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Single-handed practice — the reality

It is with sadness that I read the article 'The end of single-handed practice?'[1] and it is with corresponding regret that I feel I have to reply.

Harold Shipman is a killer who happened to be a single-handed general practitioner; there is no evidence that he killed patients *because* he was a single-handed doctor. Harold Shipman left a trail which should have alerted the authorities much earlier that this was a person at risk. The greater-than-average number of deaths per year of patients in his care, the greater-than-average number who died at home or in his surgery, and the failure of the authorities to act earlier, all point to a failure in a system that allowed Harold Shipman to practice medicine and so afforded him the opportunity to continue with his gruesome acts.

Notwithstanding the view of Frankel *et al*,[2] it is important for general practitioners to keep a record of deaths in their practices. A simple record of the cause of death, where the death occurred, and numbers, should in my view be sufficient to alert authorities to persistent variations from the norm that require investigation. I have for some years now maintained a register of deaths in the practice and, despite small numbers, find the register of use. PCG/Ts could take on a monitoring role in this respect. This could also be a useful educational/planning exercise.

Peterkin and Coid draw attention to the difficulties in managing illness in a doctor in practice. With the current shortage of locums, illness and absence of a doctor is a problem in most practices, large or small. However, with PCG/Ts taking an active role practice affairs this should not be any more of a problem in a single-handed practice than in a larger one. Suboptimal performance is as likely to occur in a larger practice as it could in a single-handed practice — it is more a function of the practitioner than of where he/she practices.

It is said that 'there is no system of education yet devised that could hold back a good student'. It is easy for poor practice to be submerged and even go unrecognised in a large practice. Kennedy,[3] in his report into the Bristol cardiac deaths, warned the profession against a 'club culture', which seems to have pervaded all levels of medical practice. It is important for all practices to be the subject of performance audits.

There is no justification for a greater burden of performance assessment for single-handed doctors. Floyd and Evans[4] found that smaller practices were better at providing information and results care than larger practices, which they viewed as having difficulties with chronic disease management, data entry, and audit. Hippsley-Cox *et al*[5] found no evidence of underperformance by single-handed general practitioners. Interestingly, Campbell *et al*[6] found that no particular practice type could claim a monopoly on quality.

In my PCT, all practices contribute to audits which are run by Equip, the successor to the Multidisciplinary Audit Advisory Group (MAAG). Performance of each practice is set out in the results; comparisons with other practices in the locality and other localities in Health Authority are available. This information is available to our PCT for use in its own audits of performance and for local clinical governance.

With the advent of PCG/Ts, isolation in general practice is disappearing. There are more frequent meetings with colleagues and collaboration at PCT/G and locality levels to an extent which was unthinkable even three years ago. As a single-handed doctor I would not agree that my performance is suboptimal in any system of assessment currently available. Some of the activities in my practice include: asthma care provided just as in any larger practice, with no referrals to secondary care in the past three years; no referrals for minor surgery in the past 20 years; consistent attainment of the higher performance targets; regular audit; and involvement in FBA, MAP, appraisal, etc.

If I am underperforming then I shall certainly take the necessary steps to correct deficiencies in my practice, as indeed should be the obligation of any doctor. Herein lies the crux of the matter — all doctors should be accountable, primarily to their patients, and more widely to the NHS and the public.

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TRIPS: generic irony

Apparently the Trade-related Intellectual Property Rights (TRIPS) ensured that the World Trade Organisation agreement became law in many countries.[1] The agreement was strongly supported by developed countries and the pharmaceutical industry as it strongly supported intellectual property rights and patents on pharmaceutical products. Article 31 of TRIPS, however, allows signatories, in times of national crisis, to override a patent and produce or import cheap generic copies of medication — the medication required to help resolve the crisis.[1]

The South African government felt that, at 4.7 million HIV-positive citizens, there was such a crisis in South Africa. They attempted to import cheap generic medications, relevant to the care of their HIV-positive patients, into the country. Local multinational pharmaceutical companies were incensed and threatened legal action and the US government threatened sanctions; both based their arguments on alleged contravention of TRIPS.[1] Fortunately, common sense prevailed following a public outcry and there was an out-of-court settlement.

