Conclusions

The response to these study days has demonstrated that receptionists want to increase their factual knowledge and their understanding of the physical and emotional problems of patients. They enjoy meeting colleagues from different practices and profit from the sharing of ideas and problems.

Appendix

Patient Management Questionnaire.

1. At 11.00, just as the surgery is finishing, a tired looking woman (Mrs Young) with three small children in tow, comes to the desk and asks if she can sign on with the doctor. Your doctor's list is not full and he is taking on new patients. She says that she has moved house recently. How do you deal with her?
2. She offers you three rather tatty medical cards which belong to her and two of the children. You also notice that the doctor's name is that of a general practitioner who works close by. What do you do?
3. When you have finished telling her about signing on, she asks if she can see the doctor now as one of the children is not very well. How do you handle this?
4. Some weeks later, at the end of an evening surgery, she rings up and asks for a visit for her youngest child who is about one year old and who has had diarrhoea and vomiting for two days. What do you ask her and what do you do?
5. You do not hear from the family again until one morning when Mr Young turns up at the surgery and says he wants to see the doctor as he thinks that he has the 'flu'. You have a full appointment system in the practice and there are no more appointments left for that morning (the surgery ends at 10.45 anyway). What do you say?
6. Mr Young appears to have a simple cold and looks quite well. He insists that his employers have demanded a private certificate and if the doctor will not see him now he will go home and call him out. What is your next move?
7. Your doctor declines to see him immediately but he is offered an appointment for the evening surgery. Mr Young is not happy. He tells the waiting room at large that this is a bloody useless practice as you need to be dying before the doctor will see you. He then crashes out of the surgery. Do you do anything about this?
8. Six months later Mrs Young rings up just as your doctor is starting the evening surgery and says that her youngest child is having a fit. What do you do?
9. Mr Young comes one evening at the end of surgery for a medical for an HGV licence. He is fifteen minutes early. The doctor, on the other hand, is half an hour behind with his appointments (not an unusual occurence with this particular doctor). There are still another five patients waiting ahead of Mr Young. Do you do anything about this?
10. A month later Mrs Young comes in for an appointment. She looks very run down. When she comes out she is in tears and tells you that Dr X has been sharp with her and requests that she sees another doctor in the future. Dr X appears to have been in a bad temper all morning. How do you help Mrs Young?
11. Dr X goes on being bad tempered with staff and patients during the next few weeks. Is there anything you can do?
12. That Christmas Mrs Young comes in with chocolates for the staff. Why has she done this? Do you feel guilty?

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WORKING WITH OTHER PROFESSIONS

Zoonoses and veterinary–medical cooperation: a missed opportunity?

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Similarities between medical practitioners and veterinary surgeons are often closer in the minds of their clients and patients than they are in reality. 'Don't you wish they could talk?' is frequently asked of the small animal practitioner and, on occasions, the busy general practitioner must wish that they couldn't. However, in spite of the similarity of many of our clinical problems, there is little interchange of ideas between the two professions.

ZOONOSES are a group of diseases which, by definition, demand a bilateral approach, although for a number of reasons this does not always happen. The aims of this article are to look at some of the occasions where cooperation could occur, to consider why this has not occurred in the past and to highlight the merits of a joint approach.

In 1975 the Zoonosis Order was implemented. The Order instituted a system of controls and procedures following outbreaks of salmonellosis and brucellosis in domestic species. Initially the Order was limited to cattle, sheep, pigs and some types of poultry, but there are provisions to extend this list if necessary.

Operation of the Zoonosis Order

Following the identification of salmonellae in one of these species, usually at a Ministry of Agriculture, Fisheries and Food Investigation Centre, information is passed by the veterinary officer to medical officers of environmental

health and chief environmental health officers in the relevant areas. This veterinary officer—the nomination officer—is also responsible for investigation of the outbreak and, when necessary, applying emergency control measures.

This legislation provides a formal basis for medical–veterinary cooperation but, by its nature, proceeds fairly slowly and with little involvement of either medical or veterinary practitioners. Also the Order is concerned only with two zoonoses and many veterinarians would like to see its extension to cover some other conditions where significant disease occurs in man because of contact with animals.

