

LETTERS

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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.

Patient satisfaction: a cause for concern

Sir,
With the introduction of the new contract there is a greater pressure on all areas of the profession to produce an enhanced service. Of all the performance indicators used, the most important must surely be that of patient satisfaction. I should like to report on one aspect of surgical care, related to general practice, where improvements are needed.

In a recent pilot study undertaken in a general surgical outpatients department, a questionnaire was distributed to 150 patients. Fifteen per cent of patients were unable to recall their diagnosis or explain the procedure they had experienced. As expected, the majority of patients unable to recall or explain their diagnosis were over 70 years old, but many were between 30 and 50 years old. Patient confusion was rated subjectively by the doctor and none of these patients could be considered confused. On further questioning 10% expressed some degree of dissatisfaction with the service offered to them and the majority of this group claimed to be poorly informed or were unable to recall their diagnosis or mode of therapy. There was a predominance of men in this group (ratio 4:1), but no significant pattern of age distribution was noted.

A significant burden in correcting this situation must lie with the surgeons; indeed this is being improved with the use of printed leaflets and more attention at the time of consenting. This includes a more detailed explanation by the doctor, using anatomical diagrams, and tailored to the patient's level of interest and intelligence, and also explanations from other health care workers. A reasonable proportion of the patients were, however, on long term follow up and also saw their general practitioners for the same condition on a regular basis. There is a case,

therefore, for more careful questioning of patients once they are discharged back into the community after surgery, to identify and rectify the situation for those dissatisfied patients. As in other areas, an improvement in both hospital and community practice is required in order to alter the patient's perception of the health service and enhance patient satisfaction.

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Home artificial nutritional support

Sir,
The King's Fund Centre recently convened a meeting of interested parties to define a coordinated strategy for the provision of artificial nutrition in the United Kingdom. The Primary Care Society for Gastroenterology was invited to attend and represent the view of general practice. Under consideration were total parenteral nutrition and enteral nutrition but not the use of sip feeds or supplemental feeds.

National and district surveys have demonstrated a serious lack of coordination in the provision of artificial nutritional support in the UK.^{1,2} Factors responsible include the involvement of a wide range of disciplines, all communicating poorly with each other, together with a widespread lack of understanding of the principles, potential benefits and practical techniques involved.

The use of nutritional support in the home is on the increase, since it allows the survival of patients with severe disabilities who are unable to eat normally and those who are unable to maintain an adequate food intake owing to illness.² Artificial nutritional support presents specific problems for the general practitioner; par-

ticularly the high cost of such therapy and the question of where clinical responsibility for patients receiving this support should properly lie.

Patients receiving artificial nutritional support at home face a multitude of physical, social and psychological problems. Primary care teams are unlikely to have any special expertise in the management of artificial nutrition and specialist nursing and medical support may be based in a unit up to 100 miles away. The bulk of the supplies required poses serious problems of storage and refrigeration and equipment supplied by the hospital is often unsuitable for home use. In addition, the demands of the feeding regimen make a normal social life exceedingly difficult for the patient to sustain.

Knowledge of the current prevalence of home nutritional support is sketchy. The national register of home total parenteral nutrition currently lists 300 patients and 50 new names are added each year, while the national register of home enteral nutrition lists 1300 patients.

Wilcock and colleagues found that over a 12 month period in Cambridge health district 486 non-neonates received nutritional support.² Although only 4% of these were home based, they accounted for 4829 patient treatment days, 33% of the total.

The King's Fund meeting produced broad agreement on the need for specialized nutrition teams in recognized centres using uniform management and feeding regimens. These would provide a 24 hour telephone advice service for both patients and general practitioners. There is also a need to educate district nurses and general practitioners in the principles, benefits and management of artificial nutrition. The clinical management of patients receiving total parenteral nutrition is highly specialized and should rest with the hospital nutrition team. Enteral nutrition, however, is less complex and more

amenable to management by the primary care team.

Cost is the bugbear of this therapeutic development. Artificial nutrition accounts for 1% of the pharmaceutical market in the UK. Home total parenteral nutrition for one year costs approximately £40 000 per patient, home enteral nutrition £3500. No uniform policy currently exists as to who bears the costs of home nutritional support. Some units lean heavily upon the general practitioner to pick up the responsibility, others continue to provide supplies but may now seek reimbursement from the patient's district health authority. The principle that the act of prescribing implies acceptance of clinical responsibility must surely be pre-eminant.

