riding motive when entering into the distressing business of bringing an action — that is, to avoid the same mistake occurring again to another hapless patient. This is the job of the doctors and the NHS — and it is being shirked.

Neither doctors' autonomy nor patients' respect for the profession ensure high quality practice. Thus a medical inspectorate will strengthen doctor–patient relationships, because it will raise standards. Doctors would do well to speed implementation of such a system of their own volition, rather than have it foisted upon them.

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Risk reduction and drug abusers

Sir,

The report of the Advisory Council on the Misuse of Drugs, *AIDS and drug misuse*,[1] suggests that medical services should develop a heirarchy of goals in dealing with drug injecting misusers: becoming drug free, switching from injecting to oral use and avoiding sharing equipment. The report also suggests that 'the network of general practitioners offers an unrivalled system for health care provision with great opportunities for intervention with drug using patients'.

However, general practitioners badly need information on drug users and how to treat them. I have failed to find adequate guidance on the assessment of needle sharing with a view to reducing the risk of human immunodeficiency virus (HIV) infection. The comments that follow are drawn from patients seen within the last few weeks and are not exceptional within the population attending a drug clinic.

The pattern of needle use illustrates the many ways the patient's life is arranged around drug taking. Several patients have described the importance to them of the ritual of preparing their heroin, setting up the spoon for heating the vitamin C to dissolve the powder, the companionship of being with others engaged in the same activity, and the attachment, fear or fascination of the needle. Who has first use of the clean needle and who injects may be an incidental means to an end for the user but is a component part of one couple's relationship occurring four times a day. The woman, a competent mother of three children, had relied upon her husband to inject her for seven years and arrived for help at the clinic, following his imprisonment, after finding injecting herself a messy and unrewarding task. Another hid away from her husband in a fiercely independent way. They never shared needles 'for reasons of cleanliness' but since being pregnant she had risked her own life and that of her baby by sharing needles with a casual acquaintance. A man described the difference between drug sharing in Amsterdam, where to be cool was to be hygiene conscious, and in Scotland, where to be hard meant not worrying about 'germs'.

Questions	Suggested solutions
Reduction of harm	
When did you last share needles?	Explain risks of sharing
How do you clean your needles/ equipment?	Suggest they avoid cold water rinsing and use mild bleach solution, boiling
If you share, do you use someone else's needle or do you pass your needle on to them?	Suggest they clean them well
How many people do you share with?	Suggest they reduce the number
Where do you obtain the needles?	Provide list of needle exchanges or friendly chemists
What injection sites do you use?	Suggest they avoid the femoral vein particularly
Meaning of needle sharing behaviour to the patient	
Do most people in your group share their needles in the same way?	
Is there pressure from others to change/stay the same?	Suggest strategies to resist pressure
Do you share with someone close to you?	Ask whether they are going to change Suggest the patient avoids them, or see both together for counselling
Who taught you to inject?	
Did someone first inject you?	
Does this sometimes still occur? Who is person?	Consider joint meeting
How much comfort do you get from just pricking yourself with the needle, heating up your heroin, seeing blood in the syringe?	Tackle one behaviour at a time
Do you take drugs alone or in a group?	Consider need for other social outlet

Figure 1. *Assessment of injecting behaviour.*

Thus, in the assessment of injecting behaviour, the individual can be asked about matters concerning reduction of harm but also, as with all drug related problems, the doctor and the patient should consider how the behaviour fits into the drug user's everyday life (Figure 1). Exploring some of these details with patients not willing to try abstinence may allow the issues to be confronted and specific strategies to be developed for changing behaviour that continues to place them at risk from HIV and other blood borne infections.

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Reference

1. Department of Health and Social Security. *AIDS and drug misuse. Part I. Report by the Advisory Council on the Misuse of Drugs.* London: HMSO, 1988.

Cholesterol screening in general practice

Sir,

Dr Jacobs cannot take all the credit for the drop in cholesterol levels seen in the patients who received dietary advice in his study (July *Journal*, p.321). Some fall in cholesterol level would be expected purely for statistical reasons in this type of study owing to the phenomenon of regression to the mean. On account of random

variation alone, subjects selected because they represent an extreme value in a distribution can be expected to have less extreme values on subsequent measurements. That this phenomenon applies to cholesterol was clearly shown in the multiple risk factor intervention trial[1] where there was a significant drop in cholesterol in study subjects between the first and second screening stages, before any intervention took place.

We are concerned that uncontrolled studies of this nature are being widely published, creating the impression that general practitioners are achieving more in the field of prevention than may be the case. We have learned to observe patients with high blood pressure for a period of time before intervening; should we not be doing the same with cholesterol measurements?

