Medical needs of the mentally handicapped

Sir,

I read with interest the account by Dr Howells (October *Journal,* p.449) on the unmet medical needs of adults with mental handicap.

National policies — not without their critics — are encouraging mentally handicapped patients to live in the community. Admissions to institutions for the mentally handicapped are falling, and increasing numbers of patients are being discharged from hospitals for the mentally handicapped.

These patients are also handicapped by their inability to use general practitioner services — they may be unaware of the services provided, or of how to take advantage of such services. Their communication skills may be poor, and their carers, often elderly, may themselves be low users of services.

If mentally handicapped patients are to receive an adequate medical service, it would have to be service-led, rather than patient-led. The development of community mental handicap teams, with a core membersip of a social worker and mental handicap nurse, is to be encouraged. But these cannot by themselves provide strictly medical services. A system of routine screening for physical disorders is needed, for example, for hearing loss and hypothyroidism in patients with Down's syndrome.

Are general practitioner services adequate to undertake such a screening programme? Unless a practice maintains an at-risk register of such patients, and actively intervenes, these particular patients will not benefit. Case-finding alone is inadequate for these patients. An alternative system, that of appointing clinical medical officers to adult training centres, specifically for such screening, has been tried in some areas. Such a system, however, fails those patients who do not attend such a centre. Undoubtedly, a screening service that is well-organized, and conducted by interested general practitioners, would provide the most adequate and comprehensive service.

RICHARD A. COLLACOTT

Leicester Frith Hospital
Groby Road
Leicester LE3 9QF

Care of the elderly

Sir,

The paper 'Patterns of care for the elderly in general practice' by David Wilkin and Idris Williams (December *Journal,* p.567) raises a number of issues.

Most important is the lack of an incentive or reward for providing better care for the elderly. Raising capitation fees has not stopped old people finding obstacles when seeking to join NHS lists. The growth of periodicals devoted to the financial gains to be made in practice are concerned exclusively with younger age groups.

Secondly, the workload created by elderly patients hardly justifies these across-the-board payments, to judge by the authors' findings. They indicate that the mean time spent in surgery per week for the 201 doctors was no more than 15.1 hours, yet more than 50% of them felt they were overworked. The mean time spent with each patient per year was about 25 minutes and the mean number of consultations per elderly patient per year averaged five, indicating that these people, with complex physical, social and mental problems were allotted a mean of five minutes per consultation. Not surprisingly, the authors recommend that the discrepancy between high levels of unrecognized morbidity and a low level of investigative work by general practitioners in relation to the elderly should be examined further.

My own view[1] is that we are, as a profession, deficient in education for those presenting with greatest medical needs. My own researches[2] have shown that by the age of 70 years deviations of homeostasis in the body must be present, causing overlap of at least three disturbances of accepted norms. Yet, older people are still accorded the standard five minutes, and usually treated for a single pathology; if they are then placed on a repeat prescribing list there may be risks from polypharmacy.

The authors state that general practitioners hold very different views of what is appropriate for their elderly patients. No one could fail to view the data they collected without the gravest misgivings.

M. KEITH THOMPSON

28 Steep Hill
Stanhope Road
Croydon CR0 5NS

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Accommodation for the elderly

Sir,

In his article 'Accommodation for the elderly' in the *RCGP 1986 members' reference book* John McCarthy states: 'One interesting fact that has emerged from experience and research is that most owners of sheltered housing come from the local area in which the development is built. Indeed 80% are from the local community and 15% are people who have had previous connections in the area. A very small minority represent elderly people coming into the area'.

This is contrary to our experience. A census of the inhabitants of a block of sheltered housing recently built by McCarthy and Stone in Seaton shows the following percentages of the 85 inhabitants: 8% are from the local community, 6% have previous local connections and 86% are elderly people coming into our joint practice areas afresh.

The influx of elderly people from outside the area occupying newly built or converted houses has immediate implications for our practices, as well as for the provision and planning of future services.

We should be grateful if practitioners in areas where purpose-built sheltered housing has been erected could advise us of their figures in order to discover whether our experience is unusual.

R.V.H. JONES
K.D. LAWREY
M.C. WICKINS
P.J.S. FARRELL

Townsend House
49 Harepath Road
Seaton
Devon

M.F. ASKEW
C.J. BASTIN
J.A. COOP

Seaton Health Centre
Seaton
Devon

Rural hospitals in South Africa

Sir,

I have recently returned from working in a rural hospital in South Africa and I would like to report the severe shortage of doctors in the rural areas and the resulting suffering of the black population.

The Jane Furse Memorial Hospital, a former Anglican mission, taken over by the Lebowa, homeland government in

1974, has 400 beds and 10 outlying clinics and is situated in north-east Transvaal. It is well equipped with a good X-ray department, laboratory, pharmacy and central surgical supplies department and well-qualified paramedical staff to run them.

