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Drop-out rates among GP trainees in the USA

IN this article, the authors analyse the results of a questionnaire sent to the directors of family practice residency programmes in the United States of America. The questionnaire investigated the characteristics of those residents who left general practice training programmes, and their ultimate career outcome. It compared attrition rates for USA graduates with those for international graduates — a much better description than 'foreign' or 'overseas' graduates which would be the terms used in the United Kingdom.

There is currently much interest in drop-out rates from specialty training programmes in the UK, and particular concern has been expressed about low recruitment to vocational training for general practice. Over the last two or three years there have also been concerns about the non-retention of trainees. I was hoping that light would be cast on these problems by this USA survey, and that there would be guidance as to the reasons why trainees left. Unfortunately this was not the case. The figures produced by the authors, although they apply to a 10-year period, are incomplete in that only 46% of directors of programmes responded. From the sample it appears that drop-out rates are decreasing, particularly for USA graduates, although the figure is still 8.6%. Most of those dropping out changed specialties, and I was fascinated to see that among the popular switches were those to anaesthesiology, pathology and radiology. The authors were concerned about the differences between the home-grown and the international graduates; the latter had a much higher drop-out rate in percentage terms (18.5%), but I felt this was less important because the numbers involved were small. There was no information from the residents themselves as to why they had rejected general practice but much speculation by the authors. They also found a correlation between attrition and non-selection through the national residency matching programme. This does have relevance to the somewhat haphazard selection process that some trainees go through to find a placement for their vocational training year in the UK, and subsequent problems.

This was a study in an important area of concern for the discipline of general practice, but was severely limited by the lack of any data from the consumer.

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Source: Laufenburg HF, Turkal NW, Baumgardner DJ. Resident attrition from family practice residencies: United States versus international medical graduates. *Fam Med* 1994; **26:** 614-617.

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Health education in Singapore general practice

DOCTORS in Singapore have been looking at the issue of health education in their daily work. Clearly, general practice in Singapore is different from that in the United Kingdom but the issues under discussion are similar in the two countries. Coronary heart disease and cancer are major causes of morbidity and mortality in Singapore, accounting for two fifths of the deaths in the population. The risk factors that are associated with these diseases include (as in the UK) smoking, poor diet, alcohol consumption and low levels of physical activity; all of which are behavioural issues. As in the UK it has been recognized that in order to be effective, preventive efforts must be aimed both at high-risk individuals and at the general population.

A postal questionnaire was sent to a random sample of a third of all general practitioners registered on the Singapore medical gazette. The response rate was 58%.

Of the responding doctors, 90% considered that not smoking, limiting the intake of saturated fats and excess calories, and increasing exercise were important behavioural issues. Thirty per cent considered controlling salt intake and alcohol to be of lower priority. Eighty per cent of doctors indicated that they would broach the subject of smoking even if unrelated to the subject presented by the patient; 65% would act similarly on the subjects of diet and exercise.

The doctors received most of their health education material and literature from the Ministry of Health which had recently conducted a healthy lifestyle campaign. When the Singapore doctors were asked to list the subjects on which they most commonly distributed literature they identified the areas of tertiary prevention: chronic diseases such as hypertension, diabetes and asthma (27% of doctors). Less commonly they distributed literature on diet (18%) and general suggestions for a healthy lifestyle (11%). It would appear that high-risk patients were seen by general practitioners as the group they should be targeting.

Lack of time was considered a major constraint in the practice of health education. Although no fee was charged for an additional element of lifestyle advice only 15% of respondents regarded this as a major issue. However, doctors cited poor patient cooperation as an obstacle, and a particularly difficult area was that of patients clinging to cultural or religious beliefs concerning health and disease.

Research into the issue of health promotion interventions, together with education and debate on the role of general practice in behavioural change, should have pre-dated the UK health promotion contract for general practice. If so, by now there may have been more confidence in this area of work. Singapore doctors are clearly asking important questions before they incorporate health promotion into their routine work.

JOHN NOAKES
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Source: Seow A, Goh LG. Health education in general practice on lifestyle-related subjects: opportunities and obstacles. *Singapore Fam Physician* 1993; **19:** 89-94.

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Sick building syndrome

AS a profession we are becoming more aware of environmental factors in health problems, but recently there appears to have been little published work in the general medical journals on sick building syndrome. This article gives an opportunity to revisit 'problem buildings', and re-examines the problems associated with indoor air quality and visual display unit work.

Sick building syndrome was defined by a World Health Organization expert group in 1982 as a combination of general symptoms, including mental fatigue and headache, dryness and irritation of the eyes and upper and lower airways, and skin symptoms, such as erythema and dry skin. While these symptoms are commonly reported, they are not an accepted clinical syndrome.

Stenberg and colleagues tested the hypothesis that constitutional factors (factors related to health) were fundamental to sick building syndrome symptoms. Their study in north Sweden, using a combination of questionnaire and clinical examination, was based on 5986 office workers and 450 work sites and defined syndrome cases as 'reporting at least one general symptom every month and at least one mucosal and dermatological symptom every week'. The multivariate analysis of their results supported the hypothesis that personal factors, psychosocial conditions, and physical expos-

ure factors influencing the indoor air quality are risk indicators for sick building syndrome.

