Working for patients

John Halsall (Letters, June Journal, p.260) has every right to expect that his emergency night calls should be dealt with in a professional manner.

His comparison with the armed forces raises two interesting differences in working patterns. Unlike general practitioners, soldiers spend only a fraction of their career in active service. In addition, they are retired from service rather younger. A career structure which leaves general practitioners as 'junior officers in the front line' at the age of 70 years is not ideal, especially as patient expectations continue to rise.

The problem of sleepy doctors is not going to be solved by a contract which encourages larger lists and discourages sharing the out-of-hours workload. Our chiefs of staff at the ministry are not old troopers who have risen through the ranks and remember what it was like in the trenches. Nor, in their plans for family practitioner committees and lack of interest in local medical committees, have they shown any wish to know. If, as I believe, good morale makes for better care, they cannot claim to be 'working for patients'.

Stuart Handysides

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Christian approach to whole-person medicine

Sir,
Dr Sheldon has raised a number of issues (April Journal, p.166) that should not be ignored and I wish to express my support for the working party report Whole person medicine.

Spiritual aspects of health need to be considered alongside physical, social and psychological factors. A number of patients desire and need spiritual help, and this was demonstrated by the recent response to Dr Billy Graham's meetings. General practitioners feel it is important to study culture in relation to health. Thus when so many of the population of the United Kingdom and Ireland are professsionals Christians, doctors should receive more education about Christianity, its interaction with medicine and its resources, at both undergraduate and postgraduate levels. Local doctor-Clergy groups would allow referral of patients for Christian counselling, which would provide practical help and meet spiritual needs.

In the working party report there are several cases of healing where prayer is involved and I know of several other cases. I urge you to read the case histories before you dismiss this out of hand.

If any Christian professional would like to get in touch with other Christian professionals, I suggest they contact Caring Professions Concern, Church House, 34A Hillton Road, Earlev, Reading RG6 1DB, to find out about local members.

H.N. Graham-Smith
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Value of MRCGP

Sir,
I hope the College will act to preserve the value of its qualification to its members. There seems to be a move in the recent white paper towards rewarding multiple diplomas, a tendency which will tend to devalue the MRCGP. I deliberately eschewed the chance to aggrandize my name with a mass of letters, preferring to take that qualification which seemed most appropriate to my vocation. It is my assertion that MRCGP after my name is shorthand for: DObstRCOG, DA, DCH, FRCS(pt1), MRCP(pt1), DPM.

How do other members feel about this issue?

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Reference

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DIGEST

This month • faecal occult blood screening • antibiotics • sclerotherapy • third world • non-attendance • hospices

Faecal occult blood testing for symptomless colorectal neoplasm

In a large study in Nottingham general practitioners have recruited 156 000 patients aged 50-74 years since 1985. This preliminary report compares the experience of 53 464 subjects who were sent a faecal occult blood screening kit with the 53 885 controls who were not; 53% of the subjects responded and 618 (2.3% of completed tests) proved positive. After dietary exclusions (meat and high oxidase vegetables) the tests were repeated and those who remained positive were fully investigated by colonoscopy. This revealed 63 cancers (2.3 per 1000 accepting the test) and 367 adenomas in 266 subjects. Testing is being repeated at two yearly intervals and, so far, there have been 20 'interval cancers'; 123 cancers have been diagnosed in the control group and 59 people have presented adenomas. Of the non-responders in the test group 83 have presented with tumours and 24 with adenomas.

The cancers showed a much higher proportion of early (Dukes stage A) tumours in the screening group (52%) compared with the control group (11%). The authors hope to continue yearly screening even though the percentage of positive results are diminishing with repetition. They hope to produce definite recommendations when they can be sure what effect early detection has on long-term mortality.

(F.S.)


Education and antibiotic use

There is an interesting juxtaposition of two articles on the effects of education on antibiotic use in a recent issue of Family Practice. The first is from the Ben Gurion University in Israel. Here new graduates of the health sciences faculty ran a 'health activist' course as part of a graduate project aimed at improving primary care in the Negev area. The course participants were members of the local community (mainly Jews of north African descent) who were designated to be future 'health activists'. That is, lay people trained to fill the communication gap between the community and the primary health care facilities. In the course of 12 weekly evening meetings a variety of health-related topics chosen by the participants were discussed in small groups. The discussions were followed by a for-
mal lecture. The study recorded the changes in the participants’ knowledge as a result of the course using questionnaires focusing on the appropriate use of antibiotics. The results showed, predictably perhaps, that knowledge increased significantly. The authors were pleasantly surprised that the most disadvantaged sub-groups seemed to gain the most and they were also pleased by the participants’ enthusiasm — only five of the 69 participants dropped out over the four months.

