Letters

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The saviour of the NHS — my cat

Gordon Brown should hold urgent talks with my fat 3-year-old cat Mustafa. She (I am aware her name is a boy's one) can describe without question, the faults of the current out-of-hours (OOH) service and make suggestions for a model that works.

A few weeks ago Mustafa decided to hurt her front paw. This is her diary —

Day 1: Mustafa has done something to her front paw. She won't tell me what, but she isn't weight bearing. A definite bump over her MCP joint prompts a call for help.

One quick phone call to our local vet (they are part of a large chain and easily identifiable with a branch in most high streets), and we are put through to their on-call base in a nearby town. We rush over to the OOH vet base. Happy to be seen quickly, but mid-week night shifts at base are quiet anyway. Thankfully it isn't Saturday!

See a foreign vet who speaks limited English and whose response to my wife's tearful plea for them not to keep Mustafa in overnight was a blunt: 'What else would you like me to do?'. Nice communication skills mate. X-rays done that night show no fracture and no dislocation. She is patched up and discharged the next day after 'other vets look at the X-ray'. Follow-up is planned for 3 days later at another base.

Day 4: This laughable follow-up consultation involves prodding at Mustafa's painful paw and planning follow-up again. Fobbing off does not count as continuity of care.

Day 7: She is seen by a different vet in our local surgery (finally) and deemed to be fine. No limp and the dressing removed. I can see the bony prominence on her paw. Mustafa wants to get out of there, so no arguments. As soon as we are home, she cannot weight bear again.

Day 8: An angry parent (me) calls the vet. I demand that they bring over the X-rays and for her to be seen again. We see the same vet as yesterday. For the first time ever, some continuity of care. Take a bow. I make him feel the bony MCP prominence and show him the dislocation in the X-ray (I did learn something in A&E). He has now arranged for her to have her operation in the morning.

Weeks 2–3: Regular follow-ups with our local vet. Mustafa continues to improve all the time. Harmony returns as vet–cat relationship grows strong.

Mustafa would tell Mr Brown that she is hungry. She would also go on to tell him that OOH services provided by larger, private companies can provide doctors of poorer quality (and cheaper salaries) than is acceptable for patients. In running efficiently with profit, they cut doctor work to a minimum. Nurses are cheaper. They send around memos to staff to promote 'lean-working' (cheap) management babble. Patients travel further to be seen by a random, possibly recently imported, doctor. That doctor may have travelled an impressive distance just to 'cash in' that night. There is no continuity of care or any relationship with the patient. Loyalty is the pay cheque that comes every month. Add dissatisfied and stressed doctors to this pile and you get poor patient satisfaction and, sadly, tragic mistakes.

She would then tell Mr Brown his name is not nearly as funny as her own. She would then quote the model of OOH care in the little Hertfordshire city where she lives. The OOH service is staffed by an army of local GPs. They don't easily employ outside GPs. Having sorted out quality control, they take ownership and responsibility for each other's patients. This is the motivation that keeps the service staffed. Communication and continuity of care are maintained. This service is more expensive. There is no nurse triage and there can even be 'quiet shifts'. There are increasingly few areas where an OOH service is supported so well locally. Patients here do not know how lucky they are.

PCTs need to be able to afford OOH services that deliver for their patients and not for the local funding deficits. Contracts are up for renewal and our local gold standard service is moving with the times to stay alive. Let's hope quality is not lost at the expense of quantity.

Ozan Adali
GP, Watling Medical Centre,
108 Watling Avenue, Burnt Oak, HA8 0NR.
E-mail: ozanadali@hotmail.com

OOH care and locum doctors

The global warming scenario threatens people all over the world. A widespread anxiety about our future on the green planet seems to change our opinion about economy and lifestyle in a way which has never been seen before. So it is not remarkable that even primary health care is now under suspicion of playing a role in the drama of a man-made greenhouse effect.

After the NHS allowed British GPs to hand over their responsibility for out-of-hours services to health boards in 2004, the shortage of out-of-hours (OOH) GPs led to the practice of foreign doctors working as locums in OOH services. As the weekend OOH shifts start late Friday afternoon and end on early Monday morning, European GPs can manage to commute from their home country to the UK for convenient weekend shifts only, and still continue to work in their own surgery at home over the week. Travelling by air is then the cheapest and of course the fastest way to go to 'weekend work' in the UK. Indeed, this may have an impact on the greenhouse effect as

aviation seems to be a key player in the human-made global climate change. The exact number of European — mostly German — doctors shuttling by air to do OOH service in the UK is still uncounted to date. However, based on the data from several British PCTs, we estimated the number of German GPs working as locums in the UK during 1 month. We figured out that a total number of about 400 Germans who need to shuttle monthly, results in more than 3500 tons of additional effective carbon dioxide emissions by aviation during 1 year. This emission is equal to the amount which is emitted by a mid-range car driving round the equator 526 times.

