

seed corn is at risk if excellence in academic medicine is not sustained in the United Kingdom. These include the universities, research councils, and medical research charities with their responsibilities for teaching and research; the health service with its need for better understanding of disease; and industry, particularly the pharmaceutical industry.

In particular, they need reminding that the clinical, managerial, and teaching demands placed on some clinical academics are such that they have little chance of conducting high quality research and of obtaining research funds in competition with scientists without these responsibilities. The larger medical charities have a creditable record in supporting senior posts in which research time is protected, but many branches of medical research are not directly supported by charities oriented towards a specialty or disease, or the charities are too small to support career posts.

We may hope that the heightened awareness of health

research that has followed Professor Michael Peckham's appointment as director of research and development at the Department of Health will provide a boost for academic medicine. A consensus now calls for the creation of more consultant posts to reflect the growth of specialisation and the needs of an increasingly consultant led service. Such expansion needs to be accompanied by a commensurate increase in career posts in academic medicine, and these posts must offer the same financial rewards as their full time NHS counterparts.

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## Facilitating prevention in primary care

### *Not all facilitated activities may be of benefit*

The first results of the Oxford facilitation project were published in this journal in 1984.<sup>1</sup> There are now more than 200 primary care facilitators in the United Kingdom employed either by family health services authorities or by district health authorities (Claire Lloyd, personal communication). Most are nurses with a background in community nursing. Their main tasks are to encourage good practice in prevention and the management of chronic disease and to train practice nurses. There is also an increasing band of doctors, usually known as medical advisers rather than facilitators, who are employed by family health services authorities to give personal advice to practices on prescribing policy, medical audit, and other matters.<sup>2</sup> Papers in this issue show that primary care facilitators have reached Australia and the United States. Both suggest the need for caution.

In a randomised trial of different approaches for marketing a smoking intervention kit to general practitioners Cockburn and colleagues (p 691)<sup>3</sup> found that educational facilitators cost 24 times as much as a mail shot and hardly improved the general practitioners' use of the kit.

On p 687 Dietrich and colleagues describe a randomised controlled trial in New Hampshire to assess the effect of facilitation and traditional group education on the performance in primary care of preventive procedures recommended by the National Cancer Institute.<sup>3a</sup> Help from a facilitator was associated with a significant increase in mammography, breast examination by the doctor, faecal occult blood testing, and doctors advising patients to stop smoking, examine their breasts, and eat less fat. Education alone led to an increase in only mammography. The paper confirms Fullard's report from a non-randomised trial that a facilitator providing personal contact and focusing on specific organisational problems may increase preventive activity in primary care.<sup>4</sup>

The American study also confirms that it is as easy to facilitate procedures of unproved effectiveness as those of proved effectiveness. Of the preventive procedures assessed, only cervical cytology, mammography, and advice from doctors to stop smoking are considered to be cost effective in the United Kingdom. In the case of breast cancer Day

recently concluded that, apart from mammography, "no other screening modality has been demonstrated to be of benefit."<sup>5</sup> Detecting prostatic cancer by digital rectal examination is feasible but probably does not affect survival.<sup>6</sup> The results of trials of faecal occult blood screening are awaited.<sup>7</sup> And although there is epidemiological evidence linking dietary patterns with various cancers, there is no direct evidence that advice to reduce fat intake or alter other dietary factors reduces their incidence.<sup>8</sup>

Experience of health checks suggests that enthusiasm is more easily facilitated than restraint. Anxieties about the quality, availability, and effectiveness of the interventions and the extent of follow up have been published and widely discussed<sup>9 10</sup> but do not appear to have slowed what seems increasingly like a runaway train. The effectiveness of personal contact in changing behaviour is not in question<sup>11</sup> — the pharmaceutical industry would not spend millions of pounds sending representatives to make personal contact with general practitioners if this was not effective in changing practitioners' prescribing habits. But any change in behaviour achieved by drug representatives is not necessarily beneficial to the patient or the NHS. Although the facilitators employed by the NHS may not have the same conflicts of interest as drug representatives, an adequate scientific basis for the clinical activity they are promoting may be similarly lacking.

