PRACTICE OBSERVED

Practice Research

Rubella prevention: two methods compared

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The considerable public concern over the consequences of the rubella epidemic in Britain during 1978 resulted in a national campaign by the Departments of Health in the United Kingdom to protect schoolgirls and adult women against rubella infection. Starting in June 1979 posters, advertisements in journals, and broadcasts aimed at increasing women's awareness of the problem of rubella infection in pregnancy were launched. In addition, all primary care doctors were asked to promote screening of women of child-bearing age for rubella antibody and to immunise those found to be susceptible.

We compared the effect of the national publicity campaign to encourage women to seek screening for rubella antibody with that of a programme conducted from a general practice in a mining town in the north of England.

Method

There were 2062 women aged 15 to 35 registered with the general practice in 1979. These women were randomly allocated by age into two roughly equal groups—experimental and control—by selecting alternate cards from an age-sex register. After the start of the national publicity campaign women in the experimental group received a postal invitation to visit the practice for rubella antibody screening and subsequent vaccination when appropriate. A second invitation was sent to those women who defaulted on the first appointment. During the same six months women in the control group received no advice about rubella prophylaxis unless they sought it, but they were of course exposed to national publicity, including posters exhibited in the practice reception area. A record was kept of all women in the experimental and control groups who spontaneously requested rubella antibody screening during that period. From February to June 1980, after the study period was over, the method

that had been applied to the experimental group was used on the control group. A State-registered nurse undertook all the counselling, serotyping, and vaccination. Samples of clotted venous blood in 2 ml tubes were posted to a central laboratory to be tested for rubella antibody titre by single radial haemolysis.¹ Samples containing less than 15 IU/l antibody were considered to show susceptibility. Within three weeks of the test each immune woman was sent a short letter confirming that she was protected against rubella infection. *Wistar RA27/3* vaccine (Amevax) was used to vaccinate susceptible women, who were invited by post to attend for vaccination during a menstrual period. Retesting was carried out four to six weeks after vaccination to estimate the effect on antibody status.¹

Results

ATTENDANCES

During the study 67 women spontaneously requested serotyping (table 1). This included 29 who were already allocated to the experi-

TABLE 1—Attendance rates of women who referred themselves for rubella screening

Age (years)	No. of women in age group	No. of women who referred themselves
Under 15	269	12 (4.2%)
15-19	289	21 (7.2%)
20-24	289	20 (6.9%)
25-29	289	20 (6.9%)
30-34	289	14 (4.8%)
35-39	141	1
Total	67	

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mental group, five girls below the age limit for the study, and four women aged over 35. Thus only 54 (3.5%) women in the study group responded to the national campaign in the absence of an invitation from the practice to attend for screening.

DISCUSSION

During 1978 there was a major rubella epidemic in the United Kingdom.² Between 4% and 20% of adult women were known to be susceptible at the time of the epidemic, the susceptibility rate among younger women having been influenced by the school immunisation programme.³ The immunisation rate among schoolgirls was reported by Peckham⁴ to vary considerably and to be no more than 70% overall.

Immunisation of seronegative adult women became a national priority in 1978,⁵ and those receiving regular family planning advice or attending antenatal clinics were considered to be particularly suitable. The 1979 rubella campaign⁶ was promoted particularly with the aim of making young adult women aware of the need for rubella protection in pregnancy.

The direct response to the national campaign by our study group was disappointing since only 58 women (3.5%) attended without invitation. But 1187 (62.3%) women came as a direct result of the invitation received from the general practitioner, and another 260 (13.6%) contacted the practice to decline screening for various reasons. Such a major difference in response to the national and local programmes suggests that a satisfactory response to other health education initiatives may be expected only when national campaigns are co-ordinated closely with local efforts.

Few women in either the experimental or control group seemed to have been influenced directly by the national campaign. Their recall of national publicity was poor. Only 23% of the experimental group reported having seen television coverage, and six months later only 6.9% of the control group could remember any television publicity. Some of the difficulties facing health educators are highlighted by the fact that 15% of the women in the experimental group failed to see the publicity in the reception area, despite having received an invitation for screening.

