THE TRANSMISSION OF EPIDEMIC INFLUENZA
R Edgar Hope-Simpson
Plenum Publishing Corporation, New York (1992)
251 pages. Price US$45.00

At a recent international meeting on influenza, I told an American colleague that I had been given this book to review. He commented that it was an honour and privilege to be given the task and continued to praise its author Edgar Hope-Simpson. Hope-Simpson has a worldwide reputation for his lifetime's work and that has led him to formulate a new concept for the transmission of influenza which is outlined in this book.

In his new concept, he challenges conventional thinking that influenza spreads directly from infected to non-infected persons. Painstakingly, Hope-Simpson draws on historical and contemporary opinion which questions the acceptibility of the hypothesis of direct spread. He cites, for example, the sudden and widespread appearance of the epidemic of 1775 which was researched by John Fothergill. Hope-Simpson undertook his research by maintaining regular correspondence with a network of medical observers throughout the United Kingdom — the model of a modern weekly return service. He recalls his own early practice experience in rural Dorset in 1932 where he was struck by the dramatic and sudden nature of the onset of an influenza outbreak in scattered rural communities. The discovery of an influenza virus infecting humans in 1933 gave rise to further doubts. What happened to the virus between epidemics? Could it somehow persist in a non-infectious mode? Why did epidemics seem to swing between the southern and northern hemispheres? Why did epidemics end, even when there were non-immune persons in the community who could contract the illness?

From these background questions, Hope-Simpson elaborates on his detailed practice experience of studying influenza in families. For many years he has monitored influenza clinically and supported his observations with appropriate virological investigation. He proposes that influenza is introduced into a household by a symptomless carrier of virus from a previous epidemic whose potential for infectiousness has been reactivated by external factors. Among the factors he includes season which he links to the intensity of solar radiation. He offers explanations for both antigenic drift and antigenic shift and considers the concepts in relation to non-human influenza epidemics and to relevant experimental work.

This is primarily a book for those particularly interested in influenza. However, every practice library should contain one or two books like this. It is a paradigm for potential researchers — detailed literature search, meticulous observation, careful consideration of all relevant facts, a new hypothesis proposed and carefully examined, all presented in a quality of English language which in itself is an example to us.

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DIGEST

This month ● patient satisfaction ● euthanasia ● prescribing ● asthma

Measuring patient satisfaction

CONSUMERISM and audit have underlined the importance of patient satisfaction as an objective and as an outcome of health care. In order to assess patient satisfaction and produce evidence sufficient to support change, reliable, valid tools must be applied. Richard Baker has developed two patient questionnaires, one referring to the last consultation and the other to the general practice surgery, which score components of satisfaction, such as accessibility and professional care, on five-point scales.

Existing data suggest that dissatisfied patients are more likely than satisfied patients to change general practices and less likely to have experienced continuity of care. To test whether the new questionnaires correlate with these concepts (or constructs), they were first sent to 400 patients who had moved from a general practice but not changed their home address (movers), and secondly, to 869 randomly selected patients from two practice lists (non-movers). The 68% of movers who replied were significantly less satisfied with their previous general practice than the 82% of respondents in the non-mover group were with their general practice. The movers were also significantly less satisfied with their last consultation. Non-movers were subdivided according to whether they had seen their usual doctor in the majority of their previous 12 consultations. Non-significant differences were as predicted (greater continuity of care corresponding with greater satisfaction) for the majority of components of satisfaction. A third of non-movers were asked to repeat the questionnaire a fortnight later; 55% responded, and produced similar scores, thereby confirming good test–retest reliability.

The authors conclude that the questionnaires are reliable and valid and should be preferred to untested tools. However, the constructs are mainly based on practice in the United States of America and may be inappropriate in the United Kingdom. Furthermore, although continuity is addressed by both questionnaires, its relationship with satisfaction is complex. In addition, the two groups were dissimilar in age, a factor which has strong associations with satisfaction. These timely questionnaires merit further validation and thus more widespread use.

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Source: Baker R, Whitfield M. Measuring patient satisfaction: a test of construct validity. *Qual Hlth Care* 1992; **1**: 104-109.

Euthanasia and assisted suicide

IN the last decade, much philosophical and ethical debate has occurred about the practice of euthanasia and assisted suicide by health professionals. This Dutch study aimed to determine the extent to which it is practised by family doctors and to assess the prudence of their actions.

The survey was conducted using an anonymous postal questionnaire, to which 67% (1042) of the randomly selected doctors responded. Although euthanasia or assisted suicide was practised about 2000 times every year by this sample, approximately half of them had never engaged in its practice, and the patients' requests for the procedure were complied with in only 40% of cases. Most often it was the patient who initiated a discussion of euthanasia or assisted suicide, and the commonest reason for such a request was to escape 'pointless suffering'. In

nearly all cases, both patient and doctor were unanimous in regarding the hopelessness of the patient's condition.

In cases of euthanasia or assisted suicide the family doctors often failed to act in accordance with the prevailing Dutch law. Only 26% had not issued a death certificate indicating death owing to natural causes and 12% had performed euthanasia or assisted suicide without discussion with a colleague. More than half of the doctors failed to keep a record of the procedure and more than half of those that did so only entered it in the patients' records, rather than making a separate record, as recommended.

