

ing to the HAD questionnaire. Primary care staff were more likely to make a correct diagnosis of mild to moderate anxiety. This is perhaps not surprising given the greater time available to other members of the primary care team to explore health problems with patients. Preliminary results, however, suggest that overall there were no significant differences in the total detection rates of anxiety and depression between general practitioners and other primary care staff.

These results highlight the potential role for other members of the primary care team in the diagnosis and treatment of mental illness and the importance of directing efforts to improve the detection of mental illness in primary care, not just at general practitioners, but at the whole primary care team.

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Avoiding infection after splenectomy

Sir,

The risk of serious infection following splenectomy has received increasing attention.¹ Nationally based guidelines recently published highlight the importance of preventive measures after surgery.² An active management programme for asplenic individuals within our district led to high immunization uptake, but general practitioner (GP) uncertainty over antibiotic prophylaxis remained.³

Because potentially life-threatening sepsis occurs suddenly, prior appropriate education of both patients and medical staff is essential. To assess patients' knowledge of their condition, a questionnaire was sent to 245 asplenic individuals on our district register; 222 replies were received. Only 11% were unaware of their increased sepsis risk. Patients had discovered the increased risk from various sources, with GPs responsible in 46% and hospital doctors in 35% of cases. Almost 20% had obtained information from the media. In

response to who should counsel patients, 49% nominated their GP, 27% the hospital doctor, and 24% a combination of both. Only 38% considered their current knowledge of asplenia satisfactory. The importance of immunizations was recognized by 90%, but the role of prophylactic antibiotics had been discussed with only 27% of patients. In those holding antibiotic courses at home, only 50% had an arrangement to renew an expired prescription.

When asked for further comments, nearly 50% of positive replies suggested information leaflets and a national body to be available for advice. Controversy over the role of antibiotics and how to recognize potentially serious infections was also emphasized. Over 15% specifically questioned whether an unnecessary medical fuss was being made over the issue.

A survey from the USA revealed that only 16% of asplenic were aware of potential health problems.⁴ Although it was gratifying to find 89% of our group aware of sepsis risks, 62% still considered their overall knowledge of asplenia poor. This may reflect the time of splenectomy, as 60% had undergone surgery at least 10 years ago when routine counselling was less likely.

Most patients believed their GP should be the primary source of information. However, GPs themselves need improved guidance, as illustrated by comments on the controversial role of chemoprophylaxis. The finding that 20% had relied on the media for education reflects the current inadequacies of medical counselling and emphasizes the need for multisource but consistent information. Comments questioning the necessity for an active immunization/antibiotic/education programme highlight the difficulty in raising patients' awareness without causing undue anxiety.

An information leaflet was produced from this district survey, and distributed to both patients and GPs. We support recommendations that written and verbal information regarding potential health problems should be given to all asplenic individuals,⁵ with GPs actively involved.

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Why are even fewer people dying at home in Belfast?

Sir,

We report a decrease in the number of deaths occurring at home over a 15-year period, with an apparent shift from home to nursing home or other residential accommodation for the final period of care. Hospital deaths have fallen slightly over the same period.

In 1981, Reilly¹ reported on the place of death for people dying within Greater Belfast over a 16-week period (September to December 1979). He found that 56% of people died in hospital with 36% dying at home. The intervening years have seen many changes in the delivery of health care both locally and nationally, with an emerging emphasis on community care and a primary care-led *Health and Personal Social Services*. Fifteen years later, in 1994, we replicated Reilly's work by undertaking a manual search of registered death certificates over the same 16-week period (September to December).

During the 16-week period there were 1064 deaths in a population of 279 237. Of these, 828 deaths (78%) were registered by death certificate and 236 (22%) were recorded by the coroner. To enable comparisons with Reilly's data of 1979, only

Table 1. Place of death in Greater Belfast area by location in 1979 and 1994 for deaths recorded by death certificate.