There is a need at district and regional level to identify funds specifically for artificial nutrition, though the concept of allocating part of the national drug budget to the development of this facility finds favour in some quarters. A national fund would stop the present wrangles over treatment costs but would mean difficult allocation decisions would have to be made.

A policy document on artificial nutritional support is at the draft stage, defining ways in which a national service should be planned, coordinated and financed. The role of home care will be an important feature of the report and the views of general practice need to be made clear at this stage. Those wishing to make representations on this subject should write to me at the address given.

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References

1. Payne-James J, De Gara C, Grimble G, *et al.* Nutritional support in hospitals in the United Kingdom: national survey 1988. *Health Trends* 1990; 22: 9-13.
2. Wilcock H, Armstrong J, Cottee S, *et al.* Artificial nutrition in the Cambridge health district with particular reference to enteral tube feeding. *Health Trends* 1991 (in press).

Salmeterol therapy in mild asthma

Sir,

Dr Weaving's letter makes a number of useful points about the treatment of asthma (*August Journal*, p.346). However, by making these points in the form of a criticism of our study (letters, *May Journal*, p.214) he misinterprets our research.

Our study simply showed that the ad-

dition of salmeterol to a patient's standard therapy (with and without prophylactic drugs) improved quality of life as measured by the living with asthma questionnaire.¹ Dr Weaving writes 'It would be logical that such a group of patients would feel better with additional bronchodilator therapy'. First, our dependent variable was quality of life, not 'feeling better', and although there are affect-related items in the living with asthma questionnaire, these items did not show any greater improvement than items describing functional limitation. A 'feeling better' question was included in the study, and showed a significant improvement with salmeterol, but that was not what we reported in our letter. Secondly, the relationship between a drug and its effect is an empirical not a logical relationship. Quality of life trials among patients with other diseases sometimes fail to produce significant effects, and there is a good possibility that it is the method of measurement rather than the treatment which is responsible for this failure. Our study is the first to report that the living with asthma questionnaire is capable of detecting differences in a clinical trial.

Dr Weaving goes on to write 'It would be more appropriate, however, and in keeping with the British Thoracic Society guidelines, to treat them with increased doses of anti-inflammatory drugs such as disodium cromoglycate or inhaled steroids'. We did not make any treatment recommendations in our letter, we merely reported the first quality of life study with an asthma specific questionnaire. Whether it is more 'appropriate' (presumably this means that a similar improvement in quality of life would be obtained) to use steroid therapy is an empirical question to which the answer is as yet unknown. The British Thoracic Society guidelines were drawn up before the development of a quality of life assessment for asthma and before salmeterol became available.

More research is needed on quality of life among asthmatics and on the effects of salmeterol before treatment recommendations can be based on quality of life as an outcome variable. Quality of life is just one outcome variable, which provides the patient's perspective. It should be considered by the physician when selecting therapy in addition to the outcomes of morbidity and mortality.

Finally, Dr Weaving mentions the cost implications of salmeterol therapy with an estimate of cost which was not based on data from a study of cost effectiveness which examines both costs and benefits. Our study did not address the question of cost effectiveness and valid discussion of

this topic must await the results of future studies.

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Reference

1. Hyland ME, Finnis S, Irvine SH. A scale for assessing quality of life in adult asthma sufferers. *J Psychosom Res* 1991; 35: 99-110.

Asthma care in general practice

Sir,

The editorial by Jones and the papers by Charlton and colleagues and Barritt and Staples (*June Journal*, p. 224, 227, 232) stress the benefits of treating asthma. However, there is a catch in the form of over-diagnosis and over-treatment which readers may not have met. Many candidates for the armed forces have to be rejected because of a history of use of an inhaler in the previous four years (the forces' limit for acceptance). Only too often the inhaler was prescribed on what now seem flimsy indications or was allowed to continue long after it was no longer needed, leaving the individual labelled as 'asthmatic' and later disappointed because he or she cannot follow his or her chosen career.

I am not expressing the views of the armed services but write as an individual medical examiner.

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Sir,

Dr Charlton and colleagues have carried out an interesting study on asthma clinics which has produced impressive outcome data (*June Journal*, p. 227). However, the study has one major flaw that was not addressed by the authors — no external controls were provided during the period in which the clinic was in operation. It could well be that there was a reduction in the profile of asthma in the catchment population resulting from other factors, such as reduced atmospheric pollution. Thus, possible confounding factors would have been controlled for had the authors used the experience of asthma consultations in an external practice as a standard