

PRACTICE OBSERVED

Practice Research

Dealing with Vietnamese refugees

What we found

SIMON J PHILLIPS, RACHEL J PEARSON

In November 1979 62 Vietnamese refugees came to a hastily prepared resettlement centre in Devizes. Because we could find no guidelines on how to deal with the health of refugees and we did not know whether they had been screened or given immunisations in Hong Kong, we assumed nothing had been done. In the event they came with inaccurate information. In the first article we discussed the plans we made to care for the refugees. In this article we describe what we found.

Clinical findings

SKIN LESIONS

Healed chronic sores.—There was evidence of long-standing chronic sores and of "boat sores," particularly on children's bottoms. **Active infection.**—(i) Staphylococcal infections. We saw evidence of furunculosis, axillary hidradenitis, and impetigo or perimpetigo in two patients. Swabs were taken from all most sores, and 12 were positive for staphylococci (19%). In our overcrowded conditions the possibility of an outbreak of impetigo contagiosa in association with other skin infections (scabies and lice) was a very real possibility. (ii) Streptococcal infections. Group A haemolytic streptococci were isolated from 12 patients (19%). Two swabs from skin sores in children had A haemolytic streptococcus M type 49 (Trinidad), which is specifically associated with acute glomerular nephritis. These children all required long-term follow-up. (iii) Non-specific lesions. As expected, there was evidence of indolent sores due to poor nutrition, lowered immunity, and secondary infection. The secondary infection was easily treatable but the most

important factor was an adequate diet. (iv) Infestations. We assumed that if one member of a family had head lice then every member of that family was infested and should be treated. Every family except one had more than one member with pediculosis (95%). Initially the refugees did not co-operate in using Procter. They complained that lice "were normal" and that we were trying to make them "too clean." The health visitor, interpreter, and doctor were infested with head lice. This is contrary to the findings from Moreton Hall. Scabies was managed the same as lice. It was found in eight (12.9%) refugees and treated with benzyl benzoate, but this was unsatisfactory because again the patients did not co-operate well.

At all times we had to be aware that any infestation in association with any other sort of vermin (rats, cockroaches, etc.) could create a grave medical hazard in overcrowded conditions.

Other skin lesions.—One family had thickened skin and conjunctivitis. We thought that the dryness and roughness of the skin and other changes were sufficient to call it follicular hyperkeratosis (phrynodermis) and in association with their obvious conjunctivitis we diagnosed hypovitaminosis A. Other members of the same family had gross sterile conjunctivitis. It was impractical to take blood samples to estimate serum carotene concentrations, but all these features completely disappeared with an adequate diet. Though hypovitaminosis A has been looked for elsewhere there was no evidence of gross vitamin A deficiency.¹

We found no specific skin manifestations of leprosy, which is also said to be uncommon in refugees to the USA.² **Conjunctivitis.**—In addition to the cases associated with vitamin A deficiency, 15 refugees had sterile conjunctivitis (24%); of these three adults (48%) had evidence of gross pterygium and one (16%) evidence of non-dendritic corneal ulceration.

RESPIRATORY INFECTIONS

Paragonimiasis.—One man had gross healed calcified foci in both lungs thought not to be tuberculous but more likely to be due to an old infection with *Paragonimus westermani*, which was inactive. Two children were ill enough with a coryzal infection to go to hospital.

Saw the Children's Refugee Resettlement Centre, Devizes, Wiltshire
SIMON J PHILLIPS, MB, BS, medical officer and general practitioner
RACHEL J PEARSON, SRN, SCM, resident health visitor

only and should in no way affect the general treatment and further placement of the refugees. **Hyperimmune gamma globulin** cannot be used routinely, but must be considered in cases when there are medical accidents—for example, with needles. Seven (13.4%) of our refugees were positive for HBsAg. Our two Vietnamese interpreters requested the same test and one was positive, bringing the figure for all the Vietnamese in the centre (staff and refugees) to 14.8%. Figures from other centres are given in table 11.