Many rubella programmes in general practice have concentrated on women who attend for contraceptive advice.^{1, 14} In these studies it was not reported what percentage of the base population was screened. In our study 380 (30.5%) women screened were not using any contraception and another 137 (10.9%) were using barrier methods. All would have been excluded from a programme aimed solely at users of the family planning service.

Women aged under 25 had an appreciably lower susceptibility rate than those aged 25 and over, confirming Clarke's¹⁵ finding among a more selective group of young people. Comparing the susceptibility rates that we found with those in other general practices is difficult because we used the more sensitive radial haemolysis test.¹ Zealley and Edmond¹⁶ found that the results of the haemagglutinating antibody (HA) test are variable, and this may account for Clubb et al's failure to find a trend for age and susceptibility in the group of women they examined.¹⁴ Rowlands and Bethel¹⁷ described a screening programme among women from predominantly professional social groups in whom there was no appreciable difference in immunity between the age groups 15 to 24 and 25 to 44. Since they excluded women who were known to be immune from the study, however, any real difference in susceptibility rates may have been obscured. We attempted to get an accurate history of previous rubella infection by asking each woman if she remembered an infection or vaccination. Confirmation was only occasionally found from the medical records of the general practice or local authority. No women had in their possession documentary evidence of having been immunised. When the history was correlated with serological results many women who thought that they had rubella immunity were incorrect. Since it is unlikely that vaccine immunity was lost,¹⁸ it must be presumed that some women's memory of vaccination was inaccurate and recollection of previous rubella infection appeared similarly unreliable. It is important that such histories, unless confirmed from other reliable sources, should not dissuade doctors from offering rubella screening to any young woman.

Parous women accounted for 92 (69.2%) of a total of 133 women found susceptible. Since Marshall¹⁹ has suggested that parous women are the most likely to resort to termination of pregnancy should there be a risk of rubella infection during pregnancy, it is an important preventive measure to ensure that this group are rubella immune.

Failure to vaccinate all women who are found to be susceptible is a common problem.^{1, 14, 17, 20} Twenty-seven (20.3%) susceptible women failed to attend our practice for vaccination though their records showed understandable reasons for all but 10. It has been suggested²¹ that immunisation without screening, as is done in the United States,¹⁴ would reduce susceptibility among adult women more effectively than the current policy in Britain of immunising only susceptible women, and it would overcome the problem of women who default on vaccination or who are afraid of venepuncture. Such a policy, however, could only be applied to those who use effective oral contraception. Since women who fail to return for immunisation or are dissuaded from screening by a dislike of venepuncture may be least able to use effective contraception, an immunisation without screening policy might result in more women requesting termination of pregnancy after vaccination.

At 1981 prices, excluding the cost of laboratory tests, each patient who attended the screening programme cost £34.00, of which £1 was borne directly by the general practice. Such costs may well dissuade many general practitioners from conducting similar programmes, and consideration must be given to recently suggested solutions,²² including the full reimbursement of the cost of staff who do the screening and the provision of a freepost mailing service for general practice.

In Britain at least 50 babies a year are born with evidence of intrauterine rubella infection.²³ A planned programme to contact a defined population at risk has been shown to be an effective method of protecting adult women against rubella. Planned screening by general practitioners could lead to a reduction in the incidence of infants being born damaged by the fetal rubella syndrome.

Conclusions

To compare the effect of the national campaign for rubella screening in 1979 with a screening programme in one general practice 1005 women aged 15 to 35 were randomly allocated to two groups. One group was given intensive health education about rubella; the other was in a control group against which to measure the response to the national campaign. Twelve hundred and fifty-four women attended the practice for screening, 67 in response to the national campaign; 133 (10.6%) women were susceptible to rubella when tested by single radial haemolysis; 106 susceptible women were immunised with RA27/3 vaccine. The health education programme conducted by the practice

was much more effective in reaching patients who were susceptible to rubella.

