# LETTERS



**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.

## Drug information for family doctors — is an informal style acceptable?

Sir,

Clear, readable, independent and clinically relevant drug information is mailed free and frequently to all UK family doctors, providing them with the essential information for safe prescribing. Over 70% of doctors in a Northern Ireland sample were found not to have read important bulletins and complained that existing sources were 'too academic'. We prepared a very informal educational leaflet summarizing current advice from the UK *Adverse drug reaction bulletin* no. 118 (1986) on benzodiazepine problems. The printing was large and clear and cartoons were added to increase the readers' curiosity and relieve the unattractiveness of lists and jargon. The acceptability of this format was tested by confidentially polling 60 senior family doctors and 38 trainee family doctors at two seminars in October 1987. The two groups were allowed eight minutes to read the leaflet and five minutes to complete a questionnaire about it.

The results showed no resistance or objection to the new format. Eighty seven per cent of participants thought the leaflet contained about the right amount of detail and 91% found it easy to understand. Sixty four per cent of established doctors and 80% of trainees thought the new format better than existing sources. However, only 75% of all doctors managed to read most or all of the new leaflet in eight minutes and only 65% thought they could immediately recall most of what they had read.

Therefore, we now have evidence that reading time may be the most important factor in providing useful information. This is dependent first on the quantity of information presented and second on the readers' pre-existing knowledge of the subject. Ultimately, adequate drug knowledge cannot be maintained unless doctors devote a specified time each week to further reading. Our results suggest that the presentation of information can facilitate the reading process and we must now try to identify the optimal amount of information for complete assimilation within a 10 minute period.


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## The advertising debate

Sir,

In his interesting article (December *Journal*, p.559) Dr Tudor Hart argues the case against advertising by family doctors by preferring to see health care as a form of production of values rather than as a commodity. While this enables him to put a strong case against advertising it fails to cover the alternative view that health care may be treated as a commodity. Even from this point of view there are many problems with regard to advertising.

Health economists, such as Mooney,[1] have discussed the problems of health as a commodity. It is a commodity that no one wishes to consume *per se*, rather they want the improvement in health that they perceive they will gain from health care. The consumption of health care is likely to be irregular and unpredictable and, since it is heterogeneous, consumers may have different attitudes to different elements of it. Finally, and most importantly, there is the 'information asymmetry' (knowledge gap) between the consumer and the supplier (the patient and the doctor).

On one side doctors have greater medical knowledge about the treatment of disease but patients have greater personal knowledge about what might make them feel better. A man with influenza wants to recover. He goes to his general practitioner seeking relief for his symptoms, thus expressing a demand for health care. The doctor takes a history, performs an examination and advises that paracetamol would help. The doctor has converted the patient's need for health and demand for health care into needs for health care before attempting to meet the patient's requirements. Compare this with purchasing apples in a shop. The consumer needs food and feels that apples are the appropriate food to satisfy his hunger. He is the only judge of whether his demand for food is best satisfied with apples or oranges. Furthermore the apple buyer knows what good apples look like and what price he is prepared to pay. However, the patient does not know whether paracetamol is a good treatment for influenza or not, nor what price (in terms of time off work and so on) is appropriate. For conventional commodities the consumer is sovereign in expressing choice and applying value and is thus the sole source of demand. For the commodity health care this sovereignty is reduced because of information asymmetry.

Advertising and the maximization of competition imply free markets which seem particularly attractive to the present government. Even if health care can be seen as a commodity, it differs in several ways from other commodities and the limitation of consumer sovereignty makes advertising and free markets highly problematic. However, it is the medical profession's failure (as also the legal profession's) to inform the public which has fed the consumers' demands to know more about the services we offer, thus changing the climate of public opinion and making the possibility of doctors advertising attractive to some.

Since asserting an alternative view of our society may be over-ambitious it might be more practical to ensure that the commodity health care is properly

understood. This would require exactly the wider public role for general practitioners that Dr Tudor Hart advocates. When consumers are knowledgeable advertising becomes impotent.

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**Reference**

1. Mooney GH. *Economics, medicine and health care.* Brighton: Wheatsheaf, 1986.

Sir,

I do not know of anybody or any organization that is advocating the no holds barred, unrestricted, heavily persuasive advertising by general practitioners which Dr Tudor Hart addressed in his article (December *Journal,* p.559).

