LETTERS

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Drug information and the general practitioner

Sir,

The pharmaceutical industry is said to devote 45% of its promotional budget to financing the activities of representatives, a total of over £5000 per year for each general practitioner in this country.[1] Two questions arise: (1) What do general practitioners think of the quality of information supplied by representatives, in comparison with other sources of drug information? (2) How much are general practitioners' prescribing habits influenced by the activities of representatives?

We recently circulated a questionnaire on these subjects to general practitioners working in Greenwich and Guildford. The size and characteristics of the two populations were sufficiently similar for us to combine the results, giving a total of 156 responses from a population of 229 general practitioners (response rate 68%).

Eighty-four per cent of responders regularly saw drug company representatives; 26% of responders saw two to four per week and 4% saw four or more per week. Single-handed practitioners tended to see more representatives than doctors in group practices. A clear majority (70–80%) of these general practitioners were happy with the accuracy of information supplied to them by representatives as regards the efficacy of the drugs discussed and the indications for their use. However, on cost and contraindications, 47% felt that the information supplied was unreliable.

Drug company representatives ranked highly (together with advertisements in medical journals) as sources of information about the existence of new products. However, for information about the usefulness of new products, the general practitioners said they turned to non-industry sources such as the *Prescribers' Journal,* articles in medical journals, the *British national formulary* and contact with other doctors. The *Drugs and Therapeutics Bulletin* scored very highly for finding out about both the existence and usefulness of new products.

The 16% of responders who as a rule saw no representatives said that they doubted the impartiality of employees whose job it is to promote their firm's product, and they saw this promotional aspect as in conflict with the provision of reliable information.

In response to a direct question on whether they felt their prescribing was influenced by drug company representatives, 63% felt that they were influenced 'slightly' or 'not at all', the rest saying that they were influenced to a 'moderate' or 'large degree'. Oddly, of those saying they were 'not at all' influenced, half saw at least one representative per week.

Doctors do not have to bear the financial costs or the possible adverse effects of their prescriptions. This places on them the responsibility to develop critical self-awareness of the ways in which they are influenced in prescribing decisions. Conversely, by demonstrating that they can assess the evidence critically and independently, doctors can have a positive impact on the quality of drug information made available to them.

JEAN SHAW
N.S. JONES

Brook General Hospital
Shooters Hill Road
London SE18 4LW

Reference

1. Smith R. Doctors and the drug industry: too close for comfort. *Br Med J* 1986; **293:** 905-906.

Training practice nurses for prevention

Sir,

In 1985 Harrow health district appointed a facilitator, called the GP screening coordinator, to organize a basic screening programme to be undertaken in individual practices by practice nurses. It was recognized at this stage that there were no training programmes for nurses interested in screening in general practice and this had led to the setting up of a course in preventive medicine for practice nurses within Harrow health district.

The initial programme included lectures and workshops relevant to the practice nurses' prevention programme in general practice. Essential ingredients of the course were: an epidemiological overview of hypertension and cervical and breast cancers, information on practical aspects of blood pressure measurement, cervical and breast cancer screening methods, diabetes in general practice, and health education, including advice on healthy eating and prevention of alcoholism.

A pilot two-day course was run in February 1986, and was attended by 16 practice nurses employed in practices within the Harrow health district, two from the health authority's well person clinics, and two from practices outside the health district but in overlapping areas. Following publicity through local and national press and radio networks, the course was subsequently offered to practice prevention nurses throughout the country, and two further courses were run in June and September 1986. These courses were oversubscribed, and we currently have a waiting list of 30 applicants for the next proposed course in June 1987.

The participants provided written feedback about the course. Each member asked for more time to be spent on all the subjects covered, and the course has subsequently been extended to three days. The evaluation of the course demonstrated to us, however, that practice nurses are concerned about their lack of formal training for their posts and are clearly asking for more information on topics outside the sphere of preventive medicine. This in itself presents many difficulties, since a training course is impossible if the role of the practice nurse is not clearly defined. One definition of the practice nurse[1] is more concerned with the place of employment and the employer than with the role of the nurse.

There were problems with the financ-

ing of these courses. Although they were concerned with education for primary care, Section 63 funds were not made available and they were financed through a sponsoring drug company and course fees. Some nurses appeared to be paying their own fees, while others had their fees paid for by their general practitioner employer. General practitioners were able to claim reimbursement only for subsistence and travel expenses of their practice nurses attending these courses. The financing of courses for practice nurses certainly needs to be looked at. It is evident that there are indeed similarities between the historical development of general practitioners and practice nurses.[2] The problems relating to nurse training are particularly the method of employment of practice nurses, the lack of funds available for training, and the lack of knowledge about practice nurses of the nursing profession's leaders.

