

LETTERS

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Experience of palliative medicine among trainees

Sir,

The teaching and experience of palliative care at the undergraduate level is often limited. Although it has been recommended that there should be an increase in teaching¹ one study calculated that students received only six hours on the consideration of death and dying.² Junior hospital doctors have expressed concerns about their education in this field³ and a study has demonstrated areas of ignorance.⁴

Trainees in general practice may be involved in the care of dying patients in the community but this experience may be limited. In one study only 17% of general practice trainees felt that they had received adequate training in terminal care and the results showed that there was still room for improvement.⁴

In the Medway general practice vocational training scheme a four month post in palliative medicine at the Wisdom Hospice has been introduced. The aim is to improve the skills and knowledge in the care of terminally ill patients and provide experience of consultation and communication skills, breaking bad news, symptom control, working as part of the larger interdisciplinary team and involvement with and support of dying patients and their families.⁷

A study was performed during one four month period in 1990 to ascertain if the experience gained was representative of the variety of conditions and patients seen at the Wisdom Hospice each year. A record was kept of all patients admitted by the senior house officer during this four month period. Patients were included in the study when the history and examination were undertaken on admission and the senior house officer was involved in the patient's day to day care.

The results were compared with the annual statistics for 1990. The sex distribu-

tion of the patients seen by the senior house officer in the four month period was the same as that for the entire year (male patients 51%, female patients 49%). The ages of the patients seen are shown in Table 1. There was little difference between the two groups, although there was a slight tendency for the senior house officer to see older patients. The diagnoses were also compared (Table 1). The range of tumours seen in the patients presenting during the four month period was similar to that over the year, although the senior house officer saw a rather higher proportion of patients with tumours of the

Table 1. Age distribution of patients seen in the two periods and their diagnosis.

	% of patients	
	Four month period (n = 114)	12 month period (n = 543) ^a
<i>Age (years)</i>		
<30	0.9	0.6
30-39	2.6	2.8
40-49	1.8	6.1
50-59	13.2	13.6
60-64	10.5	10.1
65-69	16.7	16.6
70-79	32.5	29.7
80+	21.9	20.6
<i>Diagnosis</i>		
Cancer of the:		
Gastrointestinal tract	24.6	25.5
Lung	22.8	22.6
Genitourinary tract	28.9	20.8
Breast	10.5	10.0
Central nervous system	2.6	3.1
Head/neck	1.8	3.6
Skin	0.9	2.4
Lymph/bone	0.0	2.2
Sarcoma	1.8	0.7
Unknown	6.1	9.1

n = total number of patients. ^a n = 552 for diagnoses as some patients had more than one diagnosis.

genitourinary tract. There is no obvious explanation for this difference.

Thus, this study shows that a four month period is long enough to allow the senior house officer to see a representative population of patients and pathologies. This allows experience to be gained in the care of terminally ill patients and their carers, which is of great value in the care of other patients in the community.

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Metered dose inhaler technique

Sir,

Inhaled therapy is the recommended way to deliver drug treatment for asthma^{1,2} with metered dose inhalers being the commonest devices used.^{3,4} Compliance with treatment implies that therapy is being administered properly. However, Jones⁵ and Hilton⁴ have shown that this is not necessarily correct. Their studies indicate that between 46% and 55% of patients, respectively, did not have a satisfactory or good inhaler technique.

In view of these findings the trainers-trainees group of the Afan-Nedd vocational training scheme in West Glamorgan decided to study how far these findings were duplicated in their own practices and to study, in more detail,

what the main deficiencies were.

The 16 participants agreed to approach up to 10 consecutive consulting patients with known asthma who used a metered dose inhaler. The patients were given an inhaler and were asked to demonstrate how they usually used it. Their technique was scored according to a previously agreed protocol which had been examined by the chest physician at the local district general hospital. The protocol covered six areas: shaking the inhaler (points range 0 to 1), full expiration (0 to 3), lips closed around inhaler mouthpiece (-1 to 2), inhaler activated on inspiration (0 to 3), full inspiration (0 to 3) and breath held for 10 seconds (0 to 3). Patients could thus score a maximum of 15 points, with the technique being deemed 'adequate' if a minimum of nine points were scored provided at least a partial inhalation had taken place.