In fact it has been a hallmark of this topic that the profession, represented by the General Medical Council and the Royal College of General Practitioners, has never carefully or correctly defined the degree of advertising intended by those in favour of some relaxation of the present GMC guidelines. The word advertising is all too easily connected with rampant commercialism. Therefore it is hard for people to restrict themselves to commenting on just the provision of information and not be diverted into a much easier attack on some imagined exaggerated advocational content.

Dr Tudor Hart follows the pattern and again discusses the hypothetical situation he wants to discuss but ignores the actual proposals being considered. I can understand that politically it may be expedient to fight on a false front so that a loss may be turned into a victorious compromise but this does not facilitate debate or flatter the ability of the writer's mind to define the issues.

I am equally disturbed at Dr Tudor Hart's suggestion that the profession be a force for social change. What public mandate have the GMC or royal colleges obtained to take on this role? I am sure that individual doctors will disagree about the relative merits of different social values, so what social values are the profession to uphold? I am against the private ownership of property but I would not expect the profession as a whole to support me. The purpose of a profession is to serve society not change it.

Dr Tudor Hart does, however, present some of the right evidence in coming to the wrong conclusion. He correctly emphasizes the public's right to care according to need, not ability to pay and he draws our attention to the shortfall in chronic care provision, many patients being without care at all. The importance of a good doctor–patient relationship is also emphasized, one that allows and encourages the patient to accept some responsibility. He reminds us of the mobile nature of society today with the average stay with one doctor being only nine years not for a lifetime. We were not, however, reminded that 25% of the public are dissatisfied with their general practitioner's management[1] or that one in three 35-year-olds use alternative therapies.[2]

Part of the solution for these shortcomings, which will also help facilitate the formation of good doctor–patient relationships, is to increase the public's power and choice of medical care by improving their access to relevant practice information. This means raising the profile of all locally available general medical services, NHS and private, by the use of the newspapers. Notices or announcements of the existence and availability of these services will increase the chance of the public seeking the medical care appropriate for them.

Dr Tudor Hart fails to see the problem from the public point of view. All he can say is: have faith, trust us, it will be alright in the end. But the false promise of perfection delivered tomorrow in five or 10 years time is not good enough. People are suffering today and practice information in local newspapers will benefit them now.

The profession has to adapt to the needs of the people and not vica versa.

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**Reference**

1. Jowell R, Witherspoon S, Brook L (eds). *British social attitudes. The fifth report.* Aldershot: Gower, 1988.
2. Murray J, Shepherd S. Alternative or additional medicine? A new dilemma for the doctor. *J R Coll Gen Pract* 1988; **38:** 511-514.

## Community care for the elderly

Sir,

Sharing the rising concern about the increased workload generated by artificial aggregates of elderly patients, as demonstrated in the study carried out by Dr Andrew (December *Journal,* p.546), my partner and I audited demand for the fourth quarter of 1988. The subjects were 23 patients resident in purpose built flats for the elderly with a 24 hour resident warden. There is no domestic or nursing care provided and therefore residents have to be able to care for themselves, although 'meals on wheels' and home help services are available for those who qualify. Twenty three control patients matched for age and sex and not living in special accommodation for the elderly were also studied. The average age in the two groups was 80 years (range 92–65 years) and there were four men and 19 women. The workload generated by the two groups over the three month period is shown in Table 1.

**Table 1.** Workload generated by 23 elderly patients living in special accommodation and 23 age and sex matched controls.

| | Subjects | Controls |
|---|---|---|
| No. of visits (daytime only) | 20 | 1 |
| No. of surgery consultations | 20 | 24[a] |
| Total no. of medications prescribed | 74 | 40 |
| Mean no. of medications prescribed per patient | 3.2 | 1.7 |

[a] 13 generated by two patients.

Even allowing for the small sample size, the potential workload and cost implications of these figures is alarming, with the rising elderly population and the drift into special accommodation. This problem is something to which we, as independent contractors, should address ourselves, and something which our General Medical Services Committee negotiators should have in the forefront of their mind in their current negotiations with the government.

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## Crohn's disease

Brown and colleagues (December *Journal,* p.549) set out to 'aid general practitioners in the earlier diagnosis of Crohn's disease'. In reality there is nothing in their paper to help a general practitioner evaluate lower bowel symptoms, but this is not surprising given the study design. It is difficult to imagine how the authors could have expected to provide guidance for general practitioners from a retrospective survey of hospital records. There is no information in this paper about the consultation frequency or pattern of the patients studied before they were seen in hospital and nothing about the severity of their symptoms or the effect of the symptoms on function.

Symptoms referrable to the gastro-