

p.90). To discover why patients preferred to attend accident and emergency departments rather than seeing their general practitioner, a study was undertaken in my practice looking at all new attendances at accident and emergency departments over one year (1 March 1990 to 28 February 1991).

In order to check the accuracy of the practice records I collected all discharge letters received from accident and emergency departments and checked these against the computerized record of attendance kept by each accident and emergency department. Less than 2% of the attendances were not present in both records. I also checked a sample of patient records and again there were less than a 2% discrepancy. If a patient attended with the same problem on two occasions this was counted as two attendances but attendances for follow-up appointments were not included.

In the three doctor practice of 4812 patients, there were 833 new attendances at accident and emergency departments over one year (173 per 1000 patients) and of these 808 were at the local district general hospital. Attendances at weekends or public holidays accounted for 29.9% of attendances. There were 505 self-referrals, 263 general practitioner referrals, 48 referrals by employers and 17 referrals by the police.

Patients were discharged home with follow up by their general practitioner in 68.5% of cases, 19.0% were admitted to hospital, 12.1% were referred for follow up in the outpatient department and three patients died in the accident and emergency department.

A total of 531 cases were considered to be appropriate referrals to the accident and emergency department, as agreed by myself and the local accident and emergency consultant; this included all of those patients who had been referred by their general practitioner. It was considered that 266 cases may reasonably have been treated by either accident and emergency staff or by a general practitioner; such cases included patients attending with sprained muscles and joints, grazes and bruises, skin infections and some other infections. Thirty six cases were considered to be inappropriate attendances at the accident and emergency department. The diagnoses in this group were muscular pain (nine patients), conjunctivitis or a stye (eight), hayfever or an allergy (four), ear wax (three), panic attacks (three), urinary tract infection (two), headache (two), gastritis (two), chronic osteoarthritis (two), and mild sunburn (one).

I telephoned these patients within one month of their visit to the accident and

emergency department. When asked to explain why they had attended the accident and emergency department rather than contacting their general practitioner the reasons given were convenience (nine patients, most of whom either worked in the hospital or were visiting it anyway), thinking the problem was serious (five), wanting immediate attention (five), not wanting to bother the general practitioner (four), wanting a second opinion (three), being sent by employer (three), panic (three), not realizing they could contact the general practitioner at the weekend (two), because the chemist was closed (one), and wanting an x-ray (one).

I therefore agree with Dr Dale's statement that there is 'no clear cut boundary between problems that belong in accident and emergency departments and those of general practice' and I would support the further development of appropriate planning and provision for primary care in accident and emergency departments, as approved by the Royal College of General Practitioners.

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Prophylaxis against malaria

Sir,

Prophylaxis against malaria must be safe, effective, acceptable and appropriate. Any regimen should also be simple and easily remembered by the prescriber. We recommend the use of chloroquine and proguanil together for all malarial areas and all patients except for those at high risk, typically people travelling for prolonged periods or to areas with high levels of drug resistance, and those with special risks such as aid workers.¹ There is no evidence that these drugs when used for prophylaxis have any life threatening side effects.² Our recommendation is supported by a risk benefit analysis.¹

It is important to realize that conflicting advice will lead to reduced compliance. Visitors to West Africa who did not comply with their chemoprophylactic regimen were at a two and a half times greater risk of infection than fully compliant users.³

Nevill and colleagues have suggested that personal protection such as the use of insect repellents, sleeping in screened accommodation with mosquito nets and

covering exposed areas after sunset, plays as effective a role in the prevention of malaria as do prophylactic drugs.⁴ Indeed, Manson as long ago as 1900 demonstrated that the attack rate can be reduced by 10 times if suitable protection against mosquito bites is used.⁵

We interviewed a randomly selected group of travellers departing from terminal four at London's Heathrow airport for malarial areas over a two day period in March 1989. A directly administered questionnaire with predominantly yes/no responses was used. Children under five years, doctors, nurses and non-United Kingdom citizens were excluded. All 100 travellers identified who fulfilled the inclusion criteria agreed to take part in the study. Of the 100, 64 were male; 32 were business travellers.

Fifty of the travellers had visited their general practitioner prior to departure. Seventy of the travellers had been offered advice about antimalarial chemoprophylaxis and were taking the recommended medication; 60 had received correct instructions on the usage of these drugs. Only nine travellers were advised about other methods of personal protection such as the use of insect repellents.

If the incidence of imported malaria is to be reduced the health knowledge of patients travelling abroad must be improved. At the surgeries where we practise patients seeking advice or immunizations for foreign travel complete a proforma listing destinations and other relevant information. In conjunction with the patient's notes the general practitioner can therefore evaluate an appropriate prophylaxis regimen. Patients are specifically advised on how to take antimalarial tablets and on the need to take additional precautions, and are routinely supplied with the Department of Health leaflet *The traveller's guide to health*.⁶

All travellers should be encouraged by non-health agencies such as travel agents and airlines to seek medical advice before travel. Those travellers who do are likely to be better informed, especially those attending general practices where a clear policy exists.

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References

1. Peto TEA, Gilks CF. Strategies for the prevention of malaria in travellers: comparison of drug regimes by means of a risk-benefit analysis. *Lancet* 1986; 1: 1256-1260.
2. Bruce-Chwatt LJ (ed). *Chemotherapy of malaria*. Geneva: World Health Organization, 1981.
3. Phillips-Howard PA, Radolowicz A, Mitchell J, Bradley DJ. Risk of malaria in British residents returning from malarious areas. *BMJ* 1989; 299: 1087-1089.
4. Nevill CG, Watkins WM, Carter YJ, Munafu CG. Comparison of mosquito nets, proguanil hydrochloride and placebo to prevent malaria. *BMJ* 1988; 297: 401-403.
5. Manson P. Experimental proof of the mosquito-malaria theory. *Lancet* 1900; 11: 923-925.
6. Department of Health. *The travellers guide to health (T1)*. London: HMSO, 1990.

