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Minor surgical procedures performed by general practitioners

Sir,

In April 1990, after the advent of the new contract[1] and the minor surgery procedures listed in the new terms of service,[2] I performed a study of the involvement of general practitioners in our health district in minor surgery. Postal questionnaires were sent to 100 practitioners covering all the practices in the Great Yarmouth and Waveney health authority. The questions related to the general practitioners' participation in different surgical procedures, how their experience was obtained, the facilities they had available, the capital outlay resulting from the new contract, the appropriateness of the procedures to general practice, and attitudes to the level of remuneration.

Seventy four doctors responded within one month, and seventy two of these (97%) had applied for inclusion on the minor surgery list. Two had chosen not to apply owing to lack of facilities, and the fact that they did little minor surgery anyway. All responders except one felt that they had adequate 'medical experience and training' to provide minor surgery services. General practice itself was felt by 36% of respondents to be the major route for gaining the necessary skills, 41% cited their house officer posts, and the remainder included outpatients clinics, or experience as medical students or clinical assistants. Two respondents were fellows of the Royal College of Surgeons.

The procedures which the respondents have been performing are shown in Table 1. Respondents were not asked specifically whether they felt able to attempt all procedures listed, as the study was carried out prior to the controversy over what has been called the 'all or none ruling'.[3]

Forty nine of the respondents (68%) would perform a minor surgical procedure when it arose, rather than setting up a specific minor surgery session and 53 (74%) did not ask for written consent because they felt consent was implicit.

Table 1. Minor surgical procedures performed by general practitioners.

Procedures	Percentage of GPs who have been performing the procedure ($n=72$)
Injections	
Intraarticular	94
Periarticular	96
Varicose veins	10
Haemorrhoids	8
Aspirations	
Joints	93
Cysts	42
Bursae	86
Hydroceles	37
Incisions	
Abscesses	87
Cysts	81
Thrombosed piles	26
Excisions	
Sebaceous cysts	72
Lipomata	68
Skin lesions for histology	81
Intradermal naevi, papillomata etc	81
Warts	28
Ganglions	15
Toenails	60
Curette, cautery and cryo cautery	
Warts and verrucae	65
Other skin lesions	29
Other procedures	
Ligations of varicose veins	1
Removal of foreign bodies	50
Nasal cautery	33

n = total number of respondents.

Nearly all practices had a reasonably varied selection of equipment and four surgeries used local general practitioner hospital facilities when performing minor surgery. Seven respondents (10%) had no clinical light for better illumination, and seven (10%) had no sterilizer, but received sterile instruments on hire from the local hospital. Twelve respondents (17%) had no curette, and 33 (46%) had no gowns or masks.

Twenty four doctors (33%) felt that the new contract had necessitated a large amount of capital outlay on treatment rooms and equipment. Twenty two doctors (31%) thought they were doing more minor surgery since the changes of the new contract but 34 (47%) felt that the financial remuneration was inadequate. Forty two doctors (58%) thought some of the procedures listed in the new terms of service too dangerous to perform in general practice.

It seems therefore that a considerable number of minor surgery procedures are performed by the general practitioner. Although the commencement of payment is welcomed, it is felt by many to be inadequate. The majority of general practitioners are performing only a selection of the various procedures listed in the new terms of service. Criteria for inclusion on the minor surgery list may therefore be difficult to standardize.

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Changing patterns of drug use and HIV infection

Sir,

The human immunodeficiency virus (HIV) epidemic has resulted in more attention being given to the medical needs of people addicted to prescribed and illegal drugs. Most city general practitioners are now familiar with the approaches of drug users and their requests for help. Previous guidelines

took an over-simplistic approach but made it easy for doctors to be firm and, in their own minds, fair.[1] Current guidelines encourage a sympathetic or flexible response by doctors[2,3] but could create opportunities for the manipulative drug user.

In addition to those clearly addicted to opiates we now observe many users of prescribed drugs who have never used heroin or other traditional addictive drugs. Benzodiazepine use is the single most important problem of inappropriate drug use and the cottage industry in resold drugs includes those prescribed to all ages of patients; some older patients supplement their income by selling their sedative or hypnotic medication. We regularly see patients who are taking high doses of illegally obtained benzodiazepines and this clearly has implications for the preventive strategy of prescribing substitute opiates to drug users.

