

Two decades of experience of this system have shown the following advantages:

— The contents of the medical record envelope are easily arranged and easily retained in proper order without the use of tags.

— The contents are easily slipped in and out of the medical record envelope by the 'shoe-horn' effect of the card folder. When it gets a bit tight it is the signal to edit the letters again rather than make out a gusseted medical record envelope.

— The synopsis of previous events and adverse drug reactions is immediately available opposite the latest clinical notes. Sensitive information is always entered on page 3 and in ordinary use is always covered by other notes. An arrow or asterisk on page 2 will alert clinical users to entries on page 3.

— The simplicity of the structure has been invaluable in adapting the system to the needs of patients and staff for 21 years.

— The Aston folder has been demonstrated to trainers' courses in Wessex since 1978. It has been freely adapted by neighbouring practitioners, and many others have made favourable comments when my synoptic record has followed patients moving round the county.

I would like to hope that these innovations in record keeping will stimulate the Council of the College to press the General Medical Services Committee to keep up demands on the DHSS for simple improvements in our record system before further deterioration takes place.

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Inspection of vocational training schemes

Sir,

Doubts have recently been expressed about the validity of the inspection of vocational training schemes by visitors from the Joint Committee on Postgraduate Training for General Practice (JCPTGP).¹ The author described a visit to his large vocational training scheme which was accomplished in six hours. Visits to other schemes may have been done equally quickly, but this was not our experience; a visit to the East Cumbria Vocational Training Scheme, performed in 1980, was done thoroughly and took three and a half days to complete.

At the time of the inspection the scheme had eight training practices, in Carlisle, east Cumbria and southern

Scotland and the hospital posts were based in the four hospitals in the Carlisle area, representing a wide variety of experience in specialties of direct relevance to general practice.

The details of the visit were worked out well in advance and considerable time was taken to arrange and coordinate with all the members of the team and other persons concerned with the visit. The visitors had a working dinner with the regional adviser and the scheme organizers and they visited each of the practices, talking to the trainers and, somewhat more briefly, to the non-training partners. The premises, facilities and records were inspected. The visitors also attended the half-day release seminars, during which they had ample time to discuss with the trainees their feelings about the course in particular and vocational training in general. On the evening of the same day the team went to a trainers' workshop, when discussion with the trainers also took place. The hospital consultants involved in the scheme were not neglected and after a dinner hosted by the chairman of the then Cumbria Area Health Authority the consultants were given ample time to discuss their feelings about the scheme and air their grievances (which were, mercifully, few!). On the afternoon of the last day the visitors met with the scheme organizers to give them their preliminary report, their full and final report being received via the regional advisers and the Regional Education Committee for General Practice some weeks later.

We felt the visit was not only an inspection of the quality of training provided by the scheme but also contained educational elements which arose from the conversations that the visit engendered. The scheme organizers and all those involved with the scheme saw the final report in full and had ample time to discuss this. Indeed, nobody had any major criticism of the visit or its findings. Whether the most recent visit, which took only six hours, reflects more the attitude of the course organizers or is a reflection of the changed attitudes of the JCPTGP is not clear. Certainly, we did not feel that our visit had been skimped, and probably thereby felt justified in accepting the report of the team without dissent.

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Reference

1. Bahrami J. JCPTGP: from the other side of the fence. *Br Med J* 1986; **292**: 29-32.

What happens to surgical patients when their admissions are postponed?

Sir,

One consequence of the reduction of the number of acute beds in National Health Service hospitals and the increase in the size of waiting lists is the considerable pressure on available beds. Inevitably, when booked admissions are postponed because of shortage of beds, some patients will suffer hardship. I carried out a study at Ealing Hospital in London to assess the nature of this hardship for surgical patients and I report my findings here to draw the attention of general practitioners to this problem.

At the beginning of this study 580 patients were on the hospital's waiting list for general surgery. If an admission was cancelled every endeavour was made to give the patient priority when a bed was available, and a standard letter was sent to him explaining the reason for the cancellation, and stating that he would be sent for again soon.

Each patient placed on the waiting list was asked to complete a questionnaire detailing the nature of the inconvenience caused each time his admission was cancelled. When the patient was finally admitted the completed questionnaire was collected for analysis. The inconvenience caused to the patients was divided into medical, social and financial. Medical inconvenience was deemed to have occurred if the patient had symptoms from his condition, and would have obtained relief had the admission taken place; an example of this is continuing pain from a duodenal ulcer. Social inconvenience was one which caused disruption in the lifestyle of the patient or of his relatives and friends; for example, if the patient's spouse took time off work to look after the children and the admission was postponed. The financial loss which occurred had to be shown to be due directly to the postponement of the admission. For patients in employment the total number of days taken off work was also recorded, as well as the reason for not returning to work as soon as it was clear that admission would not take place. The study was conducted for 12 months from February 1983 and during this period there were 556 admissions from the waiting list.

