LETTERS

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.

Systematic care of diabetic patients

Sir,

The systematic care of diabetic patients described by Koperski (December *Journal*, p.508) may lead to 'a significant improvement in care for diabetic patients', but outcome is not guaranteed by recording process measures better or recording a reduction in patients' glycosylated haemoglobin levels. The link between such measures and improved quantity of life coupled with reduced morbidity and less premature mortality remains debatable.[1]

Only 64 diabetic patients (out of 111 known diabetic patients in a practice population of 13 500) were willing and able to attend the diabetic day and eligible for inclusion in the study. Perhaps another 50–100 unknown diabetic patients in the practice did not receive the same systematic care.

Our practice of 13 085 patients is similar in size and commitment to that of Koperski, and has provided systematic care for diabetic patients since 1984. In 1990 three standards were set to audit each year:[2] all patients will be offered a diabetic check-up each year; all patients aged less than 70 years will have their fructosamine concentration measured each year; and in patients aged less than 70 years 90% of patients will have a recorded fructosamine concentration less than 3.5 mmol l^{-1} and 70% will have a recorded fructosamine concentration less than 2.8 mmol l^{-1}. If no fructosamine level was recorded, it was assumed that the standard was not achieved. The results for the years 1990–92 are shown in Table 1.

Our experience has shown that the practice has a high prevalence of diabetes compared with other practices, and that despite our efforts it is difficult to provide systematic care for all patients.

Until the link between type of care and subsequent patient benefit is confirmed, we will continue to use systematic care to achieve our standards. We hope this leads to an improvement in care for all our diabetic patients.

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2. Kemple T, Hayter S. Audit of diabetes in general practice. *BMJ* 1991; **302**: 451-453.

Table 1. Outcomes for patients receiving systematic diabetes care between 1990 and 1992.

	1990	1991	1992
Practice population	13 200	13 286	13 085
No. of diabetic patients (prevalence)	223 (*1.7*)	224 (*1.7*)	234 (*1.8*)
% of diabetic patients checked in past 13 months	*85.7*	*86.6*	*91.0*
No. of diabetic patients aged <70 years	149	144	153
% of patients <70 years with fructosamine level recorded	*75.2*	*77.1*	*81.7*
% of patients <70 years with fructosamine <3.5 mmol l^{-1}	*61.7*	*75.0*	*77.8*
<2.8 mmol l^{-1}	*34.9*	*52.1*	*57.5*

Primary care teams

Sir,

In his editorial on the primary care team (December *Journal*, p.498), Colin Waine pointed out that the differing remuneration of team members can cause resentment. Management research shows that job satisfaction is not particularly related to pay.[1] More important is mutual respect among members of the team and respect by the organization (for example the practice or the health authority) for what each member of the team is contributing.

In the paper on the diagnosis and treatment of asthma in children (December *Journal*, p.501) Neville and colleagues appear to have drawn the wrong conclusion from their results. I feel that the paper demonstrates the need for us to use our records as a diagnostic tool and that we should now be more aware of the importance of certain items of history in making a diagnosis of asthma. Certainly in my practice, with the introduction of computers I can now see details of the last 17 visits on one screen and this should certainly make it easier to diagnose asthma. Three of the five authors of this paper are not medically qualified and they demonstrate that we can gain much from using other resources in preparing our strategies. Implicit in the paper is concern that patients are being undertreated. At a time when we are striving to avoid overtreatment surely the situation is not as parlous as suggested. We should indeed make better use of our records but we should not rush into treating every child without careful appraisal.

The way forward in improving general practice does not lie merely in asking for more money for the staff we now have or for the staff we would like to have. It lies in being better managers of our staff and better educated clinicians.

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Reference

1. Jones RVH. *Working together – learning together. Occasional paper 33.* London: Royal College of General Practitioners, 1986.

Heroin users on a methadone programme

Sir,

The paper by Leaver and colleagues (November *Journal*, p.465) quantifies some of the problems familiar to all general practitioners working in areas where heroin abuse is endemic. However, some of the conclusions drawn by the authors with regard to the costliness of general

practitioner drug services and their lack of success may have been too pessimistic.

The primary care drug dependency centre in Birkenhead provides holistic, client centred, multisectoral, stepwise withdrawal programmes for Wirral residents on behalf of their general practitioners. Chaotic drug abusers, treated as outpatients, are stabilized by the clinical director (who is a general practitioner) and a team drawn from community health and social care organizations. Once stabilized, the clients are transferred back to care by their own general practitioners, aided by support from drug workers (community psychiatric nurses, youth workers or counsellors). If the clients are troublesome, uncooperative or become unstable they are taken back into the centre again, or have treatment withheld until they are again ready to cooperate. A patient would expect to be on the programme for about 18 months.

