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Medical cannibalism, strangury, and the spread of erratic hyphenitis

Sir,

The title of Beales' and Dalton's article, 'Eating disordered patients...' (January *Journal*),¹ suggests an innovative solution to managing heartsink patients. However, even though we may be tempted to follow Dr Hannibal Lecter's practice, it is generally accepted that Malcolm Bradbury was correct: 'Eating people is wrong'.²

The cover of the same issue also mentions 'good books with piss-poor titles'; I find this an unusually interesting expression for a medical journal. Perhaps there is a deliberate move towards a more tabloid style, but if you can manage to hyphenate 'piss-poor', at least try and do the same to 'eating disordered' so the title makes sense.

Better still, read the recent editorial in the *BMJ*,³ 'allow very, very few hyphens' and rewrite 'self-regulation, in-practice, whole-blood, practice-based, cross-sectional, out-of-hours, doctor-staffed, and heroin-dependent'; all of which appear on the same cover.

The style and content of the *BJGP* are evolving, and some of the changes are welcome, but you must be careful to avoid attracting the accusation of being 'A piss-poor journal with a good title'.

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Ed's note:

Before we are inundated with letters from other pedants, we should like to reassure readers that we have spotted Dr Lennox's lapse: the title of Malcolm Bradbury's novel 'Eating people is wrong' was itself a quote from 'The Reluctant Cannibal', a song by Flanders and Swann!

Is there enough clinical time available in primary care?

Sir,

Pereira Gray (December '98 *Journal*)¹ stressed the importance of clinical time to general practice, calculating that 47 minutes of doctor time is available for each patient per year. Jarmen *et al*² demonstrated that the number of GPs in an area is inversely proportionate to the local standardised mortality in hospital, a 1% increase in the number of GPs being associated with a 0.368% decrease in hospital standardised mortality ratios. The availability of clinical time is therefore an important quality and clinical governance issue.

Clinical governance³ makes fresh demands on GP time but can be put to good use. Doctors who prescribe antibiotics for inter-current infections may encourage patients to return with minor ailments.⁴⁻⁶ Promoting good practice may allow re-deployment of such clinical time; its availability and use therefore becoming important aspects of clinical governance.

We examined the availability of clinical time in general practice in one health authority as part of the clinical governance baseline assessment. At the end of December 1998, North West Lancashire had 469 000 people served by 251 GPs working from 91 practices.

Pereira Gray's summary statistic of 47 minutes per patient per year¹ was used as the 'standard' of the time necessary for a GP to provide patient care. Two measurements of doctor time were made: the number of minutes, excluding locums, available per patient per year by practice, assuming each doctor provided 30 hours of clinical contact time per week for 46 weeks per year; and the number of hours needed to provide 47 minutes of contact time per patient per year.

We found that only 15 of 91 practices can provide 47 minutes per patient if doctors provide 30 hours per week clinical time: four hours more than their existing contract requires. Eight practices would have to provide more than 40 hours per week per doctor, of which five would need to provide 50 or more hours, and one over 65 hours. Variation by practice was threefold. An average of 34 hours clinical contact time per week per doctor would be necessary to provide 47 minutes for each patient.

Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

With present resources, lack of clinical time is likely to be a critical limiting factor on the quality of service provision. More effective use of time by patients and doctors, including better selection of clinical priorities and the appropriate deployment of alternative non-medical clinical skills is needed, if there is time.

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Are postal urine specimens a feasible method for genital chlamydial infection screening?

We were very pleased to read the paper on *Chlamydia trachomatis* screening using postal urine specimens in the June 1999 issue of the *Journal*.¹ Our experience confirms what the authors have described in this paper. We would like to comment on two issues raised.

First, the authors mention that postal urine specimens have not yet been used in a large-scale screening. However, the method has been used in a screening program for asymptomatic *C. trachomatis* infections in general practice in the Netherlands.² More than 11 000 men and women were invited to participate. The participation rate was 33% for men and 50% for women. The prevalence among screened men and women was 2.3% and 2.9%, respectively.