Problems in cattle

On an average dairy farm all cattle will be tested regularly for tuberculosis and brucellosis. The former stubbornly persists in some groups of the cattle population and periodically spreads back into man. Brucellosis too is almost eradicated but it is too soon to predict that it will not cause any further problems.

Many young cattle develop ringworm infections and these will readily infect the farm workers, producing large and persistent lesions. More recently, the number of dairy herds infected with *Leptospira haadjo* has risen sharply and with it there has been an associated rise in infection in farm workers.

Most farmers drink raw the milk which their cows produce and, during an outbreak of salmonellosis in the cows, infection may easily spread to involve the farmer's family. In a severe herd outbreak, the general practitioner would be one of the first people to be informed, especially when, as is often the case, young children are at risk. A telephone call at the right time could obviously be most effective. Unfortunately this happens very rarely for a number of reasons. No veterinary surgeon likes interference in his cases, and the same must be so for his medical counterpart. We like to think that we have considered all the possibilities in a problem and are fully competent to deal with them. Equally a tactless approach, which implies a missed diagnosis or even negligence, will achieve very little.

Another common problem is to know how much significance to place on a clinical problem, and this can work in both directions.

Small animals

Many small animal skin infections have effects on man. *Sarcoptes scabei,* for example, occurs commonly in dogs and will readily infect man after very brief contact. In these cases, it is important that the general practitioner and the veterinary surgeon agree on a common approach. A lack of cooperation has led to the suggestion of destruction of the dog or the persistence of skin problems in the dog's owners.

Rabies, the most serious zoonosis, does not normally occur in this country but the equally well publicized visceral larval migrans is a more relevant problem. The frequency with which dogs foul the pavements has become confused with the potential incidence of this condition in many people's minds. Common practical advice from both professions could do much to allay the public's fears, distinguishing an aesthetic problem from a medical one and indirectly improving the health of many puppies.

A similar approach to toxaplasmosis would reduce the risk of infection to owners, though the risk from raw meat should also always be stated.

Some of the more recently identified zoonoses present greater problems as they may be asymptomatic in animals. Psittacosis has been associated with parrots for many years but the incidence of ornithosis in people working in the poultry industry has led to its being recognized as an individual disease. The fact that this is one of the causes of ovine abortion has a new significance with the larger number of women working in agriculture.

On the farm too, the veterinary surgeon must not only consider husbandry and veterinary advice when dealing with a problem, but also the medical problems which his client's activities can pose to the medical profession.

The need for prompt liaison

In the UK the risks associated with zoonoses are small compared with other diseases. Outbreaks usually affect small groups of people, but those affected may develop quite severe symptoms over long periods. Prompt liaison between our professions would be beneficial to both client and patient, would reduce the spread of disease and would encourage more interchange of ideas between us.

Nurse-run hypertension clinics

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The Medical Research Council's trial for mild hypertension[1] is unlikely to go beyond the end of 1984; now is the time, therefore, to be thinking of its implications should its results show a positive benefit. Experience from the trial suggests that a nurse with extra training could help the general practitioner to identify those at risk and help in treatment and follow-up.

THE MRC trial has been carried out mainly in general practice and 176 group practices have provided 16,415 (95 per cent) of the 17,362 trial participants. One of the lessons from the pilot study was that general practitioners who tried to carry out the research without a nurse to run the project did not succeed. This was partly because they found the workload too great but chiefly because they found the necessary organizational aspects unacceptable.

In the main trial carefully selected nurses were employed to run the research clinics and in most practices this has worked extremely well. By keeping strictly to a structured drug schedule, nurses under medical supervision were as successful as doctors in titrating dosages and achieving target blood pressure levels. The MRC trial has shown that nurse-run hypertension clinics are both feasible and effective. Defaulters are fewer and compliance improves and many general practitioners are now retaining their research nurses to run non-research hypertension clinics in their practices.

Extension of the nurse's role

It would seem to be only a matter of time before hypertension clinics become commonplace in group practices. However, it is necessary to proceed with caution and to look carefully at how the role of the nurse could or should be extended in order to give maximum help to the doctor.