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Romanian PGEA: doctors' dilemmas

Sir,

Our Romanian medical colleagues were cut off completely from the West for about 50 years; the cost of such professional isolation is incalculable and is to be added to the suffering already portrayed in our media under the violent communist dictatorship. The West has already helped with generous gifts of equipment but there is still a vast need to help rebuild the medical wisdom and experience that we take for granted with our plethora of magazines, lectures, and audit meetings.

For the second year running, a group of English GPs has recently organized a week of teaching in Brasov, with full PGEA approval. Accompanied by two consultants as expert teachers, we shared gynaecological and respiratory medicine with a group of Romanian GPs and specialists, concentrating particularly on the huge tuberculosis problem.

It is hard to portray the enthusiasm and delight with which we were welcomed. While grateful for the gifts and teaching themselves, our hosts were especially blessed by the presence of professional colleagues.

It seemed to be a new experience for them to have the opportunity to grow in medical confidence and stature through sharing everyday management problems. They are used to didactic lectures and dry textbooks, but small group work with equal colleagues is a new way of learning, giving hope and encouragement for individuals at their point of need.

Therefore, the greatest gift we feel that we can give them after 50 years of such suffering is the opportunity to learn. We hope to arrange repeated PGEA courses out there, and to invite colleagues from nearby countries as well. In addition, we see great value in opening up opportunities for Romanian colleagues to travel to England to observe and participate in our hospitals and general practices, noting that this will require a healthy trust fund to cover air fares.

Our hearts went out to these charming, amusing, and highly intelligent doctors. With the cost of food approaching that in the United Kingdom, it is humbling to discover that a senior doctor earns only £50 a month. It is poignant to note that the £800 fee for PGEA approval represents 16 months' Romanian medical salary; equivalent in England to well over £60 000. Perhaps our senior UK colleagues in authority might graciously consider passing on the fee to our Romanian hosts for future conferences, which the doctors of both countries eagerly anticipate.

JOHN CAROE

20 Prideaux Road
Eastbourne
East Sussex BN21 2NB

Managing depression: cognitive behaviour therapy training for GPs

Sir,

We read with interest Moore's views on improving the treatment of depression (September *Journal*), and agree that there is much to gain from improving the acceptability and availability of existing treatments,[1] particularly with reference to cognitive behaviour therapy (CBT).

In the past years we have been extensively involved in the development of an educational training package in CBT specifically designed to meet the needs of GPs in the treatment of depression and anxiety. Preliminary results of a pilot study evaluating the educational training package in CBT appear optimistic, and suggest that GPs who had undertaken the training seemed to be better at identifying depression and made fewer referrals to other mental health services and hospital psychiatrists compared with those GPs who had not.

We feel that there is potential in the use of the training package in CBT and its use in addressing the great burden that depression places on primary care resources. We are currently conducting a randomized controlled trial to fully access the potential advantages of the educational training package in CBT as an intervention to improve the effectiveness[2] in the routine care of patients with depression and anxiety. We will be reporting the results in due course, but are happy to discuss any aspect of the educational training package in CBT or the trial with interested readers.

FIONA CLAIR TAYLOR

OLIVER DAVIDSON

MIKE KING

University Department of Psychiatry
Royal Free Hospital School of Medicine
University of London
Rowland Hill Street
London NW3 2PF

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GPs' views about out-of-hours working

Sir,

Bain *et al* (September *Journal*) report results from the first year of operation of a GP cooperative in Dundee.[1] We recently undertook a survey of GP principals in Lambeth, Southwark, and Lewisham that provides further evidence of the way that new arrangements are affecting a GP's quality of life, morale, and job satisfaction, and influencing concerns about out-of-hours services.

The questionnaire included open and closed questions about current out-of-hours arrangements, satisfaction, and concerns. Following reminders, a response rate of 68.5% (285/416) was achieved. Of these, 73% (208) were cooperative members (established in April 1996), and 25% (70) used a deputizing service.

Most responders (82.2%) were satisfied with their current arrangements, and 90.1% (245) thought that their patients were at least as satisfied as a year ago. Widespread satisfaction with the quality of care provided was reported (98%; 272), reflecting findings from a comparative evaluation of a GP cooperative in 1995.[2]

The new arrangements appeared to be leading to improved quality of life; for example, family/social life had improved for 78.1% (213) of respondents. Issues of concern included uncertainty about when to visit, high workloads on shifts (for cooperative members), perceptions of rising demand and need for patient education, safety (for those doing their own on-call), and costs of service provision (for deputizing service users).