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ONE HUNDRED YEARS AGO The influence of the electric light upon the sight is a subject likely to attract much attention. Numerous observations, especially in France, lead to the undoubted conclusion that there is nothing prejudicial in the nature of the rays derived from electric light, but that, on the other hand, light may be of great benefit by reason of its superior illuminating power. Indeed, it is highly probable that many eye-diseases, myopia among others, are produced, and more are aggravated, by the strain of vision under circumstances of defective illumination. The sense of discomfort experienced even by a possessor of sound eyesight, who reads for some time in the dim twilight, will demonstrate to anyone the probability of what we have said. On the other hand, there is a risk attendant on the use of electric light in the home. Practically this is effective only in the case of those whose occupations in connection with electricity lead them into close relation with the light; but, even

in such cases, the resulting inflammations, whether of the iris or conjunctiva, are neither grave nor lasting. And, in the not so distant days of electric house-illumination, the companies may be trusted, if only for the sake of their own credit, to see that no serious injury to the general public by an excessive supply of light. It may, however, conduce to the peace of mind of nervous persons to know that, even in such a case, glasses, worn by those who give relief. We must remember, however, that electric lighting is still in its infancy. Future scientific improvements may be trusted to remove what now is a more serious drawback to the light in an hygienic point of view than that of which we have spoken, viz, its unreliability. This once palliated, we shall find direct benefit, not only from the more perfect illumination of the interior, but also from the fact that the light, being so placed, that the eyes are protected, especially in near work, from their direct rays. (*British Medical Journal*, 1882.)

The attendance rates in response to the invitation by the women in the experimental, and subsequently the control, groups are shown in table 11. The postal service returned 157 letters—a problem with the age-sex register that was reported by Forbes.⁵ Overall, 1187 out of 1905 (62.3%) responded to a request to attend. The experimental and control groups were similar in social class distribution (predominantly social classes III and IV), marital status, and parity. The age distribution for women in the practice was similar to the national population. In the 15 to 19-year-olds there was a significant difference ($\chi^2=11.572$, $p=0.01$) in attendance rates between the experimental and control groups.

TABLE 11—Attendance rates for rubella screening in response to invitation

Age (years)	Experimental group No. in age group	Percentage who attended	Control group No. in age group	Percentage who attended
Under 15	165	69.7	124	90.0
15-19	165	88.5	189	86.2
20-24	165	85.5	231	86.2
25-29	165	85.5	231	86.2
30-34	165	85.5	231	86.2
35-39	165	85.5	231	86.2
Total	963	85.1	942	89.4

SUSCEPTIBILITY TO RUBELLA

We assumed that women aged up to 24 in the two study groups had been offered vaccination at school, rubella vaccination having begun in British schools in late 1970. There was a significant change in the rate of susceptibility between the age groups 15 to 24 and 25 to 40 ($\chi^2=12.650$, $p=0.01$) (table 11).

TABLE 12—Rubella susceptibility for all women who attended

Age	Percentage susceptible	No. of women who attended
Under 15	40.0	5
15-19	9.8	189
20-24	6.4	295
25-29	13.0	323
30-34	13.0	323
35-39	15.5	344
Overall susceptibility rate	10.6	
Mean age of women who attended	28.2 years	
Mean age of susceptible women	27.7 years	

There was no significant correlation between a previous history of infection or vaccination and immunity to rubella. Fourteen (10.5%) of the susceptible women thought that they had been immunised, and another 15 (11.4%) were unsure about previous immunisation. Fifty-seven (50.4%) of the susceptible women thought that they may have had a rubella infection.

VACCINATION FAILURE

Of 133 women identified as susceptible, 106 (79.7%) accepted vaccination. Twenty-seven women failed to attend for vaccination despite three letters inviting them to do so, but an examination of their medical records gave possible explanations for failure to attend for all but 10 (table IV).

TABLE 13—Reasons for susceptible women failing to return for vaccination (n=27)

Reason	No. of women
One partner sterile or awaiting sterilisation	9
Plan for more children	2
Attempting to become pregnant	2
Immunity (by health)	2
Pregnancy awaiting immunisation	1
Moved to another area	1
No apparent reason	10
Mean age of susceptible women	27.7 years
Mean age of women who failed to return for vaccination	27.6 years

Organising a Practice

A case against deputising services

PAUL A CREIGHTON

In this article I say why I believe that general practitioners who use deputising services are doing a disservice to their patients and to general practice as a whole. I believe that personal care is the best care that general practitioners have to offer, and as most people and their doctors live in relatively stable communities then personal care can be provided if general practitioners have a mind to do so. I concede that practising in inner cities is difficult, for many well known reasons, and that some form of organised deputising service may well be necessary.

