holes are often used to overcome this problem. A metal tea strainer has multiple holes and is easy to

hold and manipulate. Tea strainers are available for less than £1.00 in supermarkets and although most have holes larger than the ideal 1 mm,² in the author's experience they are nearly as effective as the pin hole discs used by ophthalmologists. Good background illumination on the chart is necessary, since the pin hole diminishes the amount of light entering the eye.¹

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The telephone — an under-used instrument?

Sir,

Recent studies have shown there is a need for more efficient communication between secondary and primary care.¹⁻⁴ The shift of responsibility for care and recovery at an earlier stage to the general practitioner has made this particularly important. The time taken for the general practitioner to receive information following a patient's discharge from hospital has been shown to be a problem.¹⁻³

In order to explore the speed, reliability and acceptability of early transfer of information by the junior hospital doctor making use of a telephone, an attitude questionnaire was sent to the 245 general practitioners who refer patients to the medical inpatient services of Plymouth general hospital. The 87% response rate was felt to indicate a representative sample of opinions. Of these general practitioners, all confirmed a telephone message would be helpful but 90% preferred the service to be limited to particular cases. A similar proportion (92%) said they did not object to being disturbed during surgery hours. However, reservations were expressed at the inconvenience of being in-

errupted during consultations. The possibility of mistakes arising from verbal messages was also raised.

The system was thought to be particularly helpful following the death of a patient and also where early follow up was important, as in serious illness, essential changes in medication and pressing changes in social support.

Many general practitioners felt the present system was unreliable, with unreasonable delays in receiving discharge letters which at times contained inadequate and inaccurate information. This confirms a study by Harding³ who found that general practitioners were dissatisfied with the delay in receiving over one third of letters and the content of almost a fifth, and that this adversely affected their management in a quarter of cases. Lockwood and colleagues⁵ found that for one fifth of patients no information was available to the general practitioner at the time of the first consultation after hospital discharge, and that a third of these patients suffered poor continuity of care as a result. Penny⁴ showed most of the problem lay in delay in the typing of summaries and recommended an increase in secretarial staff.

In order to assess the practicality of the proposed telephone message system in my role of general medical senior house officer, I telephoned discharge information on 100 consecutive cases to the general practitioner's surgery. The time taken and the member of the primary health care team spoken to was recorded. A subjective reaction to the general practitioner's response was noted. Communication time was quick with a mean of 2.4 minutes. It was possible to speak directly to the patient's general practitioner or partner in two thirds of cases, while in the remaining one third, a message was left with the receptionist. In most cases (87%) the general practitioners responded favourably to being contacted in this way and appreciated the opportunity of discussing their patient's further management.

Clearly, there is a need to improve the present system of handover of patient care. As more practices and hospitals become computerized the possibility exists for direct linkage between the two and this could pave the way for future quick transfer of information. However, an opportunity for hospital doctors and general practitioners to discuss the management of their patients allows a greater understanding of respective difficulties and skills and leads to a smoother, more efficient handover of care.

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Action thresholds

Sir,

The paper by Grol and colleagues about attitudes to risk taking among general practitioners from different countries and health care systems takes into consideration how hospital rather than community-based training may lead to a tendency to overdiagnose serious illness (April *Journal*, p.134). Certainly, the making of generalizations on the basis of limited clinical experience, and errors in probability estimation, fall within the realms of 'pathological learning'.¹

Within British general practice, great variations in doctors' behaviour exist in many areas of professional activity.² Wide differences occur where doctors are least confident in their behaviour, for ex-

ample, when prescribing antibiotics in respiratory illness and tranquilizers in anxiety.³

In an attempt to explain this phenomenon, 'thresholds' for activities such as referring⁴ and prescribing⁵ have been postulated. Individuals may be expected to differ in their reactions to uncertainty: in the area of perceptual judgement, a distinction has been drawn between doctors who prefer the risk of reacting, and possibly being wrong, and doctors who prefer the risk of not reacting and possibly being wrong.⁶ In terms of the abstract concept of 'tolerance of uncertainty', not prescribing or not visiting may involve a more active consideration of risk than prescribing or visiting.

'Prescribing thresholds' for antibiotics in acute sore throat were defined for the doctors in two general practices.⁵ During a study which assessed the out of hours workload of one of these practices,⁷ the data were then analysed to determine the responses of individual doctors in terms of the action of visiting or offering advice on the telephone, and hence a 'visiting threshold' was determined. A comparison was made between individual doctors for both thresholds. A statistically significant correlation between readiness to prescribe and readiness to visit was demonstrated (Figure 1) and, despite the small number of subjects involved in the study we believe that it represents evidence of differences between individuals in their approach to risk taking. The existence of this is consistent with observations that interven-

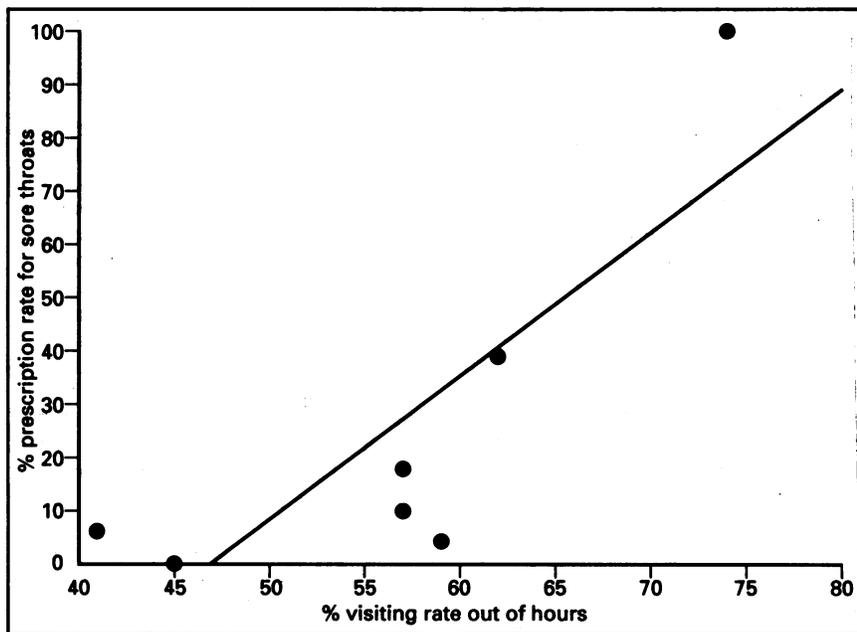


Figure 1. Correlation between prescription and visiting rates ($r=0.82$, $P<0.05$) for seven general practitioners.