Of particular interest was the considerable agreement on priorities for future service developments (Table 1). This related particularly to the need for GP training in telephone consultation skills. Inter-agency

Table 1. General practitioners' preferences for future developments.

	Perferences for future developments					
	Very important (%)	Important (%)	No view (%)	Not very important (%)	Not at all important (%)	*n*
GP training in telephone consultation skills	36.4	48.0	6.7	4.5	4.5	269
Development of patient education materials	30.4	46.0	12.5	8.7	2.3	263
Protocols for treating emergencies	29.5	44.3	15.9	7.6	2.7	264
Developing nurse-led telephone advice	24.2	35.5	23.0	11.3	6.0	265
Development of nurse triage	24.3	34.7	25.1	8.5	7.3	259
	Preferences for inter-agency developments					
Social services	28.5	52.4	11.6	6.0	1.5	267
Community nurses	19.4	60.4	14.2	4.9	1.1	268
Accident and emergency departments	19.1	46.8	22.8	10.1	1.1	267
Pharmacists	13.2	49.1	24.9	10.2	2.6	265

developments with social services and community nurses were considered important, reflecting difficulties in out-of-hours communication and concerns with 'appropriate' responses to the variable nature of out-of-hours demand.

Current issues, while reflecting continued concern with demand, now appear to be more focused on the quality of out-of-hours care. This contrasts starkly with data from a survey in the same district two years earlier.[3] At that time, 55% (166) of GPs organized out-of-hours cover through a rota within their practice, and 40% (120) through a rota including other practices.[3] Considerable dissatisfaction was expressed with the amount, nature, and quality of on-call activity, and the main concerns were reducing workloads, ending the 24-hour commitment, reducing demand, and improving quality of care.

We are currently undertaking a study to assess the extent to which patients share GPs' satisfaction with out-of-hours arrangements.

CATHY SHIPMAN
JEREMY DALE
FIONA PAYNE
LYNDA JESSOPP

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Reasons for drug changes implemented by secondary care

Sir,

Munday *et al* reported the need for GPs to receive information on the reasons for drug therapy changes incurred during hospital admission (September *Journal*).[1] At the beginning of the 'Discussion' section the authors regret that little has been published on this subject. Unfortunately, the authors were less than successful in their search for relevant literature. Perhaps readers of the *BJGP* may be interested in the results of our research in this area.

In a follow-up study, we examined changes in the drug therapy of patients who were hospitalized.[2] The hospital doctors discontinued 53% of the drugs prescribed by the GP. The GP received detailed information about drug changes in less than 10% of the hospital discharge letters.

In a survey,[3] we asked a representative sample of GPs (n = 554), stratified to the former East and West Germany, about the extent of hospital drug changes. Additionally, we asked the doctors about the quality of the discharge letters and the quality of cooperation. Fifty per cent of GPs from the West and 39% of GPs from the East of Germany thought that their patients' medication had been changed in hospital in more than 60% of all cases. According to the experience of most of the GPs, drug change is rarely a subject of broader communication in hospital discharge letters. In an open-ended question most GPs voted for more information exchange and better collaboration between doctors in primary and secondary care. Awareness of economic aspects in drug prescribing and a stronger acceptance of GPs' prescriptions was also frequently mentioned.

We also studied the attitudes of hospital physicians towards GPs' prior medication.[4] More doctors on the surgical wards than on the medical wards would usually follow GPs' medication (82% versus 25%). Compared with conventional criteria of clinical pharmacology, patients' needs and the maintenance of a satisfying GP–patient relationship were considered of minor importance for drug selection.

In conclusion, GPs should not only receive more and better information on the reasons for drug changes,[1] but, since GPs feel disparaged by a high rate of drug turnover during hospitalization, hospital doctors should also try to continue the GP's drug regime more often, if appropriate, and thus support the GP–patient relationship after hospital discharge.

WOLFGANG HIMMEL
MICHAEL M KOCKEN

Department of General Practice
University of Göttingen
Robert-Koch Straße 42
D-37075 Göttingen
Germany

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