GPs' attitudes towards drug users

Sir,

General practitioners have long been exhorted to involve themselves in the management of patients with drug problems.^{1,2} Unfortunately, for the drug user, there is a wealth of research pointing to a poor doctor-drug user relationship. Bewley warned doctors about deception and manipulation by drug users,³ and more recent research⁴ depicted drug users as unreliable and unrewarding patients.

A study by McKeganey and Boddy stressed that the lack of established individual and practice policy creates confusion and enables drug users to manipulate the service.⁵ The authors recommended that strategies be developed which maintained continuity and consistency in treatment. The advent of community drug teams ushered in the era of shared care. This 'integrated model of care'⁶ implied collaboration between drug workers and general practitioners.

Following a seminar in May 1991 on addiction, attended by doctors in Worthing, 65 West Sussex general practitioners completed a postal questionnaire (81% response rate) canvassing their attitudes to treating drug users, especially the provision of methadone for opiate addicts. Their responses indicated continued distrust of this patient group, 59% of respondents agreeing with the statement that intravenous drug users were a threat to general practice, and 89% of respondents agreeing that given the chance, intravenous drug users exploit doctors. Hardly any general practitioners (6%) favoured injectable methadone, and short term reduction programmes were preferred to longer term maintenance (60% versus 34%, respectively). Harm reduction was seen as a legitimate treatment goal by 81% of respondents, with

the vast majority of respondents (90%) favouring needle and syringe exchange schemes and education in safer drug use (72%).

Half of the sample of general practitioners (44%) were aware of intravenous drug users on their lists. One fifth (21%) would not accept a new patient with a known history of addiction, while the remainder would take them on a permanent or temporary basis. Importantly, most general practitioners had no explicit practice policy on accepting addicted patients (65%) or treating existing patients (66%). The majority (73%) saw the acquired immune deficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) as a greater threat to public health than the individual health issue of drug addiction but only half (51%) had altered their attitude to drug treatment as a consequence.

The data from this attitudinal survey present a more hopeful view of shared care, with 60% of the sample of general practitioners expressing a willingness to engage in the medical management of opiate dependency. This may be an indication of successful partnership between general practitioners and the community drug team.

General practitioners are faced with difficult and challenging decisions. Although many doctors have overcome their reluctance to get involved with treating drug misusers, the effectiveness of this involvement is hampered by the negative attitudes of both doctors and drug misusers and the lack of common, negotiated and explicit policies within and between practices. The sound advice in the government's *Guidelines on clinical management*² should encourage improved collaboration between general practitioner and drug abuser.

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References

1. Department of Health and Social Security Medical Working Group on Drug Dependence. *Guidelines for good clinical practice in the treatment of drug misuse*. London: HMSO, 1984.
2. Department of Health Medical Working Group on Drug Misuse and Dependence. *Guidelines on clinical management*. London: HMSO, 1991.
3. Bewley TH, Teggins AF, Mahon TA. Conning the general practitioner — how drug abusing patients obtain prescriptions. *J R Coll Gen Pract* 1975; 25: 654-657.
4. Abed RT, Neira-Munoz E. A survey of general practitioners' opinions and attitudes to drug addicts and addiction. *Br J Addict* 1990; 85: 131-136.

5. McKeganey NP, Boddy FA. General practitioners and opiate-abusing patients. *J R Coll Gen Pract* 1988; 38: 73-75.
6. Strang J, Donnall M, Webster A, et al. *A bridge not far enough: community drug teams and doctors in the north western region 1982-1986. ISDD research monograph three*. London: HMSO, 1991.

Cost effectiveness of minor surgery in general practice

Sir,

The paper by O'Cathain and colleagues compared the cost effectiveness of minor surgery in general practice.¹ We have few doubts about the abilities of properly trained general practitioners to perform technically adequate surgery, though the high incidence of inadequately excised lesions (5%) in this study indicates that the desire to make small excisions often overrides the surgical necessities.

O'Cathain and colleagues list the conditions treated in both settings¹ but it is not clear whether they were all excised. In many cases excision may not have been appropriate. Certainly there are better ways of treating many of these lesions, but choice of an appropriate technique requires an accurate diagnosis. In addition, 44% of specimens sent for histopathology examination from general practice had an incorrect diagnosis¹ and there is no reason to believe that those not sent were diagnosed any more accurately. Other studies have found similar problems.^{2,4} Many of the lesions mentioned, if accurately diagnosed on clinical grounds, require no treatment at all.

It has been recommended that all lesions removed by non-specialists, or where the diagnosis is uncertain should be sent for histopathological examination,^{4,6} and we would agree with this. This obviously has cost implications, but nothing is more expensive than unnecessary treatment. The advantage to patients of the general practitioner performing their minor surgery is of little value if their lesion did not require excision.

Unsightly scarring and poor cosmetic results were reported more frequently by patients who had received treatment in hospital than in general practice, but as the authors point out, the case mix in the two settings was significantly different.¹ The removal of more seborrhoeic warts, moles and other lesions would inevitably lead to a less satisfactory cosmetic result than the treatment of skin tags and warts.

The cost of excision by the general practitioner was 25% cheaper than in hospital (£33.53 versus £45.54).¹ Most of the additional cost in hospital was explained by the initial outpatient visit and the higher cost of follow up, which may not be re-