My practice

My four partners and I look after 11 000 patients in two small mining communities in Northumberland. We work our own practice route, which means that we are each on duty one night a week and one weekend in five. In no way could the deputising service match the care that we give our patients out-of-hours. I am not saying that the deputising service could not provide adequate cover for our patients, but they could not match our care. If they could not match our care that means that they would be second best, and the time for second best in general practice has passed. A deputising service could not match our local knowledge, could not match our experience, and could not match our commitment; in other words, deputies could not match our practice of the art of general practice, though they might very well match our clinical knowledge.

Personal and continuing care

General practitioners must return to the concept of real continuity of care. Those who are in favour of deputising services say that loss of continuity of care results from using deputising services is not a valid argument because on average the patient who calls out-of-hours is not seen by his own doctor anyway.¹ But this argument applies to a lot of patients seen during the day as well. By a right, to control our practice route, which means that we are each on duty one night a week and one weekend in five. In no way could the deputising service match the care that we give our patients out-of-hours. I am not saying that the deputising service could not provide adequate cover for our patients, but they could not match our care. If they could not match our care that means that they would be second best, and the time for second best in general practice has passed. A deputising service could not match our local knowledge, could not match our experience, and could not match our commitment; in other words, deputies could not match our practice of the art of general practice, though they might very well match our clinical knowledge.

Deputising services are an expansion of this "product" image of medical care, and patients are much more likely to show good will towards their own doctor than towards such a system. Group practice can achieve personal care by ensuring that patients know who their doctor is and then ensuring that this doctor is readily available to them. Continuity of care is inbuilt in such a system. Having been to see a patient of one of our partners in the night, I should then pass the future management of that patient back to his own doctor. A few words between partners outlining the circumstances of any night visit can do much more to convey the nature of the night call than even the most detailed case notes. Knowing the likely actions of one's partners means that one can tell the patient what is likely to happen when his own doctor revisits later on, and this surely builds up the patient's confidence not only towards his own doctor but also towards the partners as well.

Our out-of-hours work load is largely dependent on the good will of our patients, and to an extent general practitioners have lost the good will of a minority of their patients. How to regain this good will is something to which we should all apply ourselves. Dealing in person with emergencies at night increases the appreciation that the patient has for the doctor and what he is trying to do, and local gossip will spread this appreciation to the patient's family, friends, and neighbours.

Lessons from Denmark

In Denmark the spread of deputising services has been encouraged by the medical profession. There, deputising services operate exclusively in quite small towns between the hours of 6 pm and 8 am and at weekends. All the deputising services share the same telephone number, which is widely published so there is no confusion when trying to obtain the doctor for an out-of-hours call.² This expansion of the deputising service is twofold. Firstly, it has meant that there is a dual system of medical care readily available to all the patients—that is, a general practitioner in his surgery with back-up and ancillary staff and a quite separate out-of-hours system where the doctor will come and see you at home. The second effect is that there has been a relatively massive increase in the number of out-of-hours calls received by the deputising service in Denmark compared with the number of out-of-hours calls received by general practitioners in Britain.³ The demand for immediate attention to every symptom every time has led general practitioners to a concept of medicine towards which they cannot meet this demand. In the eyes of the public and the politicians this demand must be met. The experience in Denmark suggests that if the demand for medical care is met then the demand for medical care will continue to increase and I suggest that the adage has been proved over and over in the National Health Service. The way to cope with the increasing demand for out-of-hours services is to try and reduce the demand, not to introduce a system that leads to an ever-increasing out-of-hours work load.

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Quality of care

When we were doing vocational training we used to dream of a time when remuneration and quality of care were matched. We used to point our fingers at bad doctors with immense lists of patients and lock-up surgeries who had many outside commitments and who appeared in their practices to meet the minimal requirements, and we noted how these doctors earned large salaries in comparison to the doctor who tried to spend all his time and effort caring for a reasonable number of patients. The Review Body has recently tried to introduce the concept of extra payment for doctors who do their own night work.¹ Surely this is a step in the right direction. Surely it recognises at last that remuneration and the quality of care should be linked. This is an opportunity that should be welcomed with open arms by the profession—and to my astonishment our negotiators turned against this idea of the Review Body. Surely there are some doctors on our negotiating teams who do not use deputising services who can champion this cause.

