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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.

Foreign body inhalation: a danger of metered dose inhalers

Sir,
Metered dose inhalers are used by many patients as a safe and convenient way of administering bronchodilators. We report a case illustrating a potential hazard of their use.

A 54-year-old woman with a history of sarcoidosis was admitted to Papworth Hospital in acute respiratory distress. While out shopping she had experienced an episode of bronchospasm and had used a salbutamol inhaler kept in her handbag for such occasions. Immediately she gasped, as if she had inhaled something, and her symptoms worsened. She presented to her general practitioner who referred her to Papworth Hospital for further management.

On arrival in hospital she was slightly dyspnoeic with a marked wheeze. Although there was no tracheal deviation, left basal dullness and decreased air entry suggested airways obstruction on that side. A chest x-ray revealed left atelectasis but no foreign body was seen. Rigid bronchoscopy was performed and a plastic object, totally obstructing the left main bronchus, was removed. Subsequently the patient identified this as the lid of a make-up pencil which was one of the many small objects kept in her handbag with the uncapped inhaler. She made an uneventful recovery and was discharged home two days later.

Worsening symptoms following the use of a metered dose inhaler should arouse suspicion of foreign body inhalation from its mouthpiece. In other reports coins[1-3] and tablets[4] have been inhaled from uncapped inhalers kept loose in a pocket. In all cases the patient recovered after successful bronchoscopic removal. With the widespread use of such inhalers it is perhaps surprising that so few cases have been reported and in spite of the additive effect of respiratory embarrassment on acute bronchospasm, there has yet to be a fatality.

Had our patient followed the instructions supplied with her inhaler, that is to keep it capped and test fire it if infrequently used, she would have avoided this episode. No mention is made of this potential complication in the instructions and physicians should bear it in mind when counselling patients. Perhaps it is time to change inhaler design so that mouthpiece caps cannot be so readily lost.

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References

1. McGonagle M, Reams CL. The jet propelled dime. *JAMA* 1984; **251**: 1431.
2. Hannan SE, Pratt DS, Hannan JM, *et al.* Foreign body aspiration associated with the use of an aerosol inhaler. *Am Rev Respir Dis* 1984; **129**: 1025-1027.
3. Bray WR, Francis PB, Jacobs J, Burris AS. Two-penny aspiration: unusual complication of a metered-dose inhaler. *South Med J* 1985; **78**: 1527.
4. Wiesel JM, Bar ZG, Feinmesser R. Intrabronchial tablets — jet propelled. A case report. *J Laryngol Otol* 1981; **95**: 219-220.

Patients' resistance to change

Sir,
A routine survey was conducted in two practices in Upminster with the objective of finding out whether patients preferred an appointment or non-appointment system. Prior to our appointment, these practices operated different systems and we decided to undertake the survey so that we could unify the systems depending upon the patients' preference. Both surgeries have lists of 2500 patients and are two miles apart.

Clerical staff carried out the survey during normal surgeries for a period of one month and data were collected from approximately 150 adults from each practice. The results were surprising. Ninety per cent of the patients attending the practice that had an appointment system wanted to retain an appointment system while 8% preferred no appointments and 2% had no opinion. However, among patients attending the surgery with no appointment system, 97% wanted no change and 3% preferred appointments. This clearly indicates that patients are resistant to change and prefer to retain the system that they know as long as it works satisfactorily.

We decided to respect the wishes of the majority and leave things as they are.

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Spiritual healing in general practice

Sir,
If I had been asked three years ago what I knew about spiritual healing I would have replied that I knew next to nothing. The question would have conjured up images of spiritualism, laying on of hands, miraculous cures, and even the occult arts. If I had paused to reflect I would have observed that as a doctor I really ought to know something about healing, and that all too often as a general practitioner I face problems which appear to be neither physical or mental, but of a spiritual dimension. I asked myself 'What is healing, and is it something that can be learnt and integrated into day to day general practice?' The opportunity to answer this question arose when I was in-

troduced to a healer who had recently moved into the area. I invited him to sit in on one of my surgeries and this was such an interesting experience that we decided to repeat it on a regular basis once a week. We have now been holding this joint surgery for two years.

I work full time in a busy six-partner National Health Service general practice. The joint surgeries with the healer are held in the morning, and patients are informed and asked to give consent to a healer being present. Most do not seem to mind, and a sizeable minority are positively interested. At first neither of us was sure what we were trying to do or even learn, but it became clear that every consultation has a spiritual dimension and a spiritual diagnosis can be made. This is usually quite simple and commonplace, for example loneliness, fear of ill health, lack of purpose in life or low energy.