This service is not costly. At less than £1000 per client per annum for the health and social care provided, it compares favourably with competing psychiatric clinic quotes of over £3000 (Bundred P, personal communication). The clients cared for in supported general practices are less expensive, with only the marginal costs of methadone prescribing and fortnightly drug worker sessions to be met.

This service is successful by a number of measures. The Wirral enjoys one of the lowest rates of human immunodeficiency virus (HIV) infection among notified injectors while suffering the highest prevalence of injected drug abuse in the country.[1] The acquisitive crime rate in the Wirral has dropped by 30% against a national rise of 15% (annual crime statistics report, Merseyside police, 1991/92). Surveys conducted by independent psychologists show that 70% of both clients and referrers are satisfied that the service addresses most or all of their needs satisfactorily.[2] Abuse of the system by those on methadone withdrawal is minimal.

Our experience would suggest that general practitioners working in a primary care setting can be the most cost effective and appropriate agency to care for heroin addiction, provided that a modest investment in human resource support is made.

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References

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Unrecognized ovarian failure after hysterectomy

Sir,

From the letter by Lindsay and Usher (December *Journal*, p.529) and other recent reports,[1,2] it would appear that approximately 72 out of 1000 patients aged 32 to 50 years have had a hysterectomy and that 25 out of 1000 have premature ovarian failure (resulting from bilateral oophorectomy or the fact that hysterectomy advances the age of menopause by up to four years by an unclear mechanism) and 32% of those are not receiving hormone replacement therapy. They would be advised to do so as they are at significantly increased risk of myocardial infarction, stroke and osteoporosis.[3] In future, counselling at the time of hysterectomy may alert women to the need to be aware of the potential problems, but what of those who have already had a hysterectomy?

In October 1992 a computer search of the records of 9100 patients in one general practice revealed 101 women under 50 years old who had had a hysterectomy, of whom 19 were receiving hormone replacement therapy. The 82 non-hormone replacement therapy users were sent a letter inviting them to a group meeting at the surgery where myself and a medical colleague introduced them to the concept and recognition of premature menopause, its problems, its management with hormone replacement therapy and the availability of blood testing for those unsure of their status.

Of those invited 61 attended (74%); subsequently 23 had individual hormone replacement therapy counselling and/or a blood test. Two months after the meeting 14 women who were prematurely menopausal (follicle stimulating hormone level greater than 20 IU l^{-1}, or had menopausal symptoms) started on hormone replacement therapy with its long term beneficial effects.[4] The other women have been alerted to the problems and have been offered a yearly follicle stimulating hormone level test.

The use of the surgery and doctors' time for the group counselling and the expense of the letters of invitation seems justified if a group of women have been identified and have started treatment for this hitherto poorly recognized complication of hysterectomy. Readers may like to consider a similar approach.

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3. Henderson BE, Paganini-Hill A, Ross RK. Decreased mortality of users of oestrogen replacement therapy. *Arch Intern Med* 1991; **151:** 75-78.
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Euthanasia and assisted suicide

Sir,

Irwin Nazareth's digest item (January *Journal*, p.42) on van der Wal and colleagues' articles on euthanasia and assisted suicide in the Netherlands is misleading in one respect, and should be corrected.

Nazareth states that they identified a sample of 1042 Dutch family doctors and found that 'euthanasia or assisted suicide was practised about 2000 times every year by this sample'. This figure is about six times too high. What van der Wal and colleagues actually suggested, extrapolating from the 1042 questionnaires they sent out, was an estimated incidence of 2000 cases per annum for the whole population of Dutch family doctors, a total of about 6300 practitioners. Their result is therefore similar to the study of van der Maas and colleagues which reported that 62% of general practitioners had 'ever performed' euthanasia or assisted suicide, and that 28% had done so within the previous 24 months.[1]

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Reference

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Medical certification

Sir,

As a doctor working in the 'bureaucratic system' referred to by Dr Toon (November *Journal*, p.486), but having many years' experience of general practice, as have many of my colleagues, I can assure him that we are well aware of the problems of personal physicians, who are also gatekeepers to some state benefits. We do not have a 'naive faith in the objectivity and reliability of medial judgements' in the context of certification, but we do