LETTERS

Health for All by the Year 2000

Sir,

It was with mixed feelings that I read the correspondence (March *Journal,* p. 184) following Dr Barley's Editorial (December *Journal,* p. 715). I would agree that medical students and recently qualified doctors should be encouraged to work in the less developed countries, and can personally testify that this experience was taken into account when my posts were assessed retrospectively for suitability for vocational training. The College most certainly has a responsibility to promote the exchange of medical students and also to encourage more UK trained doctors to work in developing countries.

Students often return, if not to the hospital of their clerkship, at least to work in the developing world; and a significant part of the British Government's aid to these countries is the UK paid supplement that keeps their salary on a par with their home-based colleagues. The small allowance that UK volunteers receive ensures that few doctors enlist in this capacity. Almost invariably they will be better paid, if this is an important factor, by working for the overseas government on local contract terms.

I disagree with Dr Shattock's assumption that the ability of a UK trained doctor to contribute to a primary health care programme will depend on 'considerable field experience in one or more developing countries'. As he points out, where primary health care is being taken seriously, as in Zambia where Dr Shattock has wide experience, the team approach is being used and the doctor, whether at mission, district, provincial or central level, is only one part of the team. It would of course be ideal for the doctor or any other expatriate health worker to be formally trained and have wide experience but this is an impractical luxury in most developing countries where the indigenous doctors are too few. Well qualified, motivated, Western-trained doctors are warmly welcomed since most adapt quickly to the different priorities and function admirably in providing primary, secondary or tertiary care.

Like many readers of the *Journal* who have worked in district or mission hospitals in developing countries my heart sank at the thought of Dr Peppiatt's suggestion of bundling 'our unwanted drugs to agencies that will send them abroad'. I know he means well but please desist. There are crates, cartons, boxes of samples, out of date detritus, rarely required injectables, the latest beta blocker, diuretics and tranquillizers in store rooms in hospitals all over the world. Often the quantities are too small for general use. Sometimes they are labelled in an unintelligible language, as English is to many health workers in developing countries. They rarely help except for providing a supply of placebos when the clinic or hospital has run out of aspirin or vitamins. This willingness to off-load therapeutic junk on developing countries does little to alleviate their shortage of supplies and may cause resentment where their medical leaders are well aware of the shortcomings of their drug supply. When hospitals and health centres in areas of endemic malaria have no chloroquin, where aspirin or paracetamol have run out, where leprosy and tuberculosis patients cannot get the most basic regular treatment, where there is a shortage of crystalline penicillin, then it is obvious what kind of drug assistance is appropriate.

The *Journal* has occasionally shown an interest in developing countries and even ran a series on 'Primary Care around the World' (to which I contributed from the New Hebrides). It could be of much greater relevance throughout the world if it widened its net and encouraged articles on development issues and from general practitioners in developing countries. Meanwhile I welcome the interest currently being shown—perhaps it will stimulate some readers to shake off the soil of Slagthorpe and head south.

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Counselling and the Doctor

Sir,

I have read with interest this editorial (June *Journal,* p.323) and am sorry to see that yet another branch of the tree of general practice has been chopped off, given a new name and elevated to the rank of specialty!

Counselling is listening sympathetically and intelligently to people's problems and advising them how they may come to terms with these problems. It is not a difficult skill and should be well within the competence of every general practitioner. There is no evidence in the article to substantiate the conclusion that counselling is work which doctors find difficult. Similarly, pressure of time is an oft quoted excuse made by doctors for not doing the work that they should be doing. I am not aware of any published evidence that a doctor with a National Health Service list of 2,000 patients is under such pressure of work that he or she is unable to take the time to counsel where necessary.

The erosion of the substance of general practice by numerous fringe groups is a worrying trend. The world does not owe general practice a living, and if we continue to allow our traditional activities to be taken over by others, the day may dawn when there is nothing left for the general practitioner to do!

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The Format of the College Examination

Sir,

Attainment of membership of the College has been by means of examination for the last 18 years. During that time there has been little change in the examination format. Membership of the College is now, and will become increasingly, important to all doctors making a career in general practice. I feel that it is time that the College not only talked about change, but actually acted on it.

In its present form the examination has wide scope, as especially in the orals the examiners can ask the candidate any question remotely associated with general practice. However, do they actually ask the questions that will test the qualities that are required of a good general practitioner? I would contend that one can pass the examination by reading the right books and presenting the correct attitudes. It does not look at the doctor in the consultation. The examiner does not see how the candidate performs when confronted with the patient.

