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GP use and views of an inner-city GP unit

Recent shifts from acute to primary care have increased the popularity of urban GP units,[1] where GPs have admitting rights and retain clinical responsibility for patients. Proponents argue that GP wards raise standards of general practice and promote liaison between acute and primary care; however, factors such as proximity,[2] or single-handedness[2,3] can act as barriers to GPs.

We conducted a study to determine whether GP use of an inner London GP unit was affected by GPs' views or practice characteristics. Data on GPs' use of the unit were collected from the ward for the period February 1998 – March 1999. Eighteen GPs registered with the ward completed semi-structured interviews about the unit, from which a postal survey was developed and sent to the 74 registered GPs (response rate = 85%, of whom four GPs were excluded owing to insufficient data).

During the study period, 41% made no admissions to the ward; conversely, 39% of admissions came from four GPs, although these practices were not based closest to the unit, nor did they have more elderly patients. Of those that replied to the survey (n = 59), GPs thought that staff attitudes were very positive (83%), standards of care were high, and GPs retained control (80%). A total of 80% felt that there was good continuity of care and patients would rather be admitted to the GP unit than to an acute ward (71%). However, 66% of GPs felt that it created extra work and 61% felt that travelling to the unit was time consuming and parking was problematic. GPs who had not used the ward in the previous year were as positive about the ward as those who had (Table 1).

Ward use was positively associated with the view that patients preferred it to acute wards ($P<0.01$) but did not vary with other views or practice characteristics (number of partners, list size, or proportion of elderly patients). As registration with the unit remains an individual preference, motivation by registered GPs to use the service may be attributed to patient-related factors (e.g. patient preference) or reluctance to change current methods of practice.

Although the ward maintained an 80% average occupancy rate over the year, one-third of admissions were made by four GPs and most hardly used the unit, raising questions about appropriate usage and accessibility of the ward. Given the current emphasis on intermediate care,[4] development of GP units may increase; however, GPs' views require further consideration before similar services are commissioned elsewhere.

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Table 1. GP use of the unit based on GP views of the ward (n = 59 GPs who responded to postal survey).

	Used unit n = 38 Agree n (%)	Did not use unit n = 21 Agree n (%)
Positive views		
Attitude of staff is very positive	35 (97)	14 (100)
Unit provides high standards of care	34 (97)	13 (93)
GPs remain in control	32 (91)	15 (94)
Unit provides good continuity of care	33 (94)	14 (93)
Patients prefer to be admitted to GP unit rather than to acute ward	31 (100)	11 (79)
Negative views		
Creates extra work	28 (78)	11 (69)
Travelling takes up a lot of time	24 (69)	12 (71)
Parking is problematic	24 (69)	12 (86)

What are GPs for?

This is a question I have often asked myself and I'm sure most GPs do the same. Like Phil Hanlon,[1] I too work in Glasgow but unlike this Professor of Public Health I am female and I have worked as a GP in Glasgow for 17 years. I hope to do so for quite a few more years!

I agree that as a GP I am challenged by 'the need to take account of a wide range of personal issues'.[1] The system I work within does not make available to my patients, via myself, or the other members of the primary health care team, the resources that are needed to tackle these wider issues. If I identify a range of stressors that need social solutions, what are the responses available to me? Currently I have problems accessing even narrowly defined 'medical' resources. How do I get help for that single parent whose nights are disturbed by an insomniac baby? How do I get help for adults who have never developed confidence or self-esteem? My current repertoire is limited to 'sick lines' and prescriptions! The constraints of a 10-minute consultation makes the use of 'talking therapy' impossible and the volume of problems that my patients bring makes such an approach almost impossible to sustain. And yet I still measure a consultation that ends without a prescription (where one is not warranted and would be used as a 'sticking plaster') to be a measure of success, and I still finish my surgeries an hour late. (Might I fail re-accreditation?)

He states that 'primary care could make a larger impact on the health of the local population'[1] without being explicit about how this would happen. I agree that a wide range of factors including physical environment, social environment, and wealth distribution determines health. However, I am left puzzled by how he thinks primary health care teams will address these issues. Direct environmental action? Community activism? Political activity? I have been involved in all of these so I do not shy away from such activities. But such involvement has been outwith my working hours as a GP. Is he suggesting that this should now be core general practice activity?