TABLE 11.—Percentage of Vietnamese in our refugee centres who were positive for Australia antigen

Centre	% positive
Devizes	14.8
Oxford*	11
Washington*	16
Utah	18
USA	17
Manitoba*	10-15
London	14
Canada*	12

Common diseases to which Vietnamese refugees have little immunity

UPPER RESPIRATORY TRACT INFECTIONS

We think that the incidence of URTIs (including coryza) in our refugees was comparable with that in any other group, but that the malaise and general "illness" associated with an upper respiratory tract infection was greater than in our own patients. Diphtheria should always be considered in any recently arrived patient with upper respiratory tract symptoms.^{1,4,11}

CHICKENPOX

The prodromal symptoms of chickenpox, particularly in children, were much more severe in the Vietnamese and may be similar to those of many potentially serious infectious diseases and thus problems in the differential diagnosis of illness. We had one case of varicella encephalitis requiring hospitalisation.

RUBELLA

The constitutional disturbance of both the prodromal phase and the eruptive phase are more serious in Vietnamese children than in Western children.¹² The rash is more obvious and the malaise much greater. Rubella also made the differential diagnosis of other severe communicable diseases more difficult.¹³

MEASLES

Our refugees arrived in the middle of a major measles epidemic in Devizes. We know that the Vietnamese have "severe measles," as do people from many other tropical and subtropical areas. The mortality in a recent epidemic in Hong Kong was high. We gave measles vaccine to our refugees.

POLIO

Most adult Vietnamese are immune to this disease.¹⁴ We gave oral polio vaccine to the children within 24 hours of arrival.

PERTUSSIS

In 1979-80 Britain had one of the biggest epidemics of whooping cough since immunisation began. Allowing for language difficulties, the disease seemed to be unknown to our Vietnamese and certainly

their immunity to it is an unknown quantity. Fortunately we had no cases of pertussis.

PYREXIA OF UNKNOWN ORIGIN

We had five children with rashes and temperatures. The medical and intellectual exercise is frightening because although the disease they have may be unimportant, the public health risk to the community is potentially great. This is complicated by the fact that the Vietnamese may have more severe reactions to diseases considered usual in the West. Several patients had temperatures, which were caused by virus infections. In addition to the usual differential diagnoses we have had to consider brucella and particularly malaria. We found no evidence of any of the diseases that were on our medical history sheet except for those mentioned in this article. Malaria should obviously be kept in mind in the differential diagnosis of PUO lasting indefinitely in any Vietnamese. We specifically tested as many refugees as possible for previous infection with malaria, but no figures are available. Because of its seriousness plague had to be considered, but in view of its short incubation period the supposed "closed camp" where refugees stay in Hong Kong should eliminate this problem.

Audiometry

Forty per cent of the children of school age who were tested showed a hearing loss greater than 10 decibels. The average was a loss of 30 decibels which correlated with the clinical findings of long-standing scarring eardrums. Others have reported this^{15,16} but do not mention hearing loss. Fifty per cent of adults tested had hearing loss.

Eyesight

Of the 56 refugees tested, 29% had refractive errors requiring remedial spectacles. Two (3.6%) arrived with spectacles with incorrect refraction. One young man, whose eyes had never been tested, was functionally blind with a useful focal length of less than 4". Three people had pterygium, all of whom will require surgery. We found no dendritic ulcers or toxocarosis.

Dentistry

All refugees had a dental examination, and 52% required treatment. One had a periodontal abscess. Our figures for refugees who had caries and dental treatment are similar to 20% in Washington and 36% in Utah.¹⁷ The adults in most cases had no teeth on the whole had the best teeth because of a diet that was basically vegetable and fibrous, and the children have fared worse in terms of caries because of eating sweets, particularly while in Hong Kong. Normal Western dental hygiene seems to be unknown to them.

Conclusions

In view of the fact that we had no major medical disaster, we feel that we made a right initial selection about medical treatment for our 62 Vietnamese refugees. Our particular regimen worked—we hope in the best interests of our refugees—although we appreciate that there must be other ways of making a selection. Our initial selection was based on the fact that Hong Kong is still unsatisfactory although it seems to be improving. The problems of transferring the refugees from Hong Kong and admitting them immediately into the United Kingdom are still unsatisfactory. The screening that we did in Devizes should have been the bare minimum. It is clearly in the refugees' best interests to be as free of any potential problem as it is medically possible to make them. But this is impossible to do without a full history and examination and other screening tests. Of particular clinical interest are the figures for intestinal infection and the fact that one must look for each infestation in terms of the immediate and long-term morbidity. Probably the most important single therapeutic measure is a nutritionally

Five children had intermittent bouts of wheezing bronchitis with a definite eosinophilia. X-ray changes in all cases were non-specific. This raised the question of whether they had contracted "tropical eosinophilia" caused by microfilarial migration to the lungs. This diagnosis is still in doubt but is discussed under worm infestation and eosinophilia.