Allsop drew attention to the *Guardian's* description of Mikhail Gorbachev as the "great facilitator" . . . a necessary but transitional figure in the process of change" and wondered whether primary care facilitators would suffer the same fate.<sup>12</sup> They probably will unless NHS managers recognise the need for formal scientific assessment of the effectiveness of the clinical activities they employ facilitators to promote. Knowledge needs to be disseminated to primary care teams, but an equal need is for clinical research in primary care to establish knowledge of what is good, effective clinical practice. Extrapolation from personal experience, or even from hospital based trials, is seldom adequate. The continuing struggle for resources to complete the two British intervention trials of the effectiveness of facilitated health checks while the runaway train speeds into the distance suggests that

this need is still not fully appreciated by politicians and NHS managers.

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## Medical response to disasters overseas

### *Accident and emergency doctors, the armed forces, the Overseas Development Administration, and the royal colleges all have a role*

Whenever medical and other facilities are overwhelmed a disaster has occurred. When there are no medical facilities disaster is inevitable. Such was the case when thousands of Kurds fled their homeland to seek refuge in the mountains of neighbouring Turkey and Iran.

There are several ways of supporting those in such dire need of help, and all entail the dispatch of personnel and equipment. The first is to wait for disaster before gathering together what personnel and equipment are available, but the delays inherent in this approach are unacceptable and the potential for ill equipped and unprepared volunteers adding to the disaster too great. Preparation and planning are essential.

Equipment could be stockpiled and teams held on standby, but the relative infrequency of demand could mean that both were still unprepared when used. Each disaster is different so the amount of equipment to be stored is potentially huge and must be continuously (and expensively) serviced and replaced. Medicines in particular have a limited shelf life. Yet the circumstances of the next disaster may require large amounts of only a few of the items so carefully and expensively stored. It is the same with people. Skills fade when not used.

A better way to prepare a response is to draw people and supplies from disciplines that use skills and equipment related to disasters every day. The accident and emergency services of the NHS encompass the breadth of training and experience necessary, and disaster planning is already part of the training of doctors working in these services. Triage of patients and managing the early stages of a wide variety of conditions on site are basic components of accident and emergency medicine. Furthermore, the specialty is well practised in working with other specialties that can be added to a core accident and emergency team to customise the response on each occasion.<sup>1,2</sup>

The NHS has large supplies of medicines, dressings, and equipment, which are constantly renewed, readily available in regional warehouses, and easily accessed by reference to published order numbers. This system has already been used successfully to provide flexible and rapid responses to disasters overseas,<sup>1,2</sup> and the stocks were swiftly replenished without detriment to the NHS. The funding organisation (in this case the Overseas Development Administration) had to pay only for what was used when it was used.

The MEDIC I accident and emergency team of the Royal Infirmary of Edinburgh has shown just how effective this response can be and reinforced the experience of others that

adding emergency medicine to the efforts of public health doctors will save the most lives.<sup>3</sup> If the idea of drawing on those who already possess the skills and equipment is accepted then logic demands the inclusion of the armed forces.<sup>4</sup> What better way to spend the peace dividend than to divert the unrivalled abilities of the British armed forces (and those of other NATO countries) towards disaster relief. Their transport, communications, quartermastering, and logistic skills could be put to no better use than complementing and reinforcing the NHS team in circumstances that would simultaneously provide them with ideal training.

Chaos inevitably follows catastrophe: its depth and duration depend on how fast order is restored. This requires co-ordination, and the British organisation best suited to this role is the Overseas Development Administration. No other organisation is as well placed to integrate government departments with voluntary agencies and non-government organisations. The minister for overseas development has publicly endorsed the pivotal role of the Overseas Development Administration, and her plan for the early dispatch of experts to disasters is a good one and will ensure that aid is targeted on need. She has responded favourably to the repeated pleas of many for a register of the whereabouts and availability of experienced medical staff.

Details of this register have yet to be published, but it will be effective only if it retains the confidence of the medical profession. The Royal College of Surgeons of England has recognised that one severely injured patient can overwhelm the facilities if taken to an inappropriate hospital.<sup>5</sup> By focusing attention on these small daily disasters it has encouraged the Department of Health to support an experimental trauma centre to begin the process of minimising chaos by planning. Were the royal colleges to consider the response to larger disasters they could ensure that any register contained the names not only of those who might want to go but also of those who really ought to go.

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