Curettage and cautery of skin conditions in general practice

Sir,

I would like to respond to Dr Jackson's letter (October *Journal,* p.435) about the use of curettage and cautery.

I have no figures for succcess rates but my impression is that it is high. It should be emphasized that follow up is easy in general practice and recurrence, if it does occur, usually as a small nodule, is easy to treat again. Further recurrence, certainly in basal cell carcinoma, is virtually unknown.

Squamous cell carcinoma is indeed potentially more invasive and should be treated by curettage and cautery, probably three times. The lesion should always be completely removed. There is no point in using curettage for biopsy only, and the inexperienced practitioner can easily become experienced. Once again, recurrencies will almost certainly be infrequent and easier to treat.

Incidentally, histopathologists might report the original lesion as being incompletely removed in all cases. This does not mean that it will recur, only that an edge is not visible.

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GPs and work in the third world

Sir,

I read with interest the correspondence from Pearson[1] following Holden's paper on general practitioners working in the third world.[2]

I completed vocational training in 1984 with the specific intention of working overseas before returning to general practice in the United Kingdom. A very understanding surgeon taught me the basics of surgery for a year, and with some extra obstetrics and gynaecology experience, I went to western Nepal in 1989. The last two and a half years have been both testing and rewarding. In hindsight it seems that all aspects of my training have proved useful.

I have been working as the primary surgeon in a district of an estimated 500 000 people. 'Primary surgery' has become recognized as the second most important and cost effective type of health care in this part of the world.[3] The first is, of course, community health care (clean water, mother and child health, immunization, nutrition education, family planning and treatment of acute infections, especially pneumonia). King, in his excellent writings on primary surgery, stated 'after the more useful drugs and vaccines, particularly the antibiotics, there are no more cost effective, or death-and-disability preventing methods than the simple forms of surgery'.[3] Studies in rural Bangladesh and India have indicated that 10% of all deaths and almost 20% of deaths in young adults are the result of conditions that would be amenable to surgery in the industrial world, and even a simple surgical service would have prevented two thirds of these deaths.[3]

It is estimated that by the year 2000, 80% of the planet will be living in the developing world and therefore primary health care will increasingly be the health care for most of mankind.[3] Although we have three western doctors here in Amp-Pipal with the MRCGP (among other qualifications) it is evident that for those willing to work overseas a period working in casualty, surgery and obstetrics is of great value. This can be during or after the vocational training period but requires the help and cooperation of our specialist colleagues. In the light of developments in the UK towards more surgery in general practice, the two aims could be linked. The Royal College of General Practitioners, together with the Royal College of Surgeons, could lead the way forward by creating a new level of certification to add integrity to this level of skill in primary surgery, perhaps the diploma of primary surgery.

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1. Pearson CA. General practitioners and work in the third world [letter]. *Br J Gen Pract* 1991; **41**: 304.
2. Holden JD. General practitioners and work in the third world. *Br J Gen Pract* 1991; **41**: 163-165.
3. King M (ed). *Primary surgery. Volume 1. Non-trauma.* Oxford University Press, 1990.

Side effects of influenza vaccination

Sir,

I was interested to read the letter by Drs Robinson and Rayani (November *Journal,* p.476) regarding the side effects of influenza vaccine and their finding that 72 patients out of 120 (60%) reported not feeling ill after the vaccination. This con-

firms the impression received in the consulting room.

However, I do disagree with their conclusion that this result makes for more confidence in encouraging uptake. After all, which other treatment do we give annually to 6–8% of our practice population which makes 40% of recipients feel ill? Patients' previous experience with the vaccine is a noticable hindrance to a good uptake rate.

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H-PIN code

Sir,

I would like to suggest that all correspondence concerning a patient should include H-PIN code where H stands for health and PIN for personal identification number. The code would comprise of the patient's date of birth followed by M for male and F for female. For example, correspondence concerning someone called Mrs Jan Akbar, date of birth 22 February 1951 would include her name followed by the code 220551F.

Patients do not only attend one hospital throughout their life and filing letters from different hospitals can be frustrating. The H-PIN code would not be a substitute for the hospital unit number or any other reference number but would be used in addition and would make filing in the practice easier.

People of British origin often have a son or grandson bearing the same first name or names, while people of overseas origin may be known by different names and sometimes by their first or second name. If a letter arrives in the practice concerning a patient called R Patel, one does not know whether this patient is male or female and it is time consuming to look at the files of both Ram Patel and his wife Rami Patel. Use of the H-PIN code solves all these problems.

The time has come to discard the tradition of addressing people as Mr, Mrs, Miss or Ms. This may be polite when correct but can offend when wrong. I propose that all patients should be called by their first name followed by their surname whether calling out their name in the surgery or addressing letters.

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The future of the GP

Sir,

I have recently moved to Malaysia where I continue to work as a general practitioner. This has given me the chance to reflect upon issues from afar. One aspect of particular concern is the continued existence of the general practitioner. As health care is a costly commodity, we have to provide value for money, and with all the recent changes, it is imperative that we should evaluate our worth, or even existence.

It seems that general practitioners rarely carry out those practical procedures which were once seen as routine work. Our function is now to act as a sorting house, unable to be fully involved in a case from start to finish. We have become involved in the fringe medical world, advising on social problems yet we are not qualified in that field; we are involved in counselling yet our training is woefully inadequate for this. Skills acquired during our training will, in many cases, not be put to use once established in our particular field. Is there still a need, therefore, for the person of first contact in the primary health care field to hold a medical qualification? Perhaps not.

It would make excellent economic sense to replace general practitioners with paramedics whose training and ongoing costs are far less than those of general practitioners. A nurse practitioner could more than adequately fulfil our role. The position of the paramedic is well established in the armed forces: this principle could be applied in the civilian role. Perhaps in the future doctors will be found only in hospitals.

Encouragement from the new contract to take on as many patients as possible will inevitably lead to a reduction in the number of general practitioners. Inevitably, well-person clinics, often run by nurses, will decline for want of new patients and a cost-benefit analysis of nurse prescribing is currently being considered by the government. Is the demise of general practice as we know it on the horizon? We need to stop and consider our future and direction before others do it for us.

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Depression in teachers

Sir,

During the past few years I have noticed that there are an increasing number of dedicated senior teachers, particularly single women, who have become severely depressed by the recently instituted changes in education. Many of these women have given their whole lives to the profession and feel professionally 'violated' by their non-teaching, political employers who force them to do more administration at the expense of actual teaching. For some of my patients, this has resulted in clinical depression.

I would be interested to know if other general practitioners have noticed a similar rise in depression in teachers in other parts of the country? If there is a real increase in morbidity, consequent upon the government's action, perhaps a case should be brought under the health and safety at work act.

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General Practitioner Writers Association

Sir,

Having just returned from one of the most stimulating, informative and enjoyable meetings I have ever attended I would like to inform teachers about the General Practitioner Writers Association. This association exists to improve standards of writing from and for general practice and to help authors and publishers identify each other. It holds two educational meetings a year. This year a splendid meeting at New College, Oxford looked at writing for medical television and writing fiction. The recent Keele meeting concerned the general practitioner as historian and was a feast of medical history seen through the eyes of family doctors from the 17th century to the present. Fittingly in the potteries it concluded with a superb autobiographical account of a boyhood in the poverty and squalor of the Five Towns up to and during the second world war. Frequent audience sampling revealed much more dedicated attention than is usual at most postgraduate educational events.

We meet next in Dublin in the spring where, if previous meetings are anything to go by, the most dispirited of general practitioners is likely to regain lost sparkle. I should be delighted to give further details to anyone who is interested.

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