VENEREAL DISEASE

We had no cases of gonorrhoea. One man had a non-specific urethritis of two years' duration that healed spontaneously. Three refugees had a positive Wassermann reaction—one man had allegedly been treated in Hong Kong, the other two were said to be negative in Hong Kong. In the women the positive WR was thought to be a false-positive associated with a very high Australia antigen titre indicating recent hepatitis B infection). In both men investigation has shown that their infection was congenital. They both had severe Herxheimer reactions when treated with penicillin. The short-term follow-up of such patients and their families may affect the timing of their resettlement. The long-term follow up is about two years. The 38-year-old wife of one of the patients with a positive WR is pregnant. She has a negative WR. We had no evidence of yaws.

OBSTETRICS AND GYNAECOLOGY

The problem of hepatitis B carriers who have recently delivered babies has been discussed.¹⁸ One baby born after the mother's arrival was diagnosed by Western standards. Three other pregnancies were complicated by moderate anaemia, in one case possibly associated with hookworms. In view of the cultural and language difficulties we agreed that all such patients in this area would be booked for a hospital delivery in a major unit.

Family planning has been offered to all. Two women arrived with an intrauterine contraceptive device in situ; one wanted this removed and to go on to the contraceptive pill, and four others requested the contraceptive pill.

NUTRITION

The figures for initial weight and weight gain after three months are given in table 1. As others found¹⁹ in general boys seem to have fared better than girls in terms of feeding. This is probably more than fortuitous.

TABLE 1.—Mean increase in weight for three months (December-January) in the refugees

	Mean increase in weight (kg)	Mean increase in weight (kg)
	Initial weight	Initial weight
Adults	3.78	7.2
Men	4.4	9.1
Women	3.18	5.3
5-16 years	2.18	10.8
Boys	2.10	10.0
Girls	2.26	11.6
Under 5 years	2.72	36.0
Boys	2.68	27.0
Girls	2.76	45.0

TABLE 11.—Number (and percentage) of refugees in Devizes centre with worm infestation and percentage in other centres

	Devizes	Washington	Utah	Q'uebec	Australia	Moreton Hall	TAMU	Illinois
	0-5	5-16	16-18	Total	All	All	All	All
No examined	11	14	37	62	62	—	—	—
Positive	1	1	22	24	24	—	—	—
Percentage positive	9.1	7.1	59.5	38.7	38.7	—	—	—
Percentage positive	0	2.14 (13)	4.21 (6)	10.16 (16)	11.6 (18)	—	—	—
Percentage positive	0	2.14 (13)	11.35 (17)	23.44 (37)	23.44 (37)	—	—	—
Percentage positive	0	2.14 (13)	11.35 (17)	23.44 (37)	23.44 (37)	—	—	—
Percentage positive	0	2.14 (13)	11.35 (17)	23.44 (37)	23.44 (37)	—	—	—

*After treatment with Pripren x2 and Vermox x1, all were clear.

adequate diet. Of general importance to their future care are the problems of hearing, eyesight, dentistry, and pyrexia of unknown origin.

The whole question of screening refugees, who must be considered because of their particular circumstances different from immigrants, has been called into doubt. We think that there are three viewpoints from which one can approach medical screening: it is in the refugees' interests to try to make them as healthy as possible so that they can meet the considerable problems that they must face in the future; or we should screen them because we have to; or we should screen them because they may be a potential menace to the health of the rest of the community. Surely, in view of the enormous psychological and cultural difficulties that they must face, should not the first policy of human obligation be the right policy?

They are wonderful people who are in a tragic predicament through no fault of their own. We wish them every happiness and good fortune in the future.

The centre opened from October 1979 until May 1980.

