# LETTERS



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## Preparing GPs for working with drug users

Sir,

We agree with Trevor Stammers (September *Journal*) that many GPs need training in basic skills and strategies to work with patients who abuse drugs and other substances.[1] While provision of such training may not attract many GPs to traditional educational events, we do believe that it may be effective locally, and we describe a partnership between a local community drug service worker and a GP Tutor.

In West Dorset, GPs felt poorly prepared to respond to the increasing demands made by patients who have problems due to illicit drug use. We, at the Postgraduate Training Centre, offered local GPs an eight-hour programme of training, entitled 'Working with drug users in general practice.'

We believe that all training should aim towards giving participants role legitimacy and boosting confidence and competence. In dealing with an issue that has been left out of basic training and has often been the cause of problems, it is not appropriate to run courses that are too short (on the basis that the subject covered only represents a small proportion of GPs' work), nor it is appropriate to broaden the scope of the course to include other dependencies in order to justify the time spent. We therefore decided to exclude alcohol and nicotine dependence from our course.

The course consisted largley of small group work with the learners identifying their learning needs and the course presenters working to meet these. Many of the participant GPs had negative feelings about drug users and admitted uncertainty and lack of confidence in working with this patient group. This was taken as the starting point for the teaching.

Other key points in the success of the teaching have been:

- Spreading the teaching over at least one month allowing participants to integrate the theory within their own practice and test it there
- An emphasis on the negotiation of realistic treatment goals as this is of great importance in working with this patient group, and
- The advocacy of a model of shared care for this patient group, and a clearer understanding by both GPs and drug service workers of each other's roles and skills.

The first course was run over four two-hour evening meetings; subsequently we have varied the format with two longer day-time sessions. The course was approved for postgraduate educational allowance and was supported by the local GP educational trust and the Dorset Health Commission.

Members of the initial courses have now formed a local special interest group that meets quarterly for peer support, case discussion and further learning.

The course evaluation shows that it meets the needs of busy GPs who do not wish to become experts, but who feel poorly prepared for part of their everyday work. About 40 local GPs (over 30%) have now taken part in the training and most are continuing to work with a number of patients with drug-related problems in their practices, very often in partnership with our local community drug agency.

We believe that this model would be readily transferable to other districts, and that a similar model could be used to establish special interest groups in other clinical areas.


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### References


1. Stammers T. Managing drug abuse. [Letter.] *Br J Gen Pract* 1996; **46:** 552.


## Video-recorded consultations

Sir,

We read with interest Cromarty's paper (September *Journal* p525) as TC is currently analysing interview data from a project which used very similar methodology. In this study, general practitioners and TC watched video-recordings of consultations between themselves and smokers prior to participation in a semi-structured interview. We agree that the use of video-recorded consultations may be an effective aide-memoire in an interview situation, but wish to highlight some of the limitations we discovered when evaluating the use of video-recordings.

In this study it proved impossible to recruit a representative sample of GPs. GPs who responded to a survey[1] were systematically selected and asked to participate.[2,3] This was an onerous task as 57% of survey respondents (70/123) refused to allow video-recording of their consultations.[3] Furthermore, younger GPs and those working in teaching and training practices were over-represented in the final sample.[3] During the course of the study we monitored the characteristics of the patients that had been recruited. Patients' consent for the video-recording of their consultations was sought in accordance with Southgate's guidelines,[4] patients' clinical problems were recorded by their GPs, and demographic details were obtained from patients' medical records.

The percentage of adult patients who withheld consent for video-recording was 14.1% (76/538). Analysis of our data suggests that there are significant differences in the clinical problems presented and the demographic characteristics of patients who agree to video-recording, compared with those who don't. We have presented a preliminary analysis of our data to a national conference[5] but cannot divulge further details here as we intend to publish these fully in a peer-reviewed journal.

Cromarty is justifiably cautious when discussing the extent to which he believes his findings can be applied. We hope that our conclusions, when published, will enable a greater understanding of how video-recorded consultations compromise the representativeness of patients recruited to research projects.