When doctors are paid for the quality of care they provide and when we agree what is good quality of care, then I think the deputising services will disappear. The occasional trainees of today who have seen general practice and the deputising services from both sides of the hospital/general practice fence will hasten their demise when they take up their posts as principals. Certainly my vocational training created the suspicion that I had had as a pre-registration houseman—that patients admitted to hospital from the deputising services were by and large not getting as good a deal from the Health Service as those patients who were looked after by their own general practitioners. I think that this view is still generally held by junior hospital doctors.

Doctors who are in favour of deputising services argue that they need to be brightly-eyed and bushy-tailed every morning so that they can devote themselves to their patients in a proper fashion. The use of deputising services is diametrically opposed to my concept of devotion to patients, and arguments about mental freshness are solely a justification for doing less work. Devotees of deputising services compare their hours of work with lorry drivers' and menders of washing machines, and yet surely it is the very nature of our profession that we do work harder and for longer hours and because of this attract a respect, a place in society, and remuneration greater than the majority of our fellows.

Best use of the Health Service

I believe that if these principles are accepted the result will be better care for the patient, less demand for the doctor, and a great improvement in the working relationship between doctors and patients. But even if all these principles were applied there is still likely to be a minority of patients who care nothing for the disruption caused to the doctor's life by trivial out-of-hours calls. The way to preserve the relationship between doctors and such patients is to educate everybody concerned in the use of the Health Service. We as doctors are not good teachers, despite the word "doctor" meaning "teacher." Balancing the expectations of patients against the most efficient way of using the Health Service needs urgent attention and as doctors have obviously failed in this educative task (with some notable exceptions) the task must be placed in the hands of professionals who are able to do it. Doctors would obviously be closely concerned with the content of such education, but the process of getting it across may be better put in the hands of experts in the art of educating the public. Whether this task is taken on nationally, regionally, or at practice level is a matter for debate.

I argue from the point of view of someone who practices in an area where deputising services are not available, and yet by applying some of the concepts discussed above out-of-hours calls in our practice average two a night and calls between

I am and 7 am average one a week. Thus with a five-man practice with 11 000 patients, mainly of social classes III to V in a mixed urban/rural area, each partner is called out of his bed once a month. If these figures were returned nationally we would have no real need for deputising services, and personal and continuing care would flourish.

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ONE HUNDRED YEARS AGO The profession will be grateful to the National Health Service for endeavouring to demonstrate the evils of tight lacing to popular audiences. I fear, however, that Mr Treves, in his enthusiasm, has taken a little too cavalierly from an aesthetic point of view. I should be very sorry if anything I said could be looked on as a discouragement to tight lacing by his colleagues, but still I think we should take them into our councils, and discuss the subject in all its bearings with moderation. I think that Mr Treves fell into an important error when he assumed that the primary use of dressing was to cover the body and maintain an equable temperature; and again, when he asserted that a small waist in a draped figure is ugly, and offends our sense of the beautiful in the human form. Now, all anthropologists agree that the primary object of dress is decoration, and this is still the only object of dress in probably a third of the human race. It is an instinct of which the physiologist takes no note, but nevertheless is as potent in High Street, Kensington, as in the centre of Africa or the provinces of North America. The decorative use of dress is not only a fact, but the first fact to be taken into consideration by reformers of the dress of the period. Again, it is idle to attempt to convince women that small waists are ugly, by comparing them with casts of nude figures of ideal proportions. Comparisons are odious, and this is a supremely odious one to women, and, moreover, a very unfair one; drag the figure, and see what becomes of its grand proportions. A custom which is so general must have some reason *d'être*, although women cannot explain it. Some women think that men admire small waists; and, until the question is decided by a vote by ballot, they will not believe otherwise. In truth, small waists in draped figures are the result of the law of proportion, which is at the bottom of our sense of the beautiful, not only in the human form, but in all other objects. Professor Zeising, to whom we owe the discovery of this law, states it thus: "If the divisions of a whole (made up of unequal parts) appear proportional, the smaller part will bear the same relation to the larger than the larger does to the whole." Now the waist forms the division of the body which gives these proportions. Thus, if we take a well proportioned figure, and represent its total height by 1000, we shall find the portion below the waist is represented by 618, and the portion above it by 382 parts, and 382 is to 618 what 618 is to 1000. Zeising's law applies equally well to the hand, the head, the arm, and the leg, and, indeed, to all animate and inanimate objects which appear proportional to us. But in some nude figures, the proportional division is not at the waist, but at the knees. In the Venus de Medici, where the arms are folded across the body, this is the case; hence the charm of young girls with short skirts and no waists (and perhaps of men in frock coats). The shorter the skirts in children, the better the proportion appears; but as they grow up, and their skirts are lengthened, a new division line becomes necessary, and the waist is constricted accordingly. The dress reformers should, therefore, bear in mind that dressing is the instinct of decorating the body, and that a small waist is the result of a law of nature; but within these limits there is ample room for their efforts for improvement; many dresses are fantastic and in bad taste, and small waists are certainly not much to be recommended from an aesthetic point of view. (*British Medical Journal*, 1882.)