For their continued help and co-operation we are greatly indebted to and thank all our colleagues in all the departments and specialists that have assisted us. In particular we thank Dr John Meadows, district community physician, Bath Health District and Dr Desmond Steele, Swindon Health District and their colleagues and staff; all the consultants and colleagues from the same areas for their time and help; Dr Bill Kenward and the pathology technicians of Kennet Hospital and Salisbury General Infirmary, and Dr Paul Mann and his staff in the Public Health Laboratory at Bath; all the officers of Kennet District Council, in particular Mr Harry Johnson and his colleagues in environmental health; Dr Patrick Morgan, MBE, Communicable Disease Surveillance Centre and his colleagues for advice, encouragement.

Medical Records

Must we improve our records?

IAN TAIT

Our records in general practice stand accused of many crimes. What say we to these charges? Some maintain that there is no case to answer, that a system that has been around for so long must somehow have intrinsic merits. But most of us live with a growing sense of frustration and guilt about the state of our records, recognising that they frequently impair the quality of the care we give our patients and, more often than we like to admit, actually expose our patients to unnecessary risk.

There have been great improvements in the physical setting in which we practise and in many aspects of the organisation of general practice, but somehow, despite good intentions, our records have remained unchanged. Health centres and group

practice premises may be impressive in their architecture and handsomely appointed and equipped, but go to the record section and all too often you will find the old chaos growing daily more chaotic. Why is this so and what can we do about it? I say "we" because it really does mean "we." Improvement in our record system simply has to come out of our own efforts. For too long we have hoped for magic answers that would relieve us of the thought and work required to reorganise our records. It is now clear that salvation will not come because we introduce A4 records or problem-oriented systems or computers. All of these may help, but none of them will do so unless we have thought out what the function of our records should be and the principle that must guide any efforts to reorganise them.

Some critical questions have to be answered. What are the functions our records are required to perform in the 1980s? Can we identify minimum standards for the design and use of our records, and can we find ways to help doctors to improve their records—not just the few obsessives but the great, sane majority? This article will consider the first two questions. Later in this series general practitioners will describe some ways in which they have been successful in making their records work better.

Aldersburgh, Suffolk

IAN TAIT, MB, FRCP, general practitioner

Why we need better records

Before we can expect most general practitioners to devote time and perhaps money to the task of improving their records we have to convince them that it is necessary. The quiet assumption that what was good enough in 1960 is good enough in 1980 still prevails among us, and many would-be reformers have given up in the face of the sceptical indifference of partners who hold that view. Perhaps a few facts will convince such sceptics that clinical care in general practice is very different from what it was 20 years ago and calls therefore for a new and more appropriate response from us in relation to the kind of records we keep. The changes that have created the present crisis for our records are the result of changes both in the organisation of general practice and in the nature of our clinical work.

It is sometimes claimed that a good general practitioner knows all his patients and doesn't need records. In 1950 I did a locum for a single-handed country doctor. It was my first experience of general practice. When I arrived he was in a hurry to leave, and I suggested I could find the facts I needed about patients in the notes. "I don't keep notes," he replied, "but if you think you need them, they are in the cellar." During the next two weeks it became clear that he was a conscientious and competent doctor. I even began to believe that perhaps I could do without notes, but I certainly couldn't. The point is, of course, that the importance of proper records increases in direct relation to the number of different people who help care for patients. In practice this is a large element in the work of a GP. Group practices, rota systems, shared lists, trainees, and the extended team are all features of practice today that demand that a doctor who takes over from another doctor the responsibility for the care of a patient has available to him any essential information he needs to provide safe and efficient care.

There have also been great changes in the nature of clinical medicine that now make it almost impossible to do without adequate records. Over the past 20 years we have lived through a revolution in treatment: there have been more changes in the investigation and treatment of patients than in any previous period in the history of medicine. The range of technical investigations and the complexity of modern drug therapy regimes make it impossible for doctors to have accurate knowledge about their patients' current medical care unless there is an efficient record system to help. For most general practitioners this does not exist. Furthermore, the investigation and treatment of patients is now shared between general practitioners and hospital colleagues to a greater degree, and this requires recognition and appropriate records to support and indeed to encourage such shared care. Doctors now entering general practice are trained in modern hospital medicine and are keen to develop relationships with their hospital colleagues. The idea of shared care for hypertension, diabetes, rheumatic diseases, and malignant disease is now accepted, but the reality requires a continuous sharing of information between the practice and the hospital. This can only be achieved with the help of good records. In the past, records were often far from perfect; those in general practice are still often useless.