A questionnaire covering demographic data and sexual history was included in the study material. An evaluation of selective screening criteria is currently submitted for publication.

Secondly, the authors mention that previous studies have suggested that the sensitivity of molecular *Chlamydia* assays could be compromised in community settings, perhaps owing to inability to maintain a 'cold chain', to ensure sample stability.³ However, in a recent study we found that a mailing time of up to seven days had no adverse effect on the reliability and sensitivity of *C. trachomatis* detection: an exception being if the sample had been frozen and then defrosted for more than four days during transport.⁴

Postal urine specimens are a feasible method for large-scale screening of genital chlamydial infections among both men and women.

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The colorectal cancer jigsaw puzzle

Sir,

The editorial by Jones and Kennedy (December *Journal*)¹ emphasises that primary care has a key role to play in the early detection of colorectal cancer: it rightly argues for the most appropriate method of service provision for the timely investigation of such patients, as the disease is potentially curable if caught early. Thus it is important that health professionals in primary care are involved in shaping local services via their primary care groups (PCGs) so that they can organise optimal care for their colorectal cancer patients. Although reconfiguration of colorectal cancer services may generate some additional demand on primary and secondary care services, it may result in reduced morbidity and mortality for the condition in the future.

At present, it appears that we are at a standstill with regard to tackling this cancer. The most appropriate screening test currently available is the faecal occult blood test. The National Screening Committee (NSC) is evaluating the feasibility of a national screening programme using this test. A decision on whether or not to recommend mass screening is expected to be made by the NSC in the next year or so.² By this time, research on primary chemoprevention may also have yielded some interesting conclusions. Moreover, advances in technology may make the detection of the condition easier; for example, by way of novel tumour markers and imaging techniques. And all this excludes advances in disease management. However, despite these and other significant advances, the single most important factor determining survival remains to be early presentation of the disease.

We know that there are delays at the patient and the professional level. The median delay between onset of symptoms and treatment for colorectal cancer is 10 months.³ It has been shown that 24% of people notice rectal bleeding at some point but only 41% consult a doctor.⁴ On average, people wait three years before seeing a doctor.⁴ People delay in seeking medical help because most do not appreciate that their symptoms signify serious illness.^{4,5} Therefore, for PCGs, the most important roles to play in completing the colorectal jigsaw puzzle are to encourage patients with bowel symptoms to present sooner to health professionals, and to make arrangements for it's GPs to be informed on all aspects of colorectal cancer. A starting point may be liaising with local public health and health promotion departments, the local colorectal cancer multidisciplinary team, and the main colorectal cancer charities. The development of closer relationships between the PCG and its population, primary care teams, and secondary care should lead to an even earlier detection of the disease. In essence, PCGs

can impact on the burden of the disease while waiting for research evidence to complete other parts of the colorectal cancer jigsaw puzzle.

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Health technology assessment in primary and community care

Sir,

Health technology assessment (HTA) in primary and community care (*January Journal*)¹ can play a very important part in ensuring that interventions and strategies can be informed by the outcome of studies such as those listed in Smithies *et al*'s editorial.

However, it is timely to remember that Cochrane's insistence on the randomised controlled trial (RCT) as the gold standard was tempered by his realisation that, only in 'cure conditions', where efficiency and effectiveness relates to cure, should the RCT be relied upon to produce evidence of effectiveness and efficiency. 'Care conditions', which he mainly applied to quality of life in patient mental health services but which are equally applicable to primary and community care, he felt should be governed by concepts of equality. Furthermore, he felt that the RCT had little relevance in 'finding out'.