The researchers did not elicit information on the patients' psychiatric status. Did the doctors attempt to assess patients for depression prior to practising euthanasia or assisted suicide? Knowledge of this would presumably have influenced their decisions.

The retrospective design of the study may have led to inaccuracies owing to faulty recall on the part of the doctors. Furthermore, questionnaires do not allow free exploration of the issues tackled in open ended interview questions, and this may have resulted in inadequate information being elicited on important areas influencing the doctors' decisions, thus making judgements of the prudence of their actions difficult. Despite these limitations, these papers report a valuable survey suggesting that the extent of euthanasia practised in the Netherlands is more balanced than suggested in previous reports. Could this be true of the United Kingdom?

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Source: van del Wal G, van Eijk J Th M, Leenen HJJ, Spreeuwenberg C. Euthanasia and assisted suicide. 1. How often is it practised by family doctors in the Netherlands? 2. Do Dutch family doctors act prudently? *Fam Pract* 1992; **9:** 130-140.

Prescribing policies

THIS article examines briefly the reasons for the continued escalation in the National Health Service drugs bill and the resultant government pressures to reduce it by introducing indicative prescribing amounts for general practice and by encouraging hospital doctors to cut costs. One of the ways the latter has been achieved has been to emulate the situation which was already in existence in Scotland, whereby outpatient dispensing has been reduced to near zero levels. This has had an impact not only on hospital physicians and general practitioners (*BMJ* 1992; **304:** 29-31 and 31-34), but also on community pharmacists. The extent of the perceived impact on community pharmacists was assessed by a postal questionnaire completed by a community pharmacist appointed by the local pharmaceutical committee in each of the 90 family health services authority areas in England. This was therefore not a representative sample of community pharmacists and many differences can only be guessed at, which the authors try to do.

The results of the survey indicate that the changes in hospital outpatient prescribing policies will indeed affect the community pharmacist. General practice prescribing costs will increase because of the additional prescribing of expensive medication. The total drugs bill will also increase owing to the higher rates charged for preparations by the manufacturer when supplying to primary care, and to the inability of the individual pharmacist to negotiate preferential prices for uncommonly prescribed preparations. There could be delays in obtaining the supplies which will be inconvenient to the patient. The pharmacists' lack of knowledge of the specialized preparations will not allow them to counsel the patient adequately. Additionally, the important communication link between prescriber and dispenser will be broken, the general practitioner being unlikely to have experience of the more specialized drugs. General practitioners have already expressed concern that they will have to take clinical responsibility for a prescription which they did not initiate (*BMJ* 1992; **304:** 31-34). Similarly, the pharmacists will be legally liable for a dispensed preparation, about which they have insufficient knowledge.

The authors conclude that it is likely that the trend will continue in spite of the apparent disadvantages highlighted by their survey. However, if a system of good communication between hospital consultant, general practitioner and community pharmacist were established, at least some of these perceived problems could be eliminated.

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Source: Wilkie P, Sibbald B, Anderson B, *et al.* Impact on community pharmacists of changes in hospital outpatient prescribing policies. *Pharmaceutical J* 1992; **249:** 184-186.

Asthma and salmeterol

ASTHMA is now the commonest of all the respiratory diseases and one of the commonest chronic diseases, being reported in some practices as affecting 8% of the entire population (*Practitioner* 1990; **234:** 417-418).

This paper reports a double-blind study in which patients with mild asthma were given treatment with either salmeterol or a placebo, over eight weeks. The testing technique was to use methacholine as a measure of provocation for the bronchi, and the measurement was the so-called provocative concentration (PC_{20}) that caused a 20% decrease in the forced expiratory volume in one second.

The findings were that there was a significant response to salmeterol initially, for example on the first day of treatment, but after one and then two months the change owing to salmeterol became significantly attenuated.

The authors, from the Department of Pulmonology at the University of Leiden, the Netherlands, conclude that 'salmeterol leads to tolerance to its protective effects against a bronchoconstrictor stimulus'. This follows other original work from the Department of General Practice at the University of Nijmegen, the Netherlands where in a PhD thesis in 1990 van Schayck found deterioration of lung function following long term use of a beta-agonist.

The paper by Cheung and colleagues dealt only with small numbers (24 patients) and only a relatively small period of time (eight weeks). Nevertheless, the work is of high quality, the results are statistically significant, and they fit well with the Nijmegen findings. On the basis of the original thesis some British authors have advised against using salmeterol (*RCGP 1991 members' reference book,* p.349-350). Cheung and his team have now substantiated this: 'Our data thus support a general concern that regular monotherapy with beta-agonists may cause control of the disease to deteriorate.'

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Source: Cheung D, Timmers C, Zwinderman AH, *et al.* Long-term effects of a long-acting B_2-adrenoceptor agonist, salmeterol, on airway hyperresponsiveness in patients with mild asthma. *N Engl J Med* 1992; **327:** 1198-1203.