He suggests that changes, not clearly specified, might spell the end of 'medical domination'. I am not afraid of this suggestion. However I wonder if he has thought through the demise of all medical domination. General practitioners do partake of this medical authority but often find their authority qualified by their 'subaltern status'.[2] How does he envisage a diminution of the power within the central hierarchies of medicine, the hospital consultants, the generals, themselves? How does he see the positioning of public health consultants themselves? A recent letter in the *BMJ* raised the important issue of how to achieve an independent public health voice.[3]

Where is the patient's voice in all of this? I don't think it is the same as 'consumer choice'.[1] I hope not, for consumers in reality do not have choice — they can take or leave what is offered, rarely are they in a position to shape what they require. I thought that was what recent government policy about involving patients in the health service was supposed to enable.

In my opening paragraph I deliberately draw attention to my gender as I feel much of what is written in Hanlon's article is based upon the assumption that we wish to continue in a system of patriarchal hierarchies that were idealised by the social Darwinists last century.[4]

To suggest that it is 'traditional' for womens' role to be limited to child-rearing and home-making is to ignore the largest part of the history of the human race.[4] Only a small number of women, those attached to and supported by affluent, middle-class men have had their role confined to the domestic arena. Women have always had dual careers. They have always made 'trade-offs' between child-rearing and other activities necessary for the economic survival of their families. Males have throughout human existence had very variable input into the rearing of their biological children. This is not a new phenomenon.

The positioning of women as 'new GPs' within a 'new society' will be an interesting area to research. Current forecasts of medical 'manpower' suggest that it will soon become medical 'womanpower' that dominates, in a numerical sense, in general practice. Does this have anything to do with Hanlon's vision of a shift in power dynamic in primary care?

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School students and the clinical arena

Dr Thistlethwaite in her recent letter[1] expresses appropriate concern in relation to the presence of school students, in contrast to undergraduates, in sensitive clinical situations including the consultation within general practice. Perhaps the time is overdue for the profession to self-regulate in this highly important area, not just in primary care but also in hospital and community settings.

It could be argued that there is never any justification for the intrusion of a school student, who in any case might choose another career, within the sanctity of the doctor–patient relationship. So why does the situation arise? Is it simply the demands of 'work experience', or of that recurrent dinner party topic, the insidious, all-important CV. Whatever the mechanism, the profession is ultimately responsible and has always possessed the power, if not the will, to control events.

Surveys indicate that around 20% of UK medical undergraduates have at least one medically qualified parent, while only a minority will have been educated in the state sector. As school students, do these young people possess inherent advantages that can unlock doors that should remain closed until formal matriculation?

It is unlikely that anyone, in particular the hapless patient, would be prepared to challenge the archetypal con-

sultant who strides masterfully on to his or her ward, accompanied by a son or daughter desperately eager to maintain the family tradition, and mesmerised by the prospect of going round all the interesting NHS cases; school students, in common with undergraduates, appear to be absent from private consultations. Moreover, there are instances when this journey has continued into the operating theatre.

Dr Thistlethwaite is surely correct to feel anxious about such issues as confidentiality, the reality of informed consent, and the misidentification of school students as undergraduates. The presence of school students in any clinical setting represents an abuse of power, privilege, and medical mystique. Much has been said about governance, most recently clinical governance. Should we not be at least as concerned about ethical governance and agree to exclude all school students from the clinical arena?

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Reference

1. Thistlethwaite JE. School students and general practice. [Letter.] *Br J Gen Pract* 2000; **50:** 1006.

Jill Thistlethwaite is not the only GP to be concerned about school children sitting alongside GPs during their surgeries.[1] Leeds Local Medical Committee (LMC) have been concerned about the same issue for the past few months, following expressions of concern about the practice from our local Community Health Council.

LMC members echoed the concerns expressed by Jill. We were particularly concerned about the young age at which some schools think it is appropriate to ask their students to obtain this type of work experience. There was also a feeling that many practices felt under considerable pressure from parents, patients, and schools to say yes to a placement. We have tried to help practices deal with requests from schools by producing 'Work observation guidelines' which have been sent to all practices in Leeds. These address the areas highlighted by Jill Thistlethwaite and more besides. We are also in the process of sending them to all secondary schools in the city.

The only way this issue will be properly addressed is if all medical schools indicate to schools that there is no advantage to be gained by trying to have this type of work experience on a university application form.