There were 171 cancellations involving 125 patients whose ages ranged from 16 to 86 years (mean 47.4 years). Thirty-one patients had their admissions cancelled on two occasions, and 11 on three occasions or more. No patients died while they were

on the waiting list. Medical inconvenience occurred in 92 cancellations and social inconvenience in 147. Financial loss to patients amounted to £7356 and 370 working days were lost. All the patients commented that the letter they received after the postponement of their admission was useful and it reassured them that attempts were being made to admit them.

For a patient to be admitted and an operation performed several facilities must be available. The most important of these are beds, staff, and laboratory and theatre services. Although availability of beds is not the only critical factor, it was the most frequent reason for cancellation of admissions in this study. This study did not quantify the severity of medical and social inconvenience, but it demonstrates that many patients suffered physically and socially because their admissions were cancelled. The mean financial loss for each cancellation was £43 but it was borne by the patient and those for whom financial loss caused hardship could not claim this money back.

If the extent of cancellations in this hospital is typical of others across the country, the loss of working days must be considerable. The cost of this loss is borne largely by the government which pays sickness benefits, and by employers who pay for temporary replacements. The reasons why patients did not return to work immediately after their admissions were postponed were obscure but health planners must be aware of the potential cost involved, for it may offset some of the savings made in closing beds. It is my view that if a patient's admission is cancelled it is humane and courteous on the part of the hospital to offer him an explanation for the cancellation and a new date of admission without delay.

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History of problem drinking in older adult male diabetic patients

Sir,

For nearly a decade my practice has compiled and maintained a modified disease register of selected major chronic health problems presented to, and recognized by, the family doctors in order to improve the long-term clinical management of patients with these diseases. The disease register has also been used to try to estimate the annual prevalence of health problems such as diabetes, hypertension and problem drinking.¹ Some patients were found to

suffer from more than one of the conditions listed in the register. Looking at the register it seemed that a large proportion of older adult male diabetic patients also had a history of problem drinking. I decided to test the significance of this observation when all patients aged 40 to 74 years were invited, by letter, to attend for a blood pressure and urine test as part of other research projects in the practice.

The three-partner training practice has 5550 patients with an average age-sex distribution. Our criteria for the diagnosis of diabetes are: an abnormal glucose tolerance test, or repeated fasting blood glucose levels greater than 7 mmol l⁻¹, or repeated two-hour post-prandial blood glucose levels greater than 10 mmol l⁻¹. Diastolic pressures (phase 5) of 100 mmHg and 105 mmHg were used as the cut-off levels for the definition of hypertension in the age groups 40 to 59 years and 60 years or more respectively.² The confidential register of patients found, by case-finding alone, to have a history of problem drinking — the list includes those patients considered to be 'dry' at the present time — is based on the Shetland practitioner survey³ check list of at-risk categories.

The number of patients aged 40 to 74 years with a recorded diagnosis of diabetes and/or hypertension (using case-finding and screening) and/or problem drinking (using case-finding alone) in the practice disease register was compared, for each sex, over a year. The prevalence of both hypertension and diabetes increased with age up to 55 years but appeared to be fairly stable thereafter. Thirty out of the 39 patients with more than one condition were over 55 years of age and therefore the statistical tests for association between any two of these conditions were done on the relatively homogeneous 55 to 74 years age group only (Table 1) using the binomial distribution with a null hypothesis of independence.

Eight of the 24 male diabetics (including two type I diabetics) had a known history of problem drinking; this association is statistically highly significant ($P < 0.01$). Three of these male patients had been diagnosed as alcoholics some years before developing diabetes; five other diabetic patients had recorded abnormal liver function tests, including an elevated gamma glutamyl transpeptidase level. There was no evidence of problem drinking for 26 out of the total group of 36 diabetic patients. The occurrence of a history of problem drinking was statistically significant ($P < 0.05$) for male hypertensives (Table 1), three of whom had been diagnosed as problem drinkers

Table 1. Occurrence of problem drinking or hypertension in diabetic patients aged 55 to 74 years (expected number, on the basis of no association, in parentheses).

Population at risk ^a	Hyper-tension	Drinking problem ^b
<i>Diabetic patients</i>		
Male (n=24)	3 (3.2)	8 (2.3)**
Female (n=12)	4 (1.5)	1 (0.4)
<i>Hypertensive patients</i>		
Male (n=59)	—	11 (5.7)*
Female (n=71)	—	3 (2.2)

* $P < 0.05$. ** $P < 0.01$. ^aTotal population at risk: 447 males, 568 females. ^bNumber of known problem drinkers: 43 males, 18 females.

before becoming hypertensive. No statistically significant association between diabetes and hypertension was found for either sex.

The association between problem drinking and diabetes has been described previously.⁴ In a group of 541 white diabetic men aged 20 to 59 years attending a hospital outpatient clinic it was found that 15% drank heavily, while a further 7% had frank alcoholism.⁵ There exists even stronger evidence for an association between hypertension and excessive alcohol consumption.⁶⁻⁸

Alcoholics who come into frequent contact with the family doctor for reasons other than alcoholism are probably more likely to be detected than problem drinkers who are otherwise fit and well. Nevertheless, these data show a high prevalence of a history of problem drinking in male diabetic patients between the ages of 55 and 74 years and I should be interested to know whether other general practitioners can confirm this finding.

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