One final point must be raised about the need to do something positive about our records at this moment. We in general practice have loudly insisted since our entry into a branch of medicine with its own special knowledge and skills, no preparation for it can be complete without a proper in-service training. Our claims have been recognised, and starting next year all doctors should be trained in general practice. At the end of his extensive personal study of general practice in Britain in 1954 Stephen Taylor wrote: "One has reached the conclusion that the key to good general practice is the keeping of good clinical records." If that was true in 1954 how

much more is it true in 1981? Good record keeping can be taught only by example.

Function of the clinical record in general practice

If we are to decide how to improve our records a necessary first step is understanding clearly the functions that they must perform. When almost any group of general practitioners discuss this subject they come up with similar answers. Let us make it simple: first and foremost we need an adequate record to supply us with information for use during our consultations, and it must do this quickly and reliably. Secondly, our notes must allow us to share information with colleagues who help to care for our patients. Thirdly, we are also beginning to see how valuable our records can be for our own education based on audit of our own clinical performance. Finally, the research we should be achieving in general practice depends absolutely on the quality of our records. We may summarise these functions with a mnemonic:

- 1—information for the consultation;
- 2—communication with colleagues;
- 3—education and audit;
- 4—research.

Records are of course also needed for medicolegal purposes, but if records are kept that fulfil the functions listed above they will be adequate for legal purposes, which arise only rarely and nearly always unexpectedly.

For everyday purposes the vital function of the record is to provide information for the doctor to use during his consultation. If the record is designed and maintained to do this successfully the other functions will mostly be fulfilled. Let us look then in greater detail at the range of information that the record should supply for the doctor when he sees his patient. Again we may use a mnemonic:

- P—past history: personal, medical, and family;
- A—active problems: physical, psychological, and social;
- R—relevant reports: relating to active problems;
- T—treatment: drugs and current dosage;
- S—sensitivities.

It is of course necessary to define the extent of the information the general practitioner requires his records to provide. He needs enough but not too much. None of us wants to record information that we are not going to use. In the language of problem-orientation, records, what we have to do is to define a minimum data base for general practice. It is convenient to think of this data base as falling under the headings described above.

Past history must include significant events in the medical, personal, and family history. Significant in this sense means that the fact or event in question has potential or actual importance for the medical care of patients in general practice. For instance, thyrotoxicosis, the death of a spouse, or a strong family history of ischaemic heart disease are all potentially significant. I am not here primarily concerned with how these facts are collected and recorded, but a questionnaire that is completed by the patient and a summary card of important events are aids that many doctors would find effective.

Active problems—The notes should remind the doctor of the active problems needing his attention. These may be physical, psychological, or social and will also vary in other ways—for example, they may be established diagnoses or vague symptoms, or perhaps unexplained abnormal findings of which the patient is unaware. A way has to be found to express these problems so that they are easily accessible to any doctor using the notes. The use of a problem list is advocated by some, others use problem statements written in red or highlighted in some other way in the continuing notes. Whatever method is used, problems should be expressed at the doctor's honest level of understanding and should not suggest a certainty that he does not feel.

Relevant report—At the same time as being aware of the

Pitfalls in Practice

Situation vacant

I: Hiring a receptionist

JOHN OLDROYD

This article is based on an authorial presentation made for vocational training in general practice by the MSD Foundation. Further information about the consulting programme which serves to train the staff from the MSD Foundation, Tavistock House, Tavistock Square, London WC1.

Employing practice staff is difficult and needs careful thought. This story illustrates many of the mistakes that may be made.

"Brian, you will have to get a receptionist." Thus spoke Barbara Bumble, wife of Dr Brian Bumble, respected general practitioner in the town of Deerford, Muddamphshire. Barbara was despatching her husband's telephone slave, having been invited to become president of Muddamphshire Good Fanciers' Society.

This order by his wife didn't entirely displease Dr Bumble. He had realised after talking to his colleagues at the Deerford Postgraduate Centre that by not having a receptionist he wasn't quite keeping up his image as a member of the Royal College of General Practitioners. After all, he could get 70% of the money back from the family practitioner committee and the remainder was a tax expense, but he hadn't been able to think of a way of breaking the news to Barbara that he was to be made redundant. Agreement having been reached at home, Dr Bumble inserted an advert in the next weekly edition of the Muddamphshire Reporter:

Wanted for doctor's surgery in Deerford Pura. Receptionist. Hours and salary by arrangement. Apply Box 24, Reporter office, 4 Deerford Gate, Muddamphshire.