The title of the second article ‘Reduction in antibiotic usage following an educational programme’, seemed to suggest the complimentary study showing change in behaviour. However, this Swedish study involved an educational programme for the doctors working in one health centre in Höör. They looked at regional resistance patterns of potentially pathogenic respiratory tract bacteria and agreed an antibiotic prescribing policy for respiratory tract infections. The prescribing of antibiotics for respiratory tract infections was monitored before and after the programme and it was found that the rate of prescribing fell significantly from 66.7% to 43.9%. The types of antibiotics prescribed also changed with fewer broad spectrum antibiotics being used and a rise in the popularity of penicillin. There was also some tentative evidence for a sustained effect as the sales of antibiotics in the Höör pharmacy remained depressed one year after the study in spite of there being no change in the incidence of respiratory disease in the absence of any similar decrease in the county as a whole. This study provides further evidence that doctors can change their prescribing behaviour as a result of education and it adds to one’s disappointment that in the UK this approach is being abandoned in favour of an unproven ‘indicative drug budget’ approach.

What was most intriguing, of course, was the study which was not done but which was suggested by the juxtaposition of these two articles — a study showing the effect of patient education on the antibiotic prescribing of doctors.

(C.B.)


Bleeding stomal varices treated by sclerotherapy

MANY general practitioners inject varicose veins (Brown JS, Minor surgery, London: Chapman and Hall, 1986: 104-107). Varicose veins around a colostomy can be injected, and this may be life saving. The portal venous pressure may rise if there are metastatic deposits of tumour in the liver. This may produce congested varicose veins around a colostomy stoma. Fatal haemorrhage has been reported from rupture of such a vein, and in other cases blood transfusion or refashioning of the colostomy has been necessary. A report from the Royal Liverpool hospital points out that the veins can be injected with about 1 ml ethanolamine on each site, after a little lignocaine infiltration. This procedure in the patient’s home would probably save hospital admission, and prolong the patient’s life for some weeks or months.

(G.P.)

Problems of village health workers in the third world

HEALTH for all’ by the year 2000 has been interpreted by some health planners and governments in the third world as ‘Village health workers for all’. This review article from Nairobi examines critically the effectiveness of village health worker training in East Africa. Its disturbing message is a familiar one. If programmes are imposed on people from on high, they tend not to succeed and resources are wasted.

Many village health worker programmes start after a tour by government officials who may hold ‘discussion’ meetings with village leaders. The person selected as health worker may have eight weeks of training, with lectures away from the village, returning with a new uniform to a new health post on the government payroll. This can alienate the person from the people they are aiming to help. Although the health workers have been trained, there may be inadequate drugs or facilities for them to use. Communities may be disinterested in someone who offers advice rather than western medicine. A survey in Asia shows that the village health workers spent 60-70% of their time on curative work, even though the programmes have been going for five years. Drop-out rates of village health workers have been high at up to 77% after five years in Tanzania.

The author suggests that sustainability is the most important quality. Programmes which have emerged from the local people’s own initiative have been much slower to emerge but much more sustainable in their impact. These need full discussion and new ideas from within the community, with support from outsiders. This external support must not patronize or stifle.

I saw many of the problems described here when I spent three months working in a health post in Brazil. There, in a small village one local woman had started the health post on her own initiative 16 years before, after only rudimentary training. Her tremendous dedication led to government recognition, but local political pressure led to the appointment of six other health workers, all friends and relatives of the village mayor. In the purpose-built health posts with all the trappings of uniforms and microscopes only curative care was practised with no health education or preventive care. The original worker had become disillusioned.

In this interesting and thought provoking article the author argues that sustainability in village health worker programmes is related to community involvement. All those concerned with primary care in the developing world should read and consider its arguments.

(J.A.)

Non-attendance at outpatients

NON-ATTENDANCE at outpatient clinics leads to a great waste in resources and is a source of concern for managers and planners of the NHS. To determine the causes of non-attendance at new outpatient appointments, questionnaires were sent to all non-attenders over a three-month period and also to a control group of attenders over the same period; 58% of non-attenders returned their questionnaires compared with 84% of attenders.

The researchers found that non-attenders were slightly more likely to be men and were significantly younger than attenders. The seriousness of their clinical condition, the duration of symptoms and the level of pain had no influence on whether patients kept their appointments or not. Non-attenders were slightly more likely to report difficulty in attending outpatient departments although this was not statistically significant and the main reasons given were difficulty in getting off work. Non-attenders were also less likely to know the purpose of their appointment and also claimed that they had not been given enough information about the appointment. The most significant finding
of all was that non-attenders were more likely than attenders to have received very short notice of their appointment. Twice as many non-attenders admitted having a previous non-attendance at outpatient appointments.