The surgery is run as any busy morning surgery, aiming to give patients 10 minutes per consultation, and running for over two and a half hours. We start with a brief meditation for several minutes before calling the first patient. The previous week we will have chosen a quality as a focus for the day, for example compassion, forgiveness or cooperation, and will try and use that quality throughout the surgery. The patients present their problems in the normal way, and I make a diagnosis from the history, examination and investigations. Like any good doctor I will try to place this illness in the context of their life, and encourage them to explore the reasons why this illness may be happening to them now. The possible therapies are then discussed with the patient. The healer may be involved with this process if it seems appropriate, but most patients are wary of the healer at first so he tends to keep an attentive silence. After the patient has left we discuss the consultation. The healer will give his intuitive impressions, and how he assesses the patient's imbalance in terms of intuitive diagnosis, energy blocks, aura fields, and the spiritual problem. We then try to make a spiritual diagnosis, and review future approaches.

It is a challenge to fit all this into a 10 minute appointment system. These surgeries are always exciting and interesting. I am learning all the time, and also rediscovering a whole area of wisdom and knowledge that I had not given adequate recognition to.

Only in the last 20 years have we fully recognized the part that our mind plays in illness, and perhaps in the next 20 years we will begin to recognize the part that the spirit plays in ill health. We will then begin to talk not only of psychosomatic illness, but spiritualsomatic or even psychospiritual illness. One day we may be able to make psychospiritualsomatic diagnoses — perhaps it is easier to say holistic. Healing of the spirit can occur in any consultation, and indeed it can happen in any human contact, when we are alone, and when we are asleep and dreaming.

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Quality assessment or quality control?

Sir,
I enjoyed reading the editorial 'Quality assessment or quality control?' (August *Journal*, 309). Having worked in the field of quality assessment in Sweden,[1] I would like to stress some of the issues raised from a Nordic point of view.

It is difficult to evaluate changes within a health care system on a general level that will be understood by readers of international journals, without losing the fundamental cultural and social conditions framing the work. It is, however, quite possible to combine theoretical work with descriptions of practical methods of quality assessment.[2-4]

The distinction between quality assessment and quality control helps to separate different aspects of medical audit. It is especially valid in the Scandinavian countries where the government and health authorities make a major impact on the delivery of care by allocating resources to different levels of care.

The enhancement of quality assessment by family physicians themselves allows the essence of our discipline to be made visible to and understood by patients and the politicians regulating our work.

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References

1. Westman G. *Planning primary health care provision. Assessment of development work at a health centre (thesis).* Umea, Sweden: Umea University, Department of Family Medicine, 1986.
2. Westman G, Andersson SO, Ferry S, Fredrikson P. Waiting room time in the assessment of an appointment system in primary care. *Scand J Prim Health Care* 1987; **5**: 35-40.
3. Mattsson LG, Westman G. Evaluation of provider continuity in primary care. Actual versus random and potential continuity. *Fam Pract* 1987; **4**: 251-259.
4. Westman G, Hanning M, Mattsson B. Utilization of inpatient and emergency care: effects of changes in a primary care system. *Scand J Soc Med* 1987; **15**: 105-109.

Physician in palliative medicine

Dr Charlton's response (August *Journal*, p.347) to the editorial by Dr Ilora Finlay (January *Journal*, p.2), highlights a number of points that are pertinent to the development of palliative care services in the community.

The Dorothy House Foundation was set up in 1977 as a home care nursing service for the terminally ill, later adding back-up beds and daycare, and ensuring the general practitioner's control of medical intervention. The Macmillan nurses offered advice, support and information for the general practitioners and district nurses working with the patient and family.

The recent appointment of myself as a physician in palliative medicine, from a background of general practice, while seeming to accept the specialty as separate, was in fact designed to do just the opposite. The physician in palliative medicine's role is dependent on the general practitioner retaining control and this complements his efforts to enable patients to be at home with their families, if that is what they wish. This acknowledgement of the role of the general practitioner is crucial to the development of the physician in palliative medicine's role. The Foundation envisaged this to be a facilitator, who can advise, support and educate in a similar way to the Macmillan nurses. That physician will be available for consultation at the request of the general practitioner and, through his or her training in both family and palliative medicine, should be in a position to offer appropriate advice or support when needed. The role is proactive in education, and will be research based.

The Foundation would agree with Dr Charlton that the development of the specialty should no longer concentrate on an increase in the number of inpatient units but on providing specialist physicians who can enable health care teams to improve the care of the dying in the most appropriate setting.

We believe it is an essential component of the work of the physician in palliative medicine to develop educational programmes and to research ways in which the specialty can be integrated into current health care systems. The Macmillan Education Centre of the Dorothy House Foundation has developed courses and workshops for many disciplines and will continue to provide appropriate teaching for all people involved in palliative care, employing a multidisciplinary approach.

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