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Little evidence of safe injecting

Injecting illegal drugs is inevitably associated with poor injection techniques. This is owing to the varying nature of drug misuse, the source of materials to be injected, the lack of knowledge, information, and education of the participants, and perhaps most difficult of all, the essential 'living dangerously' psychology of participants. to expect controlled conditions is unrealistic and major efforts have to be made yet again with a post-HIV generation of young drug users. The new surrogate markers for needle and syringe sharing may well be hepatitis C antibodies and there is evidence that transmission continues in the very youngest age groups of drug injectors.[1] Anxiety about the ongoing high death rate among injecting users has been highlighted in a recent Advisory Council document on the misuse of drugs[2] and papers and correspondence drawing attention to the role of infection in sudden death.[3,4] Indeed, the lack of HIV transmission among drug users since the early Edinburgh epidemic[5] may be less to do with harm minimisation interventions than the natural patterns of transmission in closed groups and the lack of transmission in epidemic style when prevalence is low.[6]

We do, however, have to believe in our chosen intervention, namely substitute drug prescribing and provision of sterlile injecting equipment with educational activities. At the present time these are clearly inadequate. Most drug injectors describe frequent episodes of 'bad shots' characterised by tremors, rigors, muscle aches and pains, palpitations, and headaches. A recent case in our practice occurred in two partners sharing injecting material and equipment. Emergency admission to hospital was avoided (by the rapid departure of both patients) but residual filter material and heroin from injection revealed the culture and sensitivity described in Table 1 (all sensitive to a variety of antibiotics.)

Clearly such patients are injecting highly contaminated materials. This gives rise to acute fatalities, the importance of which may be masked by the presence of drugs. Other non-fatal complications follow from blood-borne viruses and are well reported although often after a lapse of many years. It is likely that sterile and bacterial infections, as well as end-organ damage, may be significantly under-diagnosed.

Central prescribing agencies are unlikely to address these problems, providing services for largely more mature drug users. The single most important factor driving these prob-

Table 1. Culture and sensitivity within heroin sample obtained from patients' residual filter material.

Culture and sensitivity
Large numbers of *Staphylococcus aureus* isolated
Large numbers of bacillus species isolated
Large numbers of coliform organism isolated
Large numbers of streptococcus species isolated
Large numbers of anaerobes isolated

lems is availability of heroin and as this increases so do complications in the absence of any enthusiasm for dramatic legal changes in the form of decriminalisation or legalisation of harder drugs. Energies must be concentrated in areas of deprivation and maximum drug use.

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Birmingham's Condom Distribution Scheme – an opportunity to promote sexual health in a primary setting

Birmingham's condom distribution scheme was set up in 1995 in response to Health of the Nation targets which aimed to decrease the incidence of HIV, sexually transmitted diseases, and unwanted pregnancies, and to ensure effective family planning. The scheme has been available in 95 general practices in Birmingham. funding for the project is provided by HIV prevention funds; however, a reduction in central Government monies has threatened funding, particularly since there is little evidence that the scheme has reduced the incidence of HIV. Therefore, as part of our third-year public health module at Birmingham Medical School, we undertook a study to examine the opportunities other than HIV prevention that arise from the scheme.

Thirty practices, including a range from high condom ordering to low condom ordering practices, were originally approached to take part in the study. Sixteen agreed to take part, 10 practices were then randomly selected from this group and in-depth interviews using a topic guide were carried out with the practice nurse. Practice nurses rather than GPs were interviewed since they are the main health care professionals who liaise with the senior health promotion specialist managing the scheme. All interviews were carried out with the knowledge of the GPs. Interviews were recorded verbatim at the time of visit and subsequently read by three independent observers (JG, FC, HL). Data were analysed manually and themes were generated using the grounded theory approach of Glaser and Strauss[1].

Practice nurses mention that the condom distribution scheme was an important tool in initiating what could potentially be an embarrassing or difficult subject, enabling them to take a sexual history and talk about a wide range of related topics, such as relationship difficulties and travel advice including 'safe sex abroad' messages.

The results of the study suggest that the condom distribution scheme fulfills a far greater role than just providing a barrier method for safer sex. It is extremely useful in sexual health care, providing many opportunities for sexual history taking and sexual health promotion. Further research is required into the uses, benefits, and problems encountered by those operating the scheme, if this valuable tool in the primary care setting is to survive, despite funding difficulties.

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1. Glaser B, Strauss A. *The discovery of grounded theory*. Chicago (IL): Adline, 1967.

Correction

In the paper entitled 'Low back pain in general practice: reported management and reasons for not adhering to the guidelines in the Netherlands' by Henk Schers, Jozé Braspenning, Roel Drijver, *et al* (August *Journal*, page 640), the mean age given in Table 1 is incorrect. The correct mean age for Table 1 is 43 years (range = 18–92). We apologise for any confusion this may have caused.