One hundred and fifty patients were recruited to the study. Seventeen patients (11.3%) were judged to have perfect technique while 109 (72.7%) were 'adequate'. Over a quarter of the patients failed to shake their inhalers before use (29.3%) and 24.7% failed to close their lips around the mouthpiece prior to activation. Two thirds of the patients (65.3%) did not breathe out fully before activating their inhaler and a similar proportion did not hold their breath after activation for a full 10 seconds (66.7%). Over half of the patients failed to activate the inhaler on the commencement of inspiration (53.3%) and only 59.3% breathed in fully.

This survey shows that while a majority of users of metered dose inhalers probably have an adequate technique only one in 10 achieve optimal performance. With the exception of shaking the inhaler, similar steps are common to the use of virtually all inhalation devices. It would, therefore, not be unreasonable to assume that similar technique deficiencies would occur with different types of device. This might explain why Hilton⁴ found little difference in performance between users of various devices.

These findings give some guidance on where particular attention needs to be concentrated when we educate patients in the proper use of inhalation therapy devices.

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Patients' preferences for appointment or non-appointment surgeries

Sir,

Since its inception, National Health Service general practice has gradually changed from almost universal non-appointment surgeries to appointment-only systems.

My practice, of 7200 patients, has always seen patients on a first come, first served basis, with the exception of antenatal and childhood immunization clinics and practice nurse appointments outside of surgery hours. Prompted by the complaints of a small, but vociferous, minority of patients and by some of the partners' hopes of bringing predictability and order into the daily routine, it was decided to ballot approximately 1000 consecutive attenders at all routine surgeries. When reporting to reception, each patient was given a printed slip which stated that the possibility of introducing an appointment system was being considered. Patients were asked to tick the box which most closely corresponded with their views: 'I would like an appointment system' or 'I would prefer the present system to continue'. Patients were also invited to make comments.

Of the 1007 patients 698 patients voted in favour of the present non-appointment system continuing, 295 wanted appointments and 14 were undecided. Typical comments from the first category were: 'I like to know I can see the doctor when I am ill, not two days later', 'I have moved from practice X to get away from appointments', 'Why spoil a good system?' and even 'I like a good read'. In the second category comments were far fewer in number, and tended to point to the rather long waiting times that exist under the present system. Even advocates of an appointment-only system expressed concern at not being seen quickly for urgent matters. Many of the 14 undecided

patients wanted a combination of the two systems.

Clearly, a sizeable majority of patients are happy for open surgeries to continue. Having decided to seek medical advice, most patients wish to do so as soon as possible. Many people's perception of appointment systems, be it based on personal experience or anecdotal evidence, is that they delay and restrict access to the doctor. In a previous study into patients' attitudes towards appointments (Townshend P, personal communication) a similar distribution of patients preference was found. Interestingly, in that study the sub-group in favour of appointments showed a predominance of elderly people and unemployed men, rather than the working population one might have expected. The same study also confirmed the finding of Cartwright, that appointments increased patients' expectations regarding waiting times:¹ although appointments shortened the time spent in the waiting room, dissatisfaction was increased because even a short delay after the appointed time was felt to be intolerable.

Following two patient surveys, made about three years apart, showing, if anything, an increasing dislike of appointment systems, my practice will continue to operate open surgeries.

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Reference

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GP-optometrist cooperation and referral in primary health care

Sir,

As a group practice, we have recently extended and improved our health centre. A self-contained ophthalmic suite comprises part of the new facilities and this is rented by a local optometrist. While planning the details of the ophthalmic suite, the optometrist and I also developed an ophthalmic referral card. This card is now used routinely in our practice for referrals to the optometrist of the patient's choice.

The referral card is a folded card with four sides which fits into the patient's notes. The first side gives the patient's name, address, date of birth, NHS number and telephone number; the general practitioner's name, address and