The high prevalence of HIV infection in Scotland and the increase in agencies and pressure groups advocating prescribed substitutes have increased the pressure on general practitioners, other doctors and parents to respond to the perceived needs of the drug users. In an attempt to understand the needs and expectations of parents of drug users we interviewed 20 people (18 mothers and two fathers) with one or more drug using sons (15) and/or daughters (seven). Seven of the drug users still lived at home although the mean length of time drugs had been used while living at home was only 2.5 years. Parents reported a wide variety of symptoms associated with drug use including weight loss (15 children, 68%), jaundice (11, 50%), malaise (seven, 32%) and abscesses (four, 18%). Ten parents thought that their child was HIV antibody positive but in reality 15 were known to be infected.

Three main fears faced the parents — 64% (14/22) were worried that their child would contract HIV, 55% (12/22) worried that he or she might die and 45% (10/22) were principally concerned about relapse to drug injecting. For the future five (23%) thought that their child would ultimately recover, seven (32%) thought that they would get the acquired immune deficiency syndrome (AIDS) and 12 (55%) thought that they would die (some parents gave more than one response). When asked about current policies on AIDS and risk reduction for drug users 12 of the 20 parents (60%) agreed with the provision of sterile equipment but only two (10%) with substitute drug prescribing. Overall 36% of the 22 patients were judged to be coping well with the problems associated with drug use and AIDS related problems. However, 36% and 45% of patients were thought to be coping poorly with drug related problems and AIDS related problems, respectively.

The involvement of the primary care team with the families of drug users and of patients with AIDS is increasing and more resources, principally time, are required to support affected individuals and their parents. New insights and research into the complexities of drug use in a community are now required and the facile belief that treatment of drug misuse is confined to the provision of substitute drugs should be revised.

The well publicized financial problems of the Lothian health board conceal the critical problems for those areas such as dealing with drug misuse which are always at the bottom of the agenda for funding. The Edinburgh short-stay residential unit is still 'on ice' after seven years of committee work and debate. Prior to the Edinburgh AIDS epidemic it was clear that drug problems were increasing but it seems that lessons have not been learnt. AIDS is being treated but the causal problem, drug use, is not. Moreover the pattern of drug use in Edinburgh has changed with few new seroconversions resulting from sharing of injecting equipment,[4,5] even though drug use seems to be increasing. Thus the pattern of HIV transmission appears to be shifting to heterosexual spread. Service providers will have to reconsider which groups to target in an attempt to prevent the spread of HIV infection.

Involving drug users in treatment at any cost is not an adequate philosophy when the treatment consists of prescribing substitute drugs only. Treatment should be more than this and prescribing alone does not necessarily prevent the injection of drugs or HIV transmission.[6] We have an increasing number of patients who inject drugs, and who sometimes share equipment but who remain seronegative. The irony of a long-term drug user becoming HIV positive following sexual contact with an HIV positive partner epitomizes the complexity of the drug using/sexual risk picture. Our response must be an attempt to cover all angles: prescribing, support and education. In addition, much more help needs to be given to those agencies who are attempting to manage the increasing numbers of drug users.

General practitioners and others face an immense challenge in trying to help sophisticated drug users. Deception[7] can waste time, create divisions between professionals and disillusionment in individuals. A single strategy of substitute prescribing for all those who inject or misuse drugs is only tinkering with a problem that requires altogether more radical strategies. There is clearly a place for prescribing substitute opiates but it is not possible on a large scale without adequate backup from other agencies. Done badly it simply exacerbates the problem.

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Use of defibrillators in general practice

Sir,

The current interest in the role of the general practitioner in the immediate care of patients with acute myocardial infarction led us to review our experience of a defibrillator during the first 22 months of its use.

The policy in our practice of 4500 patients is for the on-call doctor to have a defibrillator available at all times. In seven cases of collapse the doctor was able to reach the patient sufficiently quickly to attempt resuscitation. The four surviving patients all went into ventricular fibrillation following a myocardial infarction and all had early cardiopulmonary resuscitation, in two cases by the doctor and in the other two by members of the public. This combination of factors was lacking in the three fatalities.

It is interesting to note the role of cardiopulmonary resuscitation by