

LETTERS

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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Inappropriate use of casualty departments

Sir,

A survey of 100 attenders was undertaken at a north London casualty department which was experiencing problems owing to increasing numbers of attenders. Nineteen per cent of the patients had no knowledge of their doctor's surgery hours and 32% had no understanding of the emergency cover provided by the practice. Fifty per cent of the patients had made no prior attempt to contact their general practitioner and 14% were not registered. Half of the presenting complaints were considered to be inappropriate for a casualty department. The main reasons given by these patients for coming first to casualty were that it was 'easier' and 'quicker' and (sometimes) 'better'. But the results indicate that lack of knowledge about practice arrangements or difficulty in contacting the doctor may also be a deterrent.

In order to provide attenders with more information and improve the department's inadequate knowledge about local practices, a questionnaire asking about surgery hours and emergency arrangements was sent out to all the 89 practices in the catchment area; 139 general practitioners from 58 practices responded.

Surgery hours ranged from 10 to 35 per week and most premises were closed outside these hours. Only a minority had reception staff available all day for appointments and messages, and only a minority were open on Saturday mornings for emergencies. Most practices operated appointment systems but said that they would give priority to emergencies. Out-of-hours cover was provided by a variety of systems, ranging from personal availability, cover by a group of doctors, answering services and deputizing services.

Opening hours and telephone numbers are displayed both inside and outside surgeries, and some practices have information cards as well. Information about general practitioners is also available from

the family practitioner committee lists in post offices and public libraries. The casualty department survey raises the question why people are not making use of this information. Is the information clear enough? Is it explicit enough? Has it been given out in a way that makes sufficient impact? Has it been understood? Is more detailed advice needed about which types of case should go to the emergency department and which are best discussed with a general practitioner? Do patients need to know more about the services offered by the practices and their policy about, for example, the treatment of minor accidents and injuries, or stitching and injections? Are patients entitled to know in more detail what response they will get during the night or at weekends, and whether they will be able to contact the doctor they know or whether a deputy will attend them? Should they know whether they will have direct contact with their first telephone call, or whether they will be required to ring a special emergency number? And if so, what will happen then?

Although it may be impossible for general practice to be as easily accessible as a casualty department with its 24 hour open door system, more thought could perhaps be given to the genuine difficulties that some patients have in contacting their general practitioner. These may range from appointment delays to inconvenient surgery hours, or when surgeries are closed, to problems with the telephone.

A recent survey has shown that when surgeries are closed, accident and emergency attendances increase.¹ But it has also been said that when patients have confidence in the ready availability of their general practitioner, emergency calls tend to be reduced.

It seems to be a universal complaint that casualty departments are overloaded, and that many of the patients going there would be more appropriately and better looked after by general practitioners. But this might mean more work for general practitioners. Are they willing

to accept it? Are they willing to supply more information about their practices to their patients and are they willing to try to inform their patients about the proper use of the emergency services? Can casualty departments play their part in this, and can a better working relationship between them and the surrounding practices be developed?

These are all difficult but important questions.

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A joint approach to smoking cessation clinics

Sir,

General practice is being increasingly considered as the most appropriate and effective area in which to practise preventive medicine.¹ The government in its recent white paper outlined incentives to stimulate primary care teams to undertake these new tasks.² Various studies have looked at the efficacy of general practitioners as health educators, and more recently attention has centred on the practice nurse.³ We decided to advance this concept one step further by training the practice nurse as a counsellor as well as health educator. She was taught how to establish and run a smoking cessation clinic within the context of her own general practice. There were five stages in setting up the service.

1. *Initial consultation with the local medical committee and family practitioner committee.*

2. *Identification of the general practitioners and practice nurses interested in such a scheme.* The project was introduced to the local general practitioners at

their weekly postgraduate meeting. A lecture was presented jointly by a respiratory physician and a community physician on the impact of smoking on the health of the local population, together with ways of tackling this problem. Following this all general practitioners were circulated with a letter inviting their practice nurse to participate.