This article gave me the opportunity to rethink my attitude to the many patients who ask if their symptoms are a result of the workplace. With such ill-defined symptoms, often the absence of any signs, and no specific diagnostic test which can be performed, it is difficult to give a meaningful response. Added to this, we are becoming more aware of the medicolegal minefield. Do we issue sick notes for ever?

This is a thought-provoking article that raises many important clinical and public health issues, and stresses the importance of all general practitioners having an awareness of occupational health medicine.

MOLLIE MCBRIDE
General practitioner, London

Source: Stenberg B, Eriksson N, Höög J, *et al.* The sick building syndrome (SBS) in office workers. *Int J Epidemiol* 1994; **23:** 1190-1197.

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Spiritual issues

IN a recent tutorial I was reminded by a student that health not only had a physical, social and psychological component, but a spiritual one as well. Perhaps in the run-up to fundholding the financial component had rather clouded my thinking. In the two weeks subsequent to this discussion we met Christian patients (Catholic, Protestant and Orthodox), Muslims, Hindus and Buddhists and other patients whose background or beliefs I did not know. Although it made for an interesting discussion we seldom ask patients how their spiritual views affect their experience of disease.

In their paper Daaleman and Nease suggest that we do not enquire about spiritual issues because they are not seen as relevant to our clinical practice and because of our own personal discomfort with the subject matter. But is this how our patients feel?

Using a nurse-administered 'spiritual and religious inquiry' questionnaire, they attempted to identify characteristics which made patients receptive to inquiry into spiritual issues. Their sample size was small (100 patients), overwhelmingly Christian in orientation and well educated.

Not surprisingly, those who most frequently attended religious services were most receptive to discussion of spiritual issues and health. However, the majority of patients, whether religious or not, agreed that doctors should refer patients with spiritual problems to pastoral professionals.

There are many spiritually sensitive physicians in primary care who, recognizing that their patients have spiritual needs or problems, would like to address them but hesitate to do so because they are uncertain whether these patients will be receptive. Writing in this *Journal*, Jones found that the great majority (more than 97%) of British general practitioners agreed that clergy could be of help in caring for patients with terminal illness or bereavement, yet over 85% rarely if ever made such referrals (*Br J Gen Pract* 1990; **40:** 280-283).

Frequency of religious service attendance is suggested by Daaleman and Nease as one possible variable that could be recorded, possibly in a questionnaire for new patients, to identify those who would welcome such referral. I wonder if I could interest the vicar in a block contract?

GORDON R W THOMAS
General practitioner, Stoke-on-Trent

Source: Daaleman TP, Nease DE. Patient attitudes regarding physician inquiry into spiritual and religious issues. *J Fam Pract* 1994; **39:** 564-568.

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Sexuality in nursing home patients

IN this paper, an associate professor and a social work researcher from the Department of Family Medicine at the University of Maryland, the United States of America, draw attention to the considerable proportion of sexually active elderly people living in nursing homes.

The authors review the physiological changes in sexual response with age and examine the few studies made of sexual behaviour in older people in the community. These studies show that the most frequent sexual behaviours in both sexes are touching their partners, masturbation and sexual intercourse; the importance of sexual activity in the past correlates positively with sexual enjoyment in later years.

Attention is then turned to studies of sexual attitudes and beliefs of nursing home staff and residents. Surprisingly, one study found that, compared with staff, residents were more likely to agree that post-menopausal women, and men aged over 65 years, do not need sex. Residents considered sexually active elderly people to be 'dirty'. Another study found that nursing home staff reported problems associated with patient sexual behaviour, such as sex talk and foul language, self exposure and touching staff, and acts implying sexual behaviour, such as reading pornography. While it was found that most elderly residents favoured participation in sexual activity, they cited lack of a partner, loss of interest, poor health and being unattractive as the main reasons for not being sexually active.

The authors suggest the removal of a number of barriers to sexual expression, such as discontinuing medications that affect sexual functioning, improving privacy and educating staff. Other solutions are proposed, such as 'do not disturb' signs on residents' doors, classes on sexuality rather than basket weaving, and a beauty salon to enhance attractiveness.

My only criticism of this paper is the lack of reference to the work of Alex Comfort on sexuality in later life and a failure to mention the number of gynaecological problems brought to light by a resumption of sexual activity in old age. Account must also be taken of the transatlantic cultural divide.

KEITH THOMPSON
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Source: Richardson JP, Lazur A. Sexuality in the nursing home patient. *Am Fam Physician* 1995; **51:** 121-124.

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Food for thought...

'In recent years much time and effort has been expended in the development of practice guidelines for several clinical conditions. The effects of these guidelines on practice will always be disappointing as long as implementation strategies are not treated as an integral part of the guideline development process. Such implementation strategies will need to be cognizant of the principles of social influence and marketing theory and of the importance of user-friendly formats, norm transfer and modification for local needs, if guidelines are to be taken off the bookshelves and dynamically incorporated into day-to-day clinical practice.'

Conroy M, Shannon W. Clinical guidelines: their implementation in general practice. July *Journal*, p.371.