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.)

Source: Frankel S, Farrow A, West R. Non-attendance or non-invitation? A case-control study of failed outpatient appointments. *Br Med J* 1989; **298**: 1343-1345.

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 ideas 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.)

Source: Seale C.F. What happens in hospices: a review of research evidence. *Soc Sci Med* 1989; **28**: 551-559.

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).

INFECTIOUS 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.