Two days after its publication, Dr Bumble received a reply in the surgery letter-box.

Rose Cottage
20 Century Road
Deerford

Dear Dr Bumble,
I saw your advertisement in this week's Reporter and thought you would like to know that I can manage it. I am at home most mornings if you want to call and let me know.
Yours faithfully,
P. Pratter (Mrs)

P.S. I should be at your surgery since Mrs Wheelwright that works at the Health Centre has told me that they haven't any jobs there.

Secretariat for London Local Medical Committee, Tavistock House North, London WC1B 6ET
JOHN OLDROYD, MR, PRCS, secretary

active problems the doctor must have all the reports and the latest information relating to those problems with which he has to concern himself in the consultation. This information may be contained in reports from hospital or elsewhere or may be in notes written by colleagues. The structure of the record should be such that hospital or laboratory reports can be filed in a way that makes them easy to find and review. Secondly, the standard format for recording consultations in the continuation notes helps other doctors to extract information (the SOAP system of recording used in problem-orientation records is an example). It is surely true that we defined for ourselves and taught our trainees a suitable method for recording clinical episodes in our continuation notes. By all means we should have flexibility, but to have no system at all is a recipe for disaster unless to anyone else. A good continuation note should allow other doctors to share all important information gained and all diagnostic and treatment plans formulated by the doctor who writes it.

Treatment—The complexity and potential dangers of drug treatment in general practice today are formidable. We should know with absolute confidence at any given time what drugs our patients are taking and in what dosage. In how many cases is this true? Too often we have to try to extract the information from the patient or his empty bottles—a humiliating and thoroughly unreliable performance. In the long-term management of patients today it is likely that drug regimens will change frequently and the dosage of drugs alter. The only way to record these changes is by using a flow sheet that allows the doctor or his ancillary staff to know what drugs the patient should be taking at what dosage. A record system that cannot do this is simply unsafe.

Sensitivities—Year by year, as more drugs are used, the problem of sensitivities and the complications of drug treatment becomes more important. General practitioners are well aware of the problem, and a variety of methods have been advocated for marking the record in some way so as to alert the doctor to the existence of a drug sensitivity. Once again we lack an agreed system that will not only inform us of known sensitivities but

also indicate the degree of risk. Furthermore, it should be possible by referring to a patient's record to be assured that he has no sensitivities—it is not enough to know that none has been recorded.

The way ahead

Discussions about improving our records too often end in disagreement about the detailed design. Record reformers quite naturally become obsessed with their particular solutions, and disagreement over details inhibits our efforts to effect change. It would be better to agree on the basic functions of the record and on what information those records should supply for us. Any record that succeeds in satisfying these criteria should then be acceptable. In this article I have tried to define the information we need using the mnemonic PARTS. Thus we should ask of any record system that a doctor examining the record is able to extract this information quickly and reliably. If this can be done the record might be said to pass the PARTS test. We should aim to make all our records do this. Just how this is achieved may reasonably be left to each doctor or practice; there is a real place for flexibility in detail, so long as essential functions are fulfilled. At the same time we must keep in mind that we have a uniform record for general practice which is used by all doctors for all patients. Such a record has great advantages in a hospital or district system such as ours. Our aim must be to agree over the basic design of our records, the method of their use, the standards that we should set for ourselves, and how we propose to maintain them. Whatever method is used, however, there are many good ideas that may help doctors to improve their records now. In the articles that follow in this series on records some of these ideas will be described by the general practitioners who use them and know them. The authors will be candid in describing the difficulties, the costs, and the extra work, but all will express a conviction that it was worth all the trouble. Those who follow these pioneers—for they are still pioneers—can learn from their failures as well as their successes.

Clinical curio

An oral antiprostaglandin agent, metamelic acid, twice produced complete and prolonged relief of the symptoms of acute urinary retention in a patient. Metamelic acid was more effective than parenteral pethidine and thus antiprostaglandin agents may be useful for treating acute urinary retention, provided that the obstruction is relieved as soon as possible.