The high proportion (13%) of subjects with a cholesterol level greater than 7.8 mM in Dr Jacobs' study raises an interesting problem. The recent policy statement of the European Atherosclerosis Society[2] recommends that referral to a lipid clinic or specialist physician should be considered at this level. We doubt that specialist medical or lipid clinics in the UK could cope with this tremendous increase in workload and it is therefore essential that these patients are properly observed and managed in general practice.

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References

1. Kuller L, Neaton J, Caggiula A, Falvo-Gerard L. Primary prevention of heart attacks: the multiple risk factor intervention trial. *Am J Epidemiol* 1980; **112**: 185-199.
2. Study Group. European Atherosclerosis Society. Strategies for the prevention of coronary heart disease: a policy statement of the European Atherosclerosis Society. *Eur Heart J* 1987; **8**: 77-88.

Inappropriate use of casualty departments

Sir,

Dr Elizabeth Horder's letter (August *Journal*, p.372) is useful because it pulls together a number of questions about the use of hospital facilities. But the questions themselves may be inappropriate. We must remember that the National Health Service is a demand-led service for patients; it is only a convention of the medical profession that hospital care is secondary.

Dr Horder does not state the overall level of attendances in the casualty department surveyed. Cardiff has had one of the busiest casualty departments in the UK for many years. A numerical survey of attenders made some years ago, in response to a similar complaint, showed that the high level of attenders actually represented one patient per consulting session per general practitioner in the district. While the department was inundated with patients, each general practitioner in the city was unaware of seeing only 19 patients per surgery session instead of the expected 20.

If casualty departments are overloaded in the eyes of their staff and management, it is not because the local general practitioners are work-shy, but because the departments provide a focus of assembly. A better relationship between casualty staff and surrounding practices can be developed if both sides take the trouble to talk to each other. In Cardiff the initiative came from general practice. Stop recriminating and start talking; and keep on talking — every six months.

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Sir,

Elizabeth Horder raises the old question of the inappropriate use of casualty departments. Our group practice was disturbed to find that in a six-month period in 1986[1] one in 25 new consultations took place in the local casualty department rather than in our surgeries. The self-referral rate was 92% (similar to other studies) and on analysis more than 50% of cases could or should have been dealt with in our surgeries. This would have increased each partner's workload by less than two patients each per week.

Many patients attend a casualty department simply because they feel it is more appropriate. Surprise at the size of the numbers highlights general practitioners' ignorance of the extent to which patients receive help from other sources. Dr Horder implies that if general practitioners provided more detailed advice about what they can deal with, if patients could contact a doctor they know with one telephone call, and if general practitioners were more willing to do the work, casualty departments everywhere would be less pressurized. Our practice provides a detailed practice booklet, does not use deputies and has demonstrated that the increase in workload would not be great. We guarantee patients an appointment the same day if they want one and the wait is usually much shorter than in the local casualty department. The patient travels a shorter distance to be seen by a more experienced doctor at the surgery. Yet all this does not help persuade patients to contact us and not go to a casualty department.

Myers[2] showed that patients' perceptions of the general practitioner's ability play an important part in their decision where to attend. Davies[3] demonstrated that more than half of the patients attending a casualty department who were questioned went there because they thought their problem was unsuitable for their general practitioner, or did not want to bother him. Fisher[4] found that 68% of attenders thought their doctor would have sent them to the casualty department anyway, 52% thought they would need an X-ray and only 10% thought their general practitioner would stitch wounds, a finding confirmed by Cartwright[5] and Morgan.[6]

Ignorance, not only of the services offered by some general practitioners but of their availability, can also be demonstrated. Holohan[7] found that 52% of patients asked did not know the practice emergency arrangements and Davies[3] demonstrated that a high proportion attended casualty departments for speed or convenience. Morgan[6] found the main reason was availability of hospital care (32%), with appropriateness (17%) and accessibility (13%) also being important factors. Fisher[4] showed that only 4% of patients preferred hospital doctors. Studies in Sheffield[4] and Newcastle[6] demonstrated that having no general practitioner was a problem in less than 2% of cases, although this may be more of a problem in London,[8] as confirmed by Horder who found that 14% of the attenders were not registered with a doctor.

Patients underestimate the willingness of their doctors to stitch cuts and strap sprains, and exaggerate the likelihood of referral, according to Holohan[7] and Peppiatt.[9] The latter showed that, for all complaints except fractures, head injuries with loss of consciousness and overdoses, 81% of general practitioners felt the patients should contact them.

I suggest this problem has no solution and no matter what action is taken, general practice will always take place in accident and emergency departments. Why then do we try to artificially divide this work and run two separate organizations for emergencies? Why not have one efficient system with general