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### References

1. Coleman T, Wilson A. Anti-smoking advice in general practice consultations: general practitioners' attitudes, reported practice and perceived problems. *Br J Gen Pract* 1996; **46:** 87-91.
2. Coleman T, Williams M, Wilson A. Sampling for qualitative research using quantitative methods 1: Measuring GPs' attitudes towards discussing smoking with patients. *Fam Pract* [in press].
3. Coleman T. Sampling for qualitative research using quantitative methods 2: Characteristics of GPs who agree to video-taping of consultations. *Fam Pract* [in press].
4. Southgate L. *Statement on the use of video-recording of general practice consultations for teaching, learning and assessment: The importance of ethical considerations.* London: RCGP, 1993.
5. Coleman T, Manku-Scott T. Comparison of video-recorded consultations with those where patients' consent is withheld. *Fam Pract* 1996; **13:** 337-338.

## Treatment of dementia

Sir,

I was very interested to read the letter from Dr Rahul Rao (September *Journal* p. 554) reporting his findings of patients with dementia not receiving analgesia for chronic pain. As he states in his letter, it is particularly difficult to assess the presence and degree of physical symptoms in patients who are cognitively impaired, and there is a lack of literature that comments upon the detection and management of physical symptoms in these patients.

I recently looked at the prevalence of pain and other symptoms in patients with end-stage dementia who died on long-stay psychogeriatric wards.[2] Seventeen case notes were retrospectively reviewed. Dyspnoea and pain were the most common symptoms in the last two weeks of life, and these symptoms were not adequately palliated: all patients appeared to be in some distress in the last 48–72 hours of life. Analgesics were prescribed on an 'as required' basis, but were rarely administered as the patients were unable to articulate their distress. The majority of patients died from bronchopneumonia, and uncontrolled pyrexias and troublesome dyspnoea were also very common. Patients were treated with antibiotics that have been shown not to influence morbidity or mortality in this population group. Steps to alleviate the distress of dyspnoea and excess secretions, however, were not taken.[3]

This study suggested that symptoms in the late stage of the disease were both underdetected and undertreated. As long-stay psychogeriatric wards are being closed, a very large number of patients with end-stage dementia will be cared for in the community, either at home or in nursing homes for the elderly mentally ill under the care of their own general practitioner.

The principles of palliative care are being increasingly implemented for patients with end-stage diseases that are not malignant. Patients with advanced dementia should also be treated according to the principles of palliative care and analgesia, including the use of opiates, which should be prescribed regularly.

As a result of this study, guidelines have been devised that look at the most common symptoms in end stage dementia, and that give a step-wise approach to palliation.

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### References

1. Rao R. Chronic pain in dementia – underdetected or undertreated? [Letter.] *Br J Gen Pract* 1996; 46: 554-555.
2. Lloyd-Williams M. An audit of palliative care in dementia. *Eur J Cancer Care* 1996; **5:** 53-55.
3. Fabiszewski K, Volicer B, Volicer L. The effect of antibiotic treatment on outcome of fevers in institutionalised Alzheimer patients. *JAMA* 1990; **263:** 3168-3172.

## Evidence-based learning in general practice

Sir,

Leone Ridsdale makes a number of pints concerning access to computerized information sources (September *Journal*, p.503). I would agree that database searching skills are not difficult to acquire. The real problem is being aware of the need to use additional tools such as Medical Subject Headings (MeSH) in order to maximize the relevance and efficiency of any search. Searching for evidence-based material requires the accurate use of some very complex search filters[1] in order to get a comprehensive result. We should not forget that, for all the empowered end-users who are in a position to do their own searching, there are others who would prefer to assign this task to a librarian. Librarians are playing more of a role in supporting the information needs of primary care. We should always ask the question, 'Who would do this search most efficiently?', when searching for evidence.

I have been testing out various 'free' MEDLINE services on the Internet. It takes about 20 minutes to train someone to use one of these systems. The problem is that the search results are to a large part uncontrollable, unpredictable and inaccurate depending on the search engine fronting the database. These systems are geared to end-users and yet would be highly unsuitable for performing accurate evidence-based search strategies. In all cases, access to MeSH would be an absolute necessity and yet this is not always obvious. The BMA free Medline service for members allows accurate searching and offers MeSH searching as a basic facility. I would recommend those who can to take advantage of this facility.

Access to the BIDS system is not as straightforward as Dr Ridsdale suggests. BIDS is only available to the academic community, which means that it is not available to general practitioners who are unconnected with education. The databases that BIDS offers (such as Excerpta Medica) can also be accessed by CD-ROM or by a premium dial-up service.

The clear message that I am receiving from GPs is that there is still a real need for mediated search services. My concern is that some practitioners may be so put off by the perceived complexities of new user-oriented services that they give up altogether. I believe that we should make library services more accessible to general practice, as an essential component of evidence-based learning.

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