A 60-year-old bookmaker had his first attack of severe colicky lower abdominal pain at midnight on a Saturday in October 1974. He was unable to pass urine, despite the feeling of a full bladder. He took the only analgesic available to him, metamelic acid 500 mg, by mouth. The pain subsided and he slept until 7 am, still unable to micturate. At 8 am he drove to the home of his family doctor who arranged hospital admission for acute urinary retention due to benign prostatic hyperplasia. The patient returned at 8 am and continued with frequent severe exacerbations until catheterisation three hours later. Seven days later the catheter was removed. Within four hours he was again in severe pain which lasted for 1½ hours until he received intramuscular pethidine 100 mg. This relieved the pain for only 45 minutes. A repeat catheterisation was necessary, after which he recovered uneventfully. He was discharged on no treatment four days later.

He resumed symptom free until last May when about 2 pm he had a second attack of acute urinary retention. Again he took metamelic acid 500 mg by mouth. Within 10 minutes he was free of pain and was able to drive four miles to his doctor's home. After the diagnosis was confirmed he drove 10 miles to hospital. He remained free of pain

until the retention was relieved by catheter at 6.30 pm, more than four hours after the onset of symptoms. The following morning he underwent a successful prostatectomy, and he has since remained well.

Drugs that inhibit prostaglandin synthetase may well act directly on the bladder wall. Prostaglandin E₁ and prostaglandin E₂ by their actions on specific prostaglandin receptors have been shown to increase the tone and the contractility of the bladder. The smooth muscle produces prostaglandins, which increase the tone and spontaneous activity of isolated muscle strips.¹ The prolonged analgesia this patient may have been due to the antiprostaglandin activity of metamelic acid inhibiting or reversing bladder muscle spasm. If so, metamelic acid may be useful for treating acute urinary retention, provided that the obstruction is quickly relieved. Reports of similar results with metamelic acid or other antiprostaglandin agents would be welcome, as there are no other effective oral drugs for the symptomatic treatment of acute urinary retention due to prostatic hyperplasia.—C. G. Smith, general practitioner, Gwynedd, Anglesey.

¹Khanna OP, Barber EF, McMichael R. Effect of prostaglandin on vesicourethral smooth muscle of rabbit. *Urology* 1978;12:624-631.

²Balchard MJ, et al. Clinical and experimental studies on the action of prostaglandins and their synthetic inhibitors on disease states and in vivo. *Br J Urol* 1978;60:531-7.

We will be pleased to consider for publication other interesting clinical observations made in general practice.—Ed, BMJ.

acquaintance at the Huntsman Arms, where he regularly called on his way home from the office to see his friend. It was this friend who was manager of the American Tractor concern on the industrial estate employing a good proportion of Deerford's more eligible young graduates of the county secondary college. £1.50 an hour was the figure pronounced in the Saddle Bar as being the least they could expect for anyone decent.

BUMBLE £1.45 an hour.

Bumble believed he had been very shrewd. Prudence was prevailing because she had found out from a friend at the job centre that £1.20 was the going rate.

PATTERSON Oh, yes, Oh, that's quite acceptable, doctor. I am sure you will be giving increases like other clerks get each year as well.

Bumble, who hadn't thought of this, agreed and decided that he had better get off benefits and start about duties. He knew about the telephone but was a bit vague about other duties. He had always kept his records in the surgery next to his desk.

BUMBLE Now, as to what you will have to do: there'll be the telephone to answer and dealing with the patients and their cards, of course.

PATTERSON Oh, I'll soon get into the way of it, don't you worry. I know a lot about that side of it from when I helped at the casualty at the hospital when Percy was away in the 8th Army.

BUMBLE You know about that sort of thing then? I didn't know you were a nurse.

PATTERSON Well, not really a nurse, doctor. I just helped sister run things. Well, that seems to be sorted out. I am sure we know one another well enough to trust and understand ourselves. When would you like me to start?

Prudence Pratter started the following morning. The seeds of disaster had been sown: he had already made some mistakes.

Mistakes he made

- (1) Dr Bumble lacked preparation because he failed to assess his needs.
- (2) The advert was unsuitable because it was not specific.
- (3) It was probably unwise to appoint a patient of the practice as his receptionist.
- (4) He should have waited longer for replies or indeed made

inquiries from other sources such as the secretarial college, other medical staff training agencies, and the job centre.