How ironic, then, that the same US government now threatens Bayer with the importation of generic equivalents of ciprofloxin, as the Centers for Disease Control and Prevention (CDC) initially recommended ciprofloxin as the antibiotic of choice against anthrax.[2] The threat of importing cheap generic equivalents was so as to persuade Bayer to lower the price on the antibiotic to the US government.

There are in fact two ironies here: the CDC now recommends vibramycin as the antibiotic of choice.[2] The greater irony, however, is the US's stance on South Africa's crisis of 4.7 million HIV sufferers — and then their own approach, when only 15 Americans have been diagnosed with anthrax.[3]

Although the politics and legalities are no doubt extremely complex, superficially the whole issue smacks of double standards.

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Management of familial breast and ovarian cancer cases

The study by Watson and colleagues reported in the October 2001 issue illustrates the potential benefits of providing GPs with education and guidelines for the management of familial cancers and illustrates the additional benefits from educational sessions over information packs.[1] We would, however, caution against over-interpretation of the results from this and other such studies. It is likely that GPs referred to their information packs when responding to the questionnaires. Future studies might ask if GPs refer to their information packs when dealing with individual patients and if educational packages result in more appropriate referrals to the genetic clinic. The authors are correct in noting that the study failed to assess the persistence of the effect of the educational programmes. We believe, however, that, given the rapid advancement of genetic technologies, continuous education may be more appropriate. By its very nature clinical genetics is diverse and complicated; there are different testing procedures for different conditions. The relevance of a genetic test to any individual will depend on their perceptions of the test itself and the potential to prevent or cure the condition. The issues are very different for, say, the patient concerned about her familial risk of breast cancer, compared with the patient who may have inherited the gene for Huntington's disease.

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Proton pump inhibitor 'porkies'

The study by Grime, Pollock, and Blenkinsopp[1] on the perceptions of prescribers and patients to proton pump inhibitors (PPIs) mirror findings from research in Victoria.[2] Both studies conclude that PPIs meet the needs of doctors and patients.

In the introductory second paragraph of the article, the authors suggest that 'demand for PPIs could be significantly reduced through the adoption of restrictive prescribing protocols'.

In Australia, PPIs were, until recently, listed on the schedule of the Authority Prescribing System. This meant that doctors must phone for authorisation to prescribe these medications. Interviews with prescribers revealed that when doctors perceived the need for a PPI, even when the indications lay outside the listed purpose, they were not averse to telling half-truths ('porkies') to authorities to obtain the drugs for their patients.

Prescribers backed their clinical judgements over regulations from central bureaucracies, which are based on evidence from pharmacoeconomic analyses.

No doubt British prescribers would identify similar loop-holes.

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Research and consumer representation

Consumer representation is increasingly regarded as central to good research practice,[1] as well as good clinical practice.[2] However, the process whereby consumers can be attracted to the research unit is fraught with difficulties.[3] Simply collecting enough people who are interested in supporting a research unit can be problem enough, before even considering whether the volunteers are genuinely representative of the population served.[1,4] Our recent experience illustrates this point.

We have been a Culyer-funded research practice for over three years, based in a health centre serving over 16 000 patients. We have a patient representative, a retired professor of education, who has been actively working in the unit for over one year, but wished to expand our consumer involvement by establishing a support group. We decided to have an open day within the practice to feedback research findings to those who had been involved in our studies and raise awareness of the practice's research, as well as recruiting volunteers for the proposed support group.

We advertised the event in the local press and radio. Fifty patients involved in practice studies were invited by personal letter. Posters in the waiting room advertised the event to patients attending for appointments. Personnel from the research team were present from 9.00 am to 6.00 pm. The research room was laid out with poster presentations and copies of publications and reports. In the evening, we had semi-formal presentations of studies — with refreshments, followed by question and answer sessions.