language must be kept very simple—but there are now many leaflets specifically designed for use in the consultation—for example, the "Give up Smoking" leaflet available from the Health Education Council.

Extending initiatives taken during the consultation

Some general practitioners acknowledge the importance of preventive advice but feel that their consultations are inevitably so brief that it is difficult for them to do more than to present other than the presenting problem. Much preventive advice, however, can be given very quickly, and initiatives taken in the consultation can be extended by other practice staff.

All members of the practice team should agree a list of priorities that may be reviewed at intervals. Initial objectives might include advice about smoking and rubella, and flu immunisation. Each member of the practice can then develop his or her own contribution. In the consultation the main task is to identify preventive opportunities. Other staff members may then give further advice or carry out specific procedures—either at the same visit or later. The receptionist can supply appropriate literature, and ensure that details of preventive action are entered in the patients' records, and the practice nurse can carry out immunisations, teach breast self-examination, or check blood pressures. The health visitor already has a

general responsibility for giving preventive advice to patients but also can reinforce specific advice given during the consultation. The most important step, however, is for every member of the practice to develop a sensitivity for preventive opportunities at each and every contact with patients.

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The GP and the Specialist

Dermatology

LIONEL FRY

Dermatology still baffles many general practitioners, and this probably reflects the lack of tuition and the way that dermatology is taught at both undergraduate and postgraduate levels. The fault cannot be placed at the door of the dermatologists alone: those who plan the undergraduate curriculum and postgraduate training schemes for general practitioners are also to blame. Dermatology also suffers because the body can function reasonably well when the skin is affected by disease, as opposed to organs such as the heart and nervous system, and thus dermatology tends to be considered of less importance than other specialties.

Common mistakes

NAILS

Patients with an abnormality of the nails are commonly referred by GPs to the skin clinic, and this abnormality is usually diagnosed and often treated as a ringworm fungal infection or oral griseofulvin before the patient attends hospital. Abnormalities of the nails commonly occur in psoriasis and eczema, and may

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RASHES IN THE GROIN

Rashes in the groin are common, and in most patients they are either eczematous (intertrigo) or due to a fungal infection (ringworm or *Candida albicans*). As a rule eczematous rashes do not take kindly to antifungal topical preparations, and fungal infections usually spread more rapidly with topical steroids. Topical preparations containing both steroids and antifungal agents do not seem to be the answer. If in doubt, the old fashioned paints, particularly magenta, seem to be effective but remember to warn the patient about the paint staining underclothes.

It is important to establish the correct diagnosis either on

Practising Prevention

Opportunities for prevention: the consultation

S A SMALL

Since the inception of the Health Service strategies for preventive care in general practice have often centred on establishing special screening programmes or clinics, such as cervical cytology or well-baby clinics. Yet many doctors now appreciate the wide potential for preventive care that exists in every consultation. About 75% of patients consult at least once every year,¹ and nearly all patients are seen at least once every five years. Patients not only trust their own doctor's general advice about health but also they expect more explanation and discussion in the consultation.² Patients are therefore receptive to advice about prevention during the consultation. Indeed, the "illness interview" may be the only opportunity to discuss prevention with those patients who are unlikely ever to attend special clinics set up to provide preventive or anticipatory care.