A particularly exciting development for the future has been the setting up after the first course of an ongoing peer group composed of local practice nurses.

Although the role of the practice nurse may be much disputed by some,[3] it is clear that changes in attitude towards both nurses and their role in screening in general practice must take place. Compulsory higher training of practice nurses will help this, and we believe that the area of preventive medicine is a useful place to start.

PETER ELLIS

Medical Centre
Simpson House
255 Eastcote Lane
South Harrow HA2 8RS

MERCEDES KELLY

Northwick Park Hospital
Harrow

References

1. Royal College of Nursing. *Training needs of practice nurses. Report of the steering group.* London: RCN, 1984.
2. Bolden KJ, Bolden S. The practice nurse: is history repeating itself? *Br Med J* 1986; **293:** 19-20.
3. Department of Health and Social Security. *Neighbourhood nursing — a focus for care (The Cumberlege Report).* London: HMSO, 1986.

When is a trainee fit to be let loose on patients?

Sir,

A recent judgement by a medical service committee, and endorsed by the Camden and Islington Family Practitioner Committee, is extremely relevant to vocational training and I believe ought to be seriously discussed by the profession.

The hearing in question[1] arose from an incident during my traineeship in 1984, when I was involved together with my trainer in treating a young man for what we had diagnosed to be an upper respiratory tract infection. His rapid deterioration led to admission to hospital where he died shortly afterwards, the cause of death being certified as pneumocystic pneumonia due to acquired immune deficiency syndrome.

Although the service committee refused to uphold the complaints about our failure to recognize AIDS and to diagnose the pneumonia, its report contained several criticisms about purely clinical matters such as the detection of signs and symptoms, their interpretation and the clinical decisions arrived at. For example:

- 'On the question of the diagnosis of pneumonia, although the precise strain was rare, there were sufficient signals from the patient and his family over a short space of time to indicate that something was wrong; neither doctor was alerted by this.'

- 'The Committee were concerned that in his examination of the patient's throat [the trainee] had failed to notice the lesion which was later identified as a Kaposi's sarcoma on the patient's hard palate.'

- 'They accepted the descriptions given by the complainant and her witnesses, which clearly illustrated a seriously ill young man, and were puzzled by the conflicting picture presented by the respondent's trainee.'

- 'The Committee considered that Dr X, the respondent's trainee, had not taken a proper history of the patient ... probably as a result of his inexperience as a GP.'

These statements, especially the last one, are difficult to reconcile with the facts known to the committee about my previous hospital training. Questioning a trainee's clinical competence in such a way suggests that previous experience counts for very little, and that a trainee needs to be very closely monitored until he can be considered competent to take a proper history from a physically ill patient. The implications for future vocational training are bewildering.

R.T. DATTANI

98a Southgate Road
London N1 3JB

Reference

1. Norell JS. In aid of doctors suffering from complaints about AIDS. *Br Med J* 1986; **293:** 1213-1215.

The complaints system in British general practice

Sir,

It sometimes requires an outsider to point out home truths. We should be indebted to Professor Max Kamien for his personal view of British general practice (January *Journal,* p.36). I was particularly interested in his comments about the complaints system and the way this influences patterns of referral to hospital.

His comments agree with much anecdotal evidence. Even though the chances of a complaint leading to a family practitioner committee hearing are one in 350 000 consultations, the answer to the problem is not to expunge the fear as Professor Kamien suggests but rather to recognize its effect.

A solution would be to change the complaints procedure. At the moment there is little scope for patients to air minor grievances which gives the impression that the complaints system is weighted against them. Many serious complaints are fuelled by multiple small resentments. At the same time there is evidence that doctors fear the present system and alter their behaviour accordingly. The professional consequences of even a single successful complaint can be disastrous. It is interesting to speculate on the cost to the National Health Service of doctors referring patients to hospital for the sole purpose of fulfilling their terms of service to the letter.

In the meantime, we have to live with an insensitive and inflexible complaints system that seems increasingly capricious and political[1] and is satisfactory to neither patients nor doctors. We are doing no one a service, least of all our patients, if we continue to deny the effect this has on practice.

CLIVE RICHARDS

The Health Centre
Old Street
Cleveland BS21 6DG

Reference

1. Norell JR. In aid of doctors suffering from complaints about AIDS. *Br Med J* 1986; **293:** 1213-1215.

Rubella immunization — what happens in our practice

Sir,

I was interested to read of the experience of rubella immunization in Brent and Harrow as reported by Drs Price, Wallace and Wilton (February *Journal,* p.82). In