

Managing patients

The term 'to manage patients' is often used by GPs: it jars on some patients as it seems to regard them as passive objects rather than autonomous beings. Presumably, the term does not offend most doctors; but it fails to do justice to those who seek to work in partnerships of mutual respect and understanding with patients. Should it now be dropped as inadvertently out of keeping with the speciality's and patients' aspirations?

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Saving money on hernia repairs?

We were delighted to read of Dhumale's enthusiasm and success in treating abdominal wall hernias.¹ We have a similar experience with 400-plus groin hernia repairs. The model is different — surgery is performed by a retiring general surgeon with an interest in hernia surgery and an enthusiastic GP with a special interest in the subject. No sedation is used and the repair is of modified Shouldice type without mesh. Recurrent hernias and anti-coagulants don't worry us and no anaesthetist is required.

The patients are more satisfied than those from a hospital day care unit, whether in a district hospital, small community hospital or private hospital. There must be savings but no-one really seems to know their true costs. Even if we only save £100 per case and only 50% of the NHS load of 100 000 hernia repairs per year were cared for this way, the savings could be considerable.

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The sessional phenomenon

In his insightful overview of what he refers to as 'the non-principal phenome-

non', Peter Davies asks if this poses a threat to patient enablement.¹ He cites Howie *et al*² who previously found that length of consultation and knowing the doctor well were positively correlated with patient enablement.

It may provide some reassurance that in this area the local non-principal (sessional) group has undertaken a survey of patient enablement and, in fact, reported results better than those of local principals surveyed as part of GPASS. The two sets of results are not directly comparable as the sessional group is a voluntary one and so not all sessional GPs participate, whereas over 90% of principals participated in GPASS. Principals were reimbursed for this activity: sessional GPs were not. Nevertheless the results do indicate that sessional GPs can obtain high levels of patient enablement. In addition, where sessional GPs undertake to work regularly in the same practice or practices — which is very much the case in this area — there are considerable opportunities to get to know individual patients well.

In the light of this and the continuing exodus of principals, some of whom are dissatisfied with partnership, the sessional phenomenon may not actually represent a threat at all, but rather an opportunity for motivated GPs who enjoy their work and are committed to patient enablement to deliver high quality clinical care.

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1. Davies P. The non-principal phenomenon: a threat to continuity of care and patient enablement? *Br J Gen Pract* 2004; **54**: 730-731.
2. Howie JG, Heaney DJ, Maxwell M, *et al*. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319**(7212): 738-743.

Dangerous jobsworths

We are concerned with the care of patients of a 52-bed charitable care nursing home in Oxford. Over the last 9 months the home has been in dispute with a regulatory body, the Commission for Social Care Inspection (CSCI, formerly the National Care Standards

Commission), over criticisms of our medicines administration system. The home works to the usual model of an NHS hospital in which a patient's Medicines Administration Record (MAR) chart functions as the definitive record of current prescriptions. The MAR is intended, where necessary, to override whatever may have been written on the label of the original medicine container. As in NHS hospitals, all medicines are administered to our patients by professionally qualified nurses.

In prescribing for ill older people dosages often need adjustment and discrepancies arise between the MAR and container labels. Initially the inspectors demanded that in such circumstances the label on each bottle or box should be altered to match the MAR. We had to point out to them that, legally, no-one is allowed to alter the label on a medicine. They then suggested that when a dosage is adjusted, the medicine should be returned to the issuing pharmacy for redispensing. This would require a new prescription, a redispensing of the medicine, and a further delivery from the pharmacy. This would involve a nonsensical waste of money and staff time and, most importantly, leave a patient without a necessary medicine until new supplies arrive.

Such proposals could only have come from people with great respect for the written word but limited awareness of the realities of providing drugs accurately and responsively to older people in nursing care. Is this a local phenomenon or are nursing homes elsewhere in the country suffering similarly? Worryingly, it seems that, like too many regulatory bodies, the CSCI is non-accountable for its competence and good sense — or lack thereof.

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Correction

The author of the letter 'Simple and effective treatment for head lice' in the October issue of the Journal (*Br J Gen Pract* **54**: 786) was incorrectly cited as Elizabeth Eames. The author's actual name is Elizabeth McMullen.