Perceiving opportunities

The most obvious examples of preventive care are those related to the problem presented by the patient. Doctors feel most comfortable discussing secondary prevention (screening) and tertiary prevention (treatment), though by inclination and training they may still find it easier to reach for the prescription pad rather than discuss preventive action with the patient. Yet patients can only avoid recurrence of problems as diverse as baccache, nutritional anaemia, or attacks of gout if they fully understand the cause of the condition and ways to avoid it. Such explanation and advice has been called "patient education," and its importance in primary care is now widely recognised, particularly in the USA,³ though it is neglected surprisingly often by British general practitioners. Patients readily accept this type of advice and invariably recognise its value.

There are opportunities for preventive care that are quite unrelated to the presenting problem in nearly every consultation.⁴ Doctors often feel diffident about discussing primary prevention or health promotion with patients. Nevertheless, patients appear to appreciate such advice and there is some evidence that it is effective. It is easy to persuade a patient who has a chest infection or who has recently suffered a myocardial infarction to give up smoking, but few actually do it. Patients may also be achieved by giving the simple advice to stop smoking to all smokers, whether or not they have consulted with a problem related to smoking.⁵ Other opportunities might include advice about exercise, or contraception.

Specific screening or case-finding procedures may be carried out during consultations. Most general practitioners now refuse that patients over 35 years of age should be screened for hypertension during the consultation, but few actually do it. Patients may also be advised about immunisation or cervical cytology—

preventive care that has the added advantage of being potentially profitable for the practice. Although immunisation of infants is generally carried out routinely it is easy to forget that middle-aged and elderly patients may never have had a primary course of tetanus toxoid injections.

Perhaps the best opportunities for offering advice are when patients consult for preventive care—for an antenatal visit or for immunisation—when other topics of primary or secondary prevention can easily be introduced. An initial routine contraceptive advice presents a wide range of possibilities and may require discussion of several of the following points:

- attitude to and knowledge of contraception, conception, and venereal disease;
- smoking (particularly in relation to sexual contraception);
- rubella immunity;
- cervical cytology;
- breast self-examination;
- diet;
- potential risks of genetic disease.

Communicating with the patient

The patient is most likely to accept preventive advice if he (or she) feels that the doctor has fully understood his problem. This is only possible if the doctor has taken the trouble to find out the patient's views and beliefs about health and disease. The patient can then be given advice that is congruent with his or her own beliefs, and there is less risk that the advice will be inappropriate. There are dangers in an over-enthusiastic approach to preventive care, particularly if the doctor gives a great deal of heavy-handed or pushy advice. There is some risk of alienating the patient, but this can be avoided by showing sensitivity to the patient's own views. After discussion with the patient it is important for the doctor to check that the patient fully understands what he has said. Although patients obviously need to understand advice before either accepting it or acting on it, in fact it is unusual for doctors to check patients' understanding of advice given.

Thus it is essential to ensure that there is sufficient two-way communication in the consultation if preventive advice is to be successful. Many general practitioners feel that they possess ample innate skills in communication, but there is evidence that although a large part of the consultation may be spent in "exposition" to the patient, much of the communication is one-way from doctor to patient and may leave patients confused.⁶ Doctors can, however, improve their skills in communication, particularly if they use audio or video recordings of their consultations to provide feedback of their own performance.⁷ This should improve the effectiveness of any preventive advice given during the consultation.

To reinforce the points made the patient can be given a simple leaflet so that he or she may refer to it later, knowing that the contents carry the doctor's approval. Practices may wish to design their own leaflets⁸—remembering that the

clinical grounds with the help of the laboratory before starting treatment.

ACNE

One of the commonest mistakes still made by general practitioners is that when antibiotics are used in the treatment of acne they are not given for a sufficient time. Most antibiotics take a month to six weeks to have an effect on acne, and giving antibiotics for less than this time is of no value. Improvement of acne with antibiotic treatment is slow and may continue for up to six months. Many dermatologists consider this as an average duration for treatment.