Place of death	1979 (%)	1994 (%)
Hospital	56	51
Home	36	24
Various institutions	8	25

JUDITH PALMER

deaths recorded by death certificate were examined. (Incidentally, 45% ($n = 107$) of deaths recorded by the coroner were sudden deaths due to cardio- and cerebrovascular disease. A further 23% ($n = 54$) were unnatural deaths.) The boundaries of the Greater Belfast area had not changed in the intervening 15 years, although the population of Belfast had fallen by 11%.

In 1979, Reilly found that 56% ($n = 663$) of deaths occurred in hospital with 36% ($n = 413$) occurring at home and 8% ($n = 99$) occurring in various institutions. In 1994, 51% ($n = 423$) of deaths occurred in hospital with 24% ($n = 199$) dying at home, 15% ($n = 129$) occurring in residential or nursing homes, and 9% ($n = 73$) dying in hospices (Table 1).

Various institutions in 1994 constituted nursing homes, hospice in-patient units and residential accommodation. In 1979 there were no hospice beds in Northern Ireland. Over the 15 years, the number of registered nursing homes increased from five to 87 (data supplied by the Registration and Inspection Unit of the Eastern Health and Social Services Board).

As yet we can only speculate as to why these changes exist. It is unlikely that the spectrum of pathology has changed much over the 15 years. It is interesting to note that the population of the Greater Belfast area fell by 11% between 1981 and 1991 (with a subsequent rise in the populations of surrounding dormitory towns). No significant difference is noted in any age group between the Belfast populations of 1981³ and 1991.² It would seem probable that economic factors and changes in health and social security policies have influenced the place of death. We propose to undertake further study to account for our findings.

There is evidence to suggest that the majority of patients who know they are dying wish to die at home.⁴ There is also evidence that care of dying patients in hospital is sub-optimal.⁵ It would therefore seem appropriate to direct resources so as to enable people to die in their own homes. Reilly *et al*¹ end their paper with the question, 'Why are so few people dying at home?'. Fifteen years later we ask, 'Why are so many people still dying in hospital, and even smaller numbers than before dying at home?'

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Primary healthcare information needs

Sir,

Your readers may be interested in the research outlined in this letter which has been reported only in publications unlikely to be seen by them. Further information is available in the publications listed or from the writers. The research looked at information aspects of 13 general practices in the Trent region^{1,2,4} and eight general practices in the Anglia and Oxford Region.^{2,3,4} In total, those interviewed consisted of 62 GPs, some practice nurses and the purchasing staff from the Anglia and Oxford study, and representatives of other practice staff in the Trent study. The data were analysed using a variety of qualitative methods.

The research topics covered included:

- why the GPs needed information and how they obtained it
- how communication worked within the practices and with external organizations
- how the NHS reforms had affected information-handling in the practice, and what GPs and staff thought could be done to improve the situation
- information for purchasing, and
- future information services for general practitioners and practice staff.

The Trent study resulted in the development of guidelines for managing information effectively in general practices. The Anglia and Oxford study ended with a workshop at which participants were encouraged to consider ways in which library and information services might be tailored to the needs of general practices, both fundholding and non-fundholding. A follow-on study — the Primary Care Sharing the Evidence Project — is now underway in Anglia and Oxford.

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Sexual harassment of doctors

Sir,

I wonder if either Dr Jarvis or the authors of the paper she quotes from (international digest section, August *Journal*) have considered the larger and more threatening problem of sexual harassment of male doctors by female patients? One suspects that if the researchers had bothered to carry out a similar survey of their male peers, they might have found that for many male doctors sexual harassment is an almost daily occurrence. Not only are the majority of consultations held with female patients; male doctors are traditionally seen (whether they welcome it or not) as objects of sexual desire. Acting within a society which generally absolves women of responsibility for their own actions and searches for male scapegoats instead, the General Medical Council happily persecutes male victims of even the most absurd, malicious sexual allegations, and yet has been known to decline to take action against female doctors who embark on sexual relations with male patients.

Sexual harassment of male doctors by female patients is not merely more common than the converse, but is done with impunity as if it were a right, bringing with it a threat which women have no need to fear from men.

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