The hospital is the only medical service for a population of over 200 000 who are mainly black, but whites are also treated and admitted, there being no discrimination according to race in the homeland hospitals. A year ago this population was cared for by nine full-time doctors, now there is only one elderly doctor remaining. Two neighbouring hospitals have no full-time doctors and a similar situation prevails in many rural areas.

Three thousand outpatients and 200 deliveries a month as well as 400 inpatients is obviously too much for one doctor to cope with. Tuberculosis, typhoid, venereal disease, ectopic pregnancy, obstructed labour, eclampsia, stab wounds and car accidents are all common and there will be many avoidable deaths.

Working in a rural area in South Africa provides valuable experience for a doctor because there are many seriously ill patients, and because the infrastructure, supplies and so on, are much better than in many other 'developing' countries. Any doctors going to work in such a hospital in the present situation will benefit themselves and their patients greatly.

EDMUND WILLIS

54 Bridge Street
Brigg
South Humberside

Who owns the patient's record?

Sir,

Dr Marshall Marinker in his editorial (October *Journal,* p.442) raises some important issues relating less to the matter of ownership of the record than to access to the record.

I am very much in favour of patients having access to their records, with the proviso that this should be initiated in the presence of the doctor. Under these circumstances any misconceptions on the part of the patient can be cleared up immediately and the arguments against access are less persuasive. The patient's understanding of the data can be checked and intellectual or emotional problems diffused.

Doctors necessarily tolerate uncertainty, take small but acceptable risks, and record opinions and best guesses in patients' records. All these matters should be conveyed to patients in the course of management so that recording them represents no difference from the usual situation. If these matters are not discussed with patients then it is usually to their disadvantage. If doctors do not wish to disclose part of their interpretation about patients then they need not record this in their record. If they feel it is important enough to record then it might be important enough for the patient to know about.

The only argument against open access which really seems cogent relates to information derived from or about a third party. It should be possible to devise a system which avoids problems arising from this.

I hope that there is considerable debate about this matter. It is, as Dr Marinker rightly says, an ethical issue, but it also is of very great importance to quality of care.

C. BRIDGES-WEBB

The University of Sydney
Department of Community Medicine
11 Croydon Avenue
Croydon
New South Wales
Australia

Restrictions on trainees applying for single-handed vacancies

Sir,

I should like to bring to the attention of trainees and trainers a legal ruling concerning single-handed practice vacancies which seems not to be well known. I finished my vocational training in January 1987 and was encouraged to apply for a single-handed vacancy which commenced in March 1987. My previous single-handed experience in the Royal Army Medical Corps seemed to make me a suitable candidate.

However, my application was deemed invalid because I would not possess a Certificate of Prescribed/Equivalent Experience at the time the Medical Practices Committee made their selection, even though I would have it by the time the post commenced. Since no one in the West Cumbria scheme was aware of this, I wrote to the MPC who confirmed the ruling under the National Health Service Act 1977 (Section 31 (1) (a)). I would hope that other trainees could avoid the disappointment I had suffered by realizing that they cannot be considered for a single-handed vacancy until they possess a current certificate.

I feel saddened by this ruling, but others must consider the possibility of change.

K.P. JONES

James Street
Workington
Cumbria CA14 2DF

Video recording in general practice

Sir,

I was disturbed to read Servant and Matheson's paper (December *Journal,* p.555) concerning the reluctance of their patients to consent to video recording of their consultations, as it runs contrary to my experience. Their low acceptance rate of only 6% makes me wonder why their experience is so different from mine and that of the others they quoted.

Of course, it may be that their patients are genuinely more resistant to this intrusive technology. Alternatively, something in the design of their study may have led to a falsely high refusal rate. May I suggest that it was the use of 'large notices placed upon the waiting room table' drawing attention to the fact that video recording was in progress.

My practice recently had a similar experience when we agreed to participate in a multicentre study and a researcher placed a large notice along similar lines in our waiting room. This caused a great deal of consternation among our patients and one patient was so distressed that she left before the consultation took place. This is in total contrast to their behaviour when, following our usual practice of many years, they are given a verbal explanation by the receptionist of what is about to happen and a form on which to consent to the procedure. Informed consent is thus achieved not by coercion, but rather by allaying natural fears and anxieties. Which of us was not anxious when first being video recorded?

Natural hesitancy can easily be transformed into refusal by factors that increase the anxiety level. One observation we have made is that when patients are asked to consent to this procedure with a new trainee in the practice, the refusal rate rises dramatically. As the trainee becomes more established the refusal rate drops.

I hope that the two illustrations above demonstrate the way in which apparently small factors can have a dramatic effect on the acceptability of video recording to patients. A high rate of consent represents a low level of anxiety and not coercion.

GEOFFREY D. ROBERTS

37 Upper Gordon Road
Camberley
Surrey GU15 2HJ