3. *Development of a course for the training of nurses in the theory and practical aspects of smoking cessation clinics.* The district health education unit developed the course. This lasted for three days and involved teaching group work skills and techniques suitable for helping people stop smoking. One occupational nurse and 11 practice nurses were recruited for the course.

4. *Establishment of the clinics.* In January 1987 three clinics were established, one run by the district occupational nurse and two by practice nurses.

5. *Evaluation of the clinics.* Each patient completes an Addiction Research Unit smoking questionnaire at the start of his or her course of counselling and the follow-up questionnaire 12 months after completing their treatment programme. Thirty patients have now been referred to the clinic by their doctor: 10 men (33%) and 20 (67%) women. The mean age was 45 years (standard deviation 12) and the mean duration of smoking was 27 years (SD 12). Mean daily cigarette consumption was 23 (SD 12). Twenty-seven clients (90%) had attempted at least once to give up smoking in the preceding year; 21 (70%) considered that their health had been affected by smoking and 24 (80%) thought that their health would improve if they stopped smoking. One year after their smoking course three had changed address and could not be traced. Of the remaining 27 clients, three who refused follow up were assumed to be still smoking and a further 14 reported smoking the same as before (total 63%); seven (26%) reported that they had reduced their daily consumption of cigarettes (mean decrease in number of cigarettes smoked 75%, SD 15%); and three (11%) had given up. These initial results are similar to other general practice based studies.⁴

Lack of facilities, time or expertise is often considered a reason for delaying the introduction of a new preventive service.⁵ This paper describes the establishment of a health promotion initiative using local departments of respiratory medicine, community medicine and health education. It represents a model of collaboration that can be repeated in any district and will be necessary if the potential of

general practice as a health promotion setting is to be realized.

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Hypertension guidelines

Sir,

The Lothian hypertension group's guidelines for the management of hypertension in general practice were published in 1984.^{1,2} The group has now produced a second edition which takes account of the findings of the Medical Research Council trial on the treatment of mild hypertension³ and the European working party's study on hypertension in the elderly.⁴ The majority of the original recommendations remain unchanged, but the group now recommends that treatment should be considered when diastolic pressure is greater than 100 mmHg, especially in men aged over 45 years (the previous recommended level for treatment was 105 mmHg), and that there is a case for extending case finding beyond the age of 65 years to 70 years. With regard to drug treatment the original recommendations about first and second line drugs remain unchanged, but it is now considered that nifedipine or one of the angiotensin-converting enzyme inhibitors should be the first choice of third line drugs.

Copies of the second edition of the guidelines have been made available to all general practitioners in Lothian; further copies are available on application to myself, or Dr Doig at the Royal Infirmary, Edinburgh.

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Rubella prevention

Sir,

In his editorial (May *Journal* p.193) Dr Hutchinson is right to identify it as the general practitioner's task to ensure that all young women reaching child-bearing age are protected against rubella infection. As providers of contraception and preconception care, general practitioners are in the best position to be responsible for identifying women who have slipped through the immunization net. Most young women are aware that they were 'probably' immunized at school but medical records are often inadequate to clarify the situation. With the new measles, mumps and rubella vaccine, we will face the problem of needing to know for sure that a woman was vaccinated 20 years before and I believe that most of our record keeping at present is inadequate for this. Patient held records, Smart cards or RCGP prevention cards might provide the answer, but unless we meet this challenge with certainty the benefits offered by the new vaccine will be lost.

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Precautions after missed contraceptive pills

Sir,

Dr Metson (Letters, May *Journal*, p.226) draws attention to the varying out-of-date information in current data sheets for both combined and progestogen-only oral contraceptive pills with regard to missed pills. Family planning doctors have been trying to persuade manufacturers to update their data sheets in a uniform manner for some years. Earlier this year a meeting was attended by every pharmaceutical company manufacturing the pill and a consensus was reached about