In the daytime, five patients who had had no previous involvement with research visited the unit. Three of the fifty patients invited by letter came to the evening. Two of these, plus one of the morning patients, were interested in joining a research support group. The event — which required a lot of planning — fulfilled its purpose to some extent, in that we now have volunteers for our support group. However, only an optimist would say that we have raised research awareness, or fed back on our findings. We are undecided about whether this exercise was worth the effort. It certainly met the obligations of the Research Governance Framework, but we are left with considerable doubts about the whole validity of the exercise, as well as a lot of uneaten sandwiches.

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What are general practices providing in terms of aid and access for the visually impaired?

We report the results of a study done as part of a BSc in Primary Health Care. There are 1.7 million people in the UK (2.8% of the population) with a visual disability severe enough to cause reading difficulties[1] and one million are registerable blind[2]. The prevalence of visual impairment of all the main disabilities, increases most with age (30% in the over-65-year-olds[3]). Of the visually impaired, 67% have one or more additional permanent illnesses or disabilities.[2] The Disability Discrimination Act 1995 refers to the provision of documents in large print, or Braille. For the health sector this means information must be available in accessible formats.[4] Clarke supplied their GP leaflet as an audiotape.[5]

This study therefore aimed to discover what GPs are doing to help the visually impaired with accessing health care. The study was a postal questionnaire cross-sectional survey of all 117 practices in the Brent and Harrow Health Authority. It received ethics committee approval.

The results were as follows: The response rate was 61 (52%). Forty-eight per cent of practices reported that they recorded patients who were visually impaired; of these, 69.6% reported having five or fewer such patients. Eighty one per cent do not flag visually impaired patients when they book appointments and 85% offer no training to staff in aiding the visually impaired. Less than 5% of practices report offering repeat prescriptions or practice leaflets in Braille or large print. However 62.3% of practice managers reported that completing the questionnaire has made them consider making changes to accommodate the needs of the visually impaired.

We conclude that practices in the sample are not recognising their visually impaired patients, helping them access services or providing information in an accessible format. This may have important health implications for this group.

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The Paddington Alcohol Test

We agree with the judgement of Aertgeerts & Buntix[1] that screening questionnaires for alcohol misuse must be brief in order to be practical; that is, to be accepted by nursing and medical staff.

The one-minute Paddington Alcohol Test (PAT) has been developed over the past seven years for use in the accident and emergency department.[2,3] It provides a quick and reliable method of detecting early onset hazardous drinkers (sensitivity 70%, specificity 85%). This enables the most worthwhile use of health care professionals' time, remembering that brief intervention is most effective early on in a patient's drinking career.[4]

We selectively screen for alcohol misuse when presented in A&E with any of the 'top ten' conditions that we have found to be most commonly associated this problem: fall, collapse etc.[5]

Although the PAT has been developed for use in A&E, we judge that it could easily be adapted for use in primary care. The equivalent 'top ten' conditions to facilitate most effective selective screening would doubtless be different.

We challenge our GP colleagues to carry out similar work using the PAT, developing the primary care 'top ten' to facilitate equivalent selective screening for alcohol misuse.

After all, primary care and A&E are the two most common points of entry to the NHS.

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The Paddington Alcohol Test is as follows:

1.(a) We routinely ask all patients if they drink alcohol — do you drink?

YES [go to 1(b)]
NO [PAT-negative]

1.(b) Quite a number of people have times when they drink more than usual; what is the most you will drink in any one day? (units: 8 g alcohol, pub measures in brackets)

Beer/lager/cider	Pints (2)	Cans (1.5)
Strong beer/lager/cider	Pints (5)	Cans (4)
Wine	Glasses (1.5)	Bottles (9)
Fortified wine (sherry, vermouth, etc)	Glasses (1)	Bottles (12)
Spirits (gin, whisky, vodka)	Singles (1)	Bottles (30)

2. If it is *more than* eight units/day for a man, or six units/day for a woman, does this happen:

— once a week or more?

YES: [PAT-positive (if every day: Pabrinex)]

— or less frequently?

YES: [PAT-negative (but PAT-positive if trumped by Question 3)

2. Do you feel that your current attendance here is related to alcohol?

YES: [PAT-positive]/NO

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