As increasing greenhouse gas emission is a major cause of worldwide climate change, it should be offset by paying money to fund projects that provide renewable energy or reduce carbon dioxide emissions. A number of non-profitable carbon dioxide offset companies exist and the service is easily available via the internet. Until today only single doctors have been willing to offset the implications of their profitable sideline voluntarily. However, this should become standard either for the European doctors who work as locums or for the PCTs and agencies that employ them.

Tobias Freund
Institute of General Medicine, Charité University Medicine Berlin, Charitéplatz 1, 10117, Berlin.
E-mail: tobias.freund@versanet.de

Ulrich Schwantes
Professor, Institute of General Medicine, Berlin

Carsten Lekutat
MD, Institute of General Medicine, Berlin

Vitamin D deficiency

I read the report on Vitamin D deficiency[1] with interest. In my practice in Hounslow we have a list size of 3700 with a large Somali population. We have been testing for Vitamin D deficiency for 2 years in any patient in an at-risk group who presents with bone or joint pain or non-specific malaise. We started to do this because we picked up several cases of young Somali women presenting with symptoms who were discovered to have frank osteomalacia and two children with rickets.

In the 2-year period we have identified 138 cases of low Vitamin D (70% frank deficiency; serum level <25 nmol/l) and 30% insufficient (serum levels 25–50 nmol/l). Of the individuals found to have low Vitamin D, 93% are non-white patients, and the majority come from the Somali, African, Asian, and Afghan communities.

We have been treating these people with oral vitamin D according to our locally developed protocol, but often find that levels do not respond. Although is has not always been possible to ascertain whether this is due to compliance issues or absorption, we have adopted a pragmatic approach and started to give IM treatment if re-testing shows little or no improvement at 6 months. There are several pregnant women, and although we have not been formally testing their babies' levels, we have started to advise supplementation from birth with appropriate vitamin drops.

We are offering blood testing to screen asymptomatic family members of affected individuals, but this does have resource implications for smaller practices such as ours. To date, of the blood tests carried out 88% have been abnormal, so we are confident that we are reaching some of the vulnerable population.

We have also identified some Read Coding issues, and hope that addressing these will assist in the process of auditing and recall of patients.

I agree with the authors that vitamin D deficiency is a significant and sizeable public heath issue in primary care.

There are likely to be a high proportion of cases that are unrecognised and untreated. The current lack of coherent guidelines about screening and treatment is a major problem.

Judith Lambert
Salaried GP, Isleworth Centre Practice, 146 Twickenham Road, Isleworth, Middlesex, TW7 7DJ.
E-mail: judy.lambert@dsl.pipex.com

REFERENCE

1. Mytton J, Frater AP, Oakley G, *et al*. Vitamin D deficiency in multicultural primary care: a case series of 299 patients. *Br J Gen Pract* 2007; **57(540):** 577–579.

Author's response

The experience of Dr Lambert in her Hounslow practice is not surprising, and adds weight to the argument for clarity on the identification and management of such patients. Personal communications with primary care and public health colleagues in East London, Cardiff, Birmingham, Liverpool, Stoke, and Bradford have all yielded similar stories of population groups with unmet needs. No doubt there are many more.

The treatment of identified deficiency and the prevention of recurrence is complicated by the range of preparations currently available on prescription. Our local policy for the treatment of adults (300 000 IU repeated at 1 month assuming no evidence of hypercalcaemia) is frequently offered as an intramuscular injection, and appears to be very acceptable. Oral calciferol tablets (either 10 000 IU or 50 000 IU) can be taken as a short course to achieve an equivalent dose, but have been more difficult for local pharmacies to obtain, and delay in providing these tablets has led to reduced compliance with treatment.

Any patient with ongoing risk factors for deficiency should commence daily supplements after completion of treatment. Prescribable oral preparations of vitamin D that are suitable for adult supplementation (that is, containing 400 IU) are only available combined with calcium. Like Dr Lambert, we have found that compliance with such preparations is very poor, and believe this is largely due to gastrointestinal side effects secondary to the calcium component. We also aim to assess other family members whenever a mother or child is found to be affected, as family history of vitamin D deficiency appears to be a very significant risk factor.

The recent position statement on vitamin D by the Scientific Advisory Committee on Nutrition[1] illustrates the extensive gaps in current knowledge on the epidemiology, diagnosis, and consequences of vitamin D deficiency. Their confirmation that all pregnant and breastfeeding women should be taking Healthy Start vitamins is welcomed, and it is hoped that their call for further research and guidance will be taken up urgently.