(5) Where should the interview have been carried out? Certainly not in an armchair on the applicant's home ground.

(6) What should the content of the interview have been?

(a) Delicacy of hours, salary, holidays, sickness entitlement, and need for confidentiality. (b) Statement of duties in some detail. These clearly may extend in this practice beyond simple reception to record keeping, keeping petty cash, and undertaking minor secretarial duties. (c) Assessment of the personality and suitability of the applicant. (d) Assessing the applicant's experience in some detail. (e) Understanding the needs and expectations of both parties.

(7) Accurate information of pay scales should have been obtained from the sources Mrs Pratter used and from local colleagues, the secretarial college, and published figures of the Whitehall Scale of Medical Secretaries, which is available from the Royal Medical Committee secretaries or from publications such as *General Practitioner*.

(8) Dr Bumble should have emphasised that Mrs Pratter was hired for a trial period. Before starting, full and adequate instructions should have been given about how to deal with telephone messages, especially the degree of responsibility Mrs Pratter should or should not have, and whether she should deal with the patients on her own.

(9) The conversation suggests that no contract of employment was going to be signed. Within 13 weeks of the start of employment the employer is required to give the employee a written statement. Forms are available from stations with appropriate headings. This statement should spell out:

- (a) the parties;
- (b) the starting date of employment;
- (c) the nature of the job and its duties;
- (d) whether previous employment counts as continuous employment;
- (e) rate of pay and intervals at which it is to be paid;
- (f) terms and conditions relating to hours of work;
- (g) entitlement to holidays and holiday pay;
- (h) arrangements in case of sickness and for retirement;
- (i) length of notice to be given on either side;
- (j) title.

(Employment Protection Act 1978; Section 1)

In the next article I will show how Dr Bumble got into difficulties and how he could have avoided them.

Clinical Curio

A patient of mine who used to drink rather a lot crashed into the back of a car at a traffic light and was charged with driving under the influence of alcohol. Could the symptoms he had recently consulted me about have caused the accident, his solicitor asked. I had tentatively diagnosed petit mal and said that it was possible but thought that alcohol was a more likely cause.

My patient, Mr A, had been driving home for lunch after his usual drinks in a pub when it happened. A policeman who saw the accident questioned him, got a stream of abuse, and arrested him. The police surgeon examined him and pronounced him unfit to drive because of drink. Mr A's solicitor then asked for a second opinion and sent for his previous general practitioner, an old friend, who smelt his breath, accepted the police surgeon's verdict, and said that there was nothing he could do. Neither doctor took a blood sample, which was not unusual years ago when this happened.

I agreed to give evidence about Mr A's petit mal at the hearing, though I did not think it would help him much. On the morning of the trial Mr A, his solicitor, a well-known barrister, and I met at the county court. Mr A was his usual charming self and did not smell of alcohol. I had noted before that he never did in the morning. The barrister glanced into the courtroom, remarked that the jury did not smell very bright, then told Mr A into a rehearsal of his case. Half-way through he seemed to ignore a question, which was repeated. He still

did not answer but stared blankly ahead for a further few seconds, seemed to had come to, and several aggressive voices, then became his normal self. The barrister looked quizzically at me. No doubt about it. Petit mal with postictic automatism. Was this what had caused the accident? Had we misjudged him? The barrister got an adjournment until the next day for further evidence. The barrister from the pub was sure that Mr A had drunk no more than his usual midday drink: one whisky and a pint of beer. A distinguished neurologist saw him that evening, agreed that petit mal could have been responsible, and would say so on court next day. The barrister cross-examined the police surgeon on the details of his examination, and the neurologist made it seem obvious that petit mal explained the accident, and the jury came in with a verdict of "not guilty." Mr A was fined a nominal sum and lost his licence on the grounds of ill health (to be restored when petit mal was shown to be stabilised), and I was not called.

Just as well, I thought, because I ought to have advised Mr A not to drive even on a tentative diagnosis. The diagnosis had been clinched only when I saw him having a drink in the barrister's room.—ANDREW SMITH, general practitioner, Newcastle upon Tyne.

We will be pleased to consider for publication other interesting clinical observations made in general practice.—Ed, BMJ.