Why is a patient element not included in the examination? I appreciate that the examination is time-consuming and costly to stage, but by the same

token the stakes are high, and surely if it means that we are going to raise standards and examine the qualities we want in our future general practitioners then it will be worth it.

In the Royal Australian College of General Practitioners' Fellowship Examination there are several practical aspects, as well as the usual essay, multiple choice and modified essay questions. There is a clinical examination section where patients are examined by a candidate who is judged not only on his clinical skills but also on his general approach and interaction with the patient. There is a practical examination where the candidate is presented with x-rays electrocardiographs, clinical photos and haematology slides to assess. There are patient management and diagnostic interviews, in which the aspiring doctor meets an examiner who is role-playing patients with every-day consultation problems.

In the 1981-82 report of Council some changes in the examination format were discussed. Let us hope that long overdue changes can be introduced, to test the qualities that will produce general practitioners of excellence in the future.

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Individual Cases

Sir,
Medical knowledge can benefit from the reporting of individual cases and observations. I would like to draw to your attention two observations that I have made:

1. A patient who had suffered a number of tonsillar abscesses which developed in spite of conventional treatment with antibiotics, improved rapidly when Metronidazol was given in the early stages. I have seen other patients with severe tonsillitis who have improved with a penicillin/metronidazol combination. I wonder if anaerobic organisms play a greater role in tonsil infections than is generally supposed.
2. Patients with prostatic symptoms, such as frequency and hesitancy, have improved rapidly when non-steroidal anti-inflammatory drugs, such as Ibuprofen have been given.

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Prescribing Costs

Sir,
My practice has recently been visited by our regional medical officer because our prescribing costs are more than 25 per cent greater than those of our colleagues in the area.

During discussions with 'the man from the Ministry' it became clear that we needed further information about prescribing in general. I would be interested to hear therefore, from doctors who have a list size of approximately 2,700 patients but who have not been visited by the regional medical officer, as presumably their drug costs are within the average for the area, in order to get their permission to approach the Pricing Bureau for a breakdown of their monthly prescriptions.

We would ask this in order that we may further audit the cost of our drugs in general practice.

TONY MAISEY

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A Health Education Video Library?

Sir,
We have recently acquired a video system in our practice. We aim to use it as a teaching aid both for health staff and for patients. There is very little by way of a video library of health education for patients.

Isn't it time that the MSD Foundation, the College, the National Association for Patient Participation and the television companies put their heads and resources together to provide a library of cheap tapes for patient education that could be borrowed or bought?

My local shop can supply *Star Wars* and soft porn to order, but they have nothing on rehabilitation after a coronary, or on contraceptive choices.

JOHN ROBSON

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Medical Practices Committee Guidance

Sir,
At the Conference of local medical committees on 16 June 1983, my Committee's guidance on vocationally trained doctors and single-handed practice vacancies was criticised as not being clear, perhaps justifiably.

Our suggestion that applicants 'should have been trained in a similar situation to that for which they are applying' is open to misinterpretation. It would be better to substitute the word 'location' for 'situation'. A doctor who had trained in a country area would not have a strong claim to be considered for an inner-city vacancy. And similarly someone who had done their training in an urban practice could not expect to be first choice for a rural practice vacancy.

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Hypotension Following Stimulation of Acupuncture Point Fengchi (G B 20)

Sir,
Acupuncture is used as an important modality in the treatment of a wide range of diseases. Although it has been thought to be a very safe procedure, several complications associated with it have been reported.[1-3] I report here a patient who developed hypotension during acupuncture treatment.

A 23 year old man presenting with chronic sinusitis for five years was scheduled for acupunture treatment. His blood pressure was 120/70 mm Hg and pulse rate 84 per minute. Physical examination did not reveal any abnormality. The following acupuncture points were selected according to the nomenclature published by the Academy of Traditional Chinese Medicine, Peking:

(a) Yingxiang (L I 20), Shangxing (D U 23), Hegu (L I 4).

(b) Yintang (Extra 1), Leique (L U 7), Fengchi (G B 20).

These two groups of points were to be used on alternate days over a period of 10 days. On the first day, needles were placed at the group(a) points and uniformly stimulated by gentle hand manipulation every five minutes for 30 minutes. The patient tolerated the puncture very well and there was no untoward reaction. On the following day, the group (b) points were stimulated similarly. Fifteen minutes later the patient complained of giddiness. The needles were removed immediately and he was made to lie flat.

He looked pale, had a pulse rate of 124 per minute and his blood pressure was 70 mm Hg systolic. He was observed for 10 minutes and since