These findings have implications for planning within the health service and suggest that improvements can be expected to follow from fairly simple adjustments and procedures. Rather than blaming the patients for failing to keep their appointments it is important to ensure that the wheels of administration function in a way which facilitates attendance.

(M.K.)


What happens in hospices

THEY'VE paved paradise and put up a parking lot. Hospices have come a long way since St Christopher's was founded in 1967 by Cicely Saunders in response to the poor quality of terminal care provided in hospitals. In a review article, Seale examines the extent to which hospices differ from hospitals and from each other and argues that hospice care is not unique to hospices.

Research has shown that the social support and relief of patients' anxieties can be achieved more effectively in hospices than in hospitals. The patient oriented nursing approach taken by many of the institutions has revolutionized the terminal phase of many patients' lives. Patients in a hospice are less likely to perceive staff as busy, and bereaved spouses are more likely to remain in contact with hospice staff. However, many of the ideals of the hospice movement have been adopted by mainstream medicine. In 1961 only 12% of American doctors would tell a patient of a diagnosis of incurable cancer, compared with 98% in 1979. A study of pain relief showed that hospitals can achieve the same results as hospices, using hospice style analgesic regimens and concentrating on the needs of patients.

The review quotes a number of studies which show that independent hospices, often run by non-consultant medical staff such as general practitioners, have taken new approaches to treatment and made hospices more like a home than a hospital. Medical students and junior doctors who are exposed to hospices during their training later adopt hospice style management of the terminally ill.

Many general practitioners are involved in the staffing of independent hospices and the work they do cannot be overstated. However in many ways the growth of hospices has been linked with the growth in the professional status of the general practitioner. When incorporated into mainstream medicine will hospices still be able to pioneer new attitudes and to be 'different'? Paradise may not yet be 'paved' but planning permission has been applied for.

(J.A.)


Contributors: Frank Sullivan, Glasgow; Colin Bradley, Manchester; Gus Plaut, York; Jonathan Anderson, Glasgow; Moya Kelly, Glasgow.

FILL THIS SPACE

Contributions to the Digest pages are welcome from all readers. These should be from recent papers in research journals which general practitioners might not normally read. Send to: The Editor, Journal of the Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE. Please quote the full reference to the article (authors, title, journal, year, volume, page range).

INFECTIONOUS DISEASES UPDATE

Costing vaccinations for overseas travellers

After a decision has been made to administer a particular vaccine to a traveller, establishing whether the vaccine can be prescribed on the National Health Service and whether or not a fee for vaccine administration can be claimed can be confusing. Unfortunately there is often no clear answer available from national guidelines. The family practitioner committees, pricing authorities and the terms and conditions of service for general practitioners do not have consensus views on the subject. Basically, however, any vaccine which can be prescribed on form FP10 (see terms and conditions of service) can be administered to a patient when the practitioner feels the risk of exposure justifies vaccination. If a vaccine cannot be prescribed on form FP10 it is normally obtained on a named patient basis from the manufacturing company and in these circumstances the patient is liable for the cost of the vaccine and its administration. A complication is that some vaccines which can be prescribed on FP10 may not be approved by a local pricing authority and hence become chargeable to the dispensing pharmacist. When vaccines such as those against rabies, hepatitis B and meningococcal infection are given to travellers for protection overseas it may be prudent to check with your local pricing authority that the cost will be reimbursed. Confusion recently arose when the Joint Committee on Immunization and Vaccination suggested in its current 'Green book' that rabies vaccine could be prescribed for travellers working in endemic areas but not to tourists. Whether this turns out to be so depends upon the decision of the practitioners' local pricing bureau. The general practitioners' statement of terms and conditions of service defines the vaccines for which an administration fee can be claimed from family practitioner committees. Patients can be charged for the administration of vaccines not on this list.

Shingles

It is not always realized that shingles is infectious. Recently six out of 21 nursing staff working on a geriatric ward in England developed chickenpox shortly after one of their patients had developed shingles. Chickenpox can be an unpleasant illness in adults and life-threatening in the immunocompromised and in pregnancy. Serological testing can be performed rapidly to check immune status and hyper-immune globulin is available for those contacts who could be at risk of serious infection but it must be given as soon as possible after exposure. This outbreak emphasizes the need to isolate patients with shingles from those who are non-immune.

Influenza

This year has seen an unusually late outbreak of influenza A which began at the end of April and went on into June. Most of the cases appear to have been due to serotype H3N2 which although active in Europe and Scandinavia earlier in the year was not the main cause of last winter's outbreak in the UK. It seems probable that this serotype will be involved in next winter's epidemic. It is covered by the currently available influenza vaccines.

Suggestions for topics to include in future updates are welcomed and should be passed to the contributor, Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (041-946-7120), from whom further information about the current topics can be obtained.