Within the HTA mindset is the tendency to disregard user experiences (and professionals' too) as so much background noise in the clean, pure confines of the gold standard RCT. Yet, as all who work in primary care know only too well, the noise carries the message; yet their valuable and valid subjective experience is ignored. As every new set of protocols and guidelines arrive on the desks of health professionals in primary care, so their hearts sink. Isn't it about time that the clinician's voice was heard and acted upon? If we ignore them, service quality, and ultimately both efficiency and effectiveness, is bound to decline even further.

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Supporting practice-based audit

Sir,

I agree entirely with the sentiments expressed by D Shepherd (*January Journal*)¹ that MIQUEST is an excellent time-saving audit tool for extracting clinical data from practice systems. Taking the approach a step further it is equally an excellent tool for conducting inter-practice audit with a group of practices, even if they have different clinical systems.

Within Northumberland, we use MIQUEST to extract data from all 53 practices focusing upon the secondary prevention of CHD. This approach has enabled the establishment of clinical targets for Northumberland's Primary Care Act Pilot practices. The approach offers enormous potential for PCGs/health authorities in implementing National Service Frameworks and establishing clinical governance arrangements.

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Needs assessment in primary care

Sir,

General practitioners are not the only health professionals who remain to be convinced that 'health needs assessment can guide the appropriate shift to primary care by identifying the most effective and efficient resource allocation to meet the needs of the populations' (*January Journal*).¹ My nine years working in a health authority suggest that most managers (excluding a few whose careers depend on it) are not convinced either. As the sceptics include most of the people whose job it is to direct resources, most GPs will not have witnessed this 'effective efficient resource allocation' at work; neither have I.

This justifiable doubt can properly be dispelled only by some convincing worked examples and not 'motivation, training, and rewards'. Even the authors advocate

'research directed specifically at identifying the tangible benefits of needs assessment'; I agree with them. But it rather gives the game away: we have no idea if it 'works' and only a rough idea of what 'works' means. Meanwhile a moratorium on unevaluated 'needs assessments' might save us all a lot of wasted effort.

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Adult learning theory

Sir,

Like Trish Greenhalgh (*January Journal*; Back Pages),¹ adult learning theory has helped my understanding of how we learn and change. Unlike her, I follow simple principles² that are free of jargon, easy to remember and to use in planning learning. These principles are paraphrased below:

- All our learning starts with a problem, so we only want solutions to problems we already have.
- We learn by asking questions, so we want to participate actively in our learning.
- We are busy people, so we do not want our time wasted.

I recommend that we avoid or quit any educational activity that ignores these principles.

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Dermaclinic: preliminary triage by GP specialoids?

Sir,

Earlier this year we reported on the outcome of a trial of telemedicine for dermatology between our general practice and Kingston Hospital.¹

We have now completed a new analysis

comparing how the diagnoses made by a GP 'specialoid'^a (BJ) compared with the consultant dermatologists (KM, LO). This was done by sending the same 23 case histories and digital clinical photographs that we reported on previously, in an identical format, via a confidential intranet to the GP specialoid, who had no knowledge of what the consultants had diagnosed.

The results of this exercise showed that in 16 out of 23 (70%) cases there was a complete match on diagnosis and action required. The consultants thought that seven out of 23 needed referral, while the specialoid wanted to see slightly less cases referred (6/23; 26%). There was discordance in only two diagnoses (8.6%). In the first of these, the consultant diagnosed the problem as 'impetiginised eczema', while the specialoid diagnosed 'solar keratosis'. In the other case, the consultant diagnosed 'eczema, while the specialoid diagnosed 'post-scabies itch'.

We feel that these results encourage us to hope that judicious use of this new technology by GP specialoids working within a consultant-led district team could safely reduce waiting times for minor skin disorder and reserve consultant energies for more serious problems.

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Footnote

^aA 'specialoid' is defined as somebody who is accepted by a local dermatologist as suitable to be their clinical assistant.

Please note that the intranet used in this study was the MD intranet and it is now freely available on the NHSnet at www.mdintranet.nhsweb.nhs.uk. The software used is available from Agora Healthcare (www.agora.co.uk).