TOPICAL STEROIDS

Topical steroids have revolutionised the treatment of skin diseases over the past three decades, but over the past few years there has been a swing away from their use. Many GPs are undoubtedly reluctant to use topical steroids, particularly the strong ones. I think that this is wrong and deprives patients of the good results that can be obtained with these drugs. If topical steroids are used correctly they are safe, irrespective of the strength. The important points to remember are that side effects are dependent on the duration of use and the strength of the steroid. Thus, using a potent steroid for a short duration is usually safe and often produces results, whereas using a weak topical steroid indefinitely does not. Side effects are also related to the thickness and moisture of the skin. If the thinner the skin the greater the risk. As a general rule strong topical steroids should not be used on the face or the intertriginous areas. Finally, some patients seem to have an idiosyncrasy to moderately strong topical steroids: usually young women with seborrhoeic eczema on the face. After using topical steroids they may develop a papular and pustular eruption around the mouth, known as circumoral dermatitis.

THE REFERRAL LETTER

Most patients who have a rash will have come to the problem before referral to hospital. Because such treatments may modify the eruption it is important that the dermatologist is aware of previous treatment. A dermatological history is not complete without knowing what treatment has been given to the patient. Many GPs who are not sure of the original diagnosis are reluctant to reveal their ignorance by stating what they have prescribed. Patients seem to realise more than the doctor that it is im-

ONE HUNDRED YEARS AGO Among the cabinets of Messrs Harrison and Beaz (Victoria Carriage Works, Elgin and Inverness) at the Crystal Palace are the "Acme Medical Car," and the "Improved Sanspareil Car," which appear specially adapted to the requirements of medical profession. The principal feature of the "Acme Medical Car," is its easy accessibility, the back seat being on a level with the bottom of the vehicle, while this seat, with the back rest, will fold down and slide under the body of the car, which (the foot-board closing up) is thus converted into a gig. The "Acme Medical Car" is fitted with hand drag, folding leather hood, lamps, and loose apron, and weighs under 4 cwt, being as light as an American buggy, while possessing the great advantage of a full lock. The wheels are of hickory, the tires and body plates of steel, the springs (Armstrong's patent) extremely easy, and the axles (Daker's patent) require no washers, being fitted with a spiral spring at back of the dustpan, and another between the nut and the collet. Thus, not only is the expense of the constant renewal of washers avoided, but the inevitable consequent on a wheel getting into a rut is greatly lessened. The "Sanspareil Car" is fitted with a single axle spring placed transversely, while a spring

important for the dermatologist to be aware of previous treatment, and they often bring a plastic bag with an assortment of ointments that they have already used. These may be topical steroids ranging from weak to strong, topical antibacterial and antifungal preparations, and oral antihistamines to relieve the itch.

What the dermatologist has to offer

It is accepted by the GP, the dermatologist, and sometimes the patient that in some instances patients cannot be cured. The dermatologist's role may be divided into the following three categories.

CLINICAL DIAGNOSIS

With his specialised knowledge and clinical experience the dermatologist may be able to make the diagnosis when the GP has not. This is important so that the prognosis can be given even if the cure cannot. The dermatologist's role is often to give the "second opinion." It is not unreasonable if a patient with persistent endogenous eczema or psoriasis wishes a second opinion of the diagnosis and management of their problem.

INVESTIGATIONS

Dermatology is still a clinical specialty and is not so dependent on extensive investigations as other specialties. However, biopsies and mycological, bacteriological, and virological studies are sometimes necessary to diagnose or confirm the diagnosis.

Patch tests for eczema are helpful for identifying allergens and for advising patients what substances to avoid. The techniques for doing patch tests have improved over the years, and it is important that these tests are carried out by an expert. Patch tests are also helpful in a negative sense: many patients think that their rash is caused by an allergy, and until they have the tests to disprove this no amount of reassurance will convince them.

TREATMENT

Obviously, until the correct diagnosis has been made it is difficult to give appropriate treatment. The "try this" approach is all too common in dermatology. The dermatology department also has specialised treatments, notably phototherapy (PUVA), to offer in certain cases.

Anonymous calls

I seek suggestions on how to deal with the following problem. For some years, when on call at night I have been regularly telephoned by somebody who, after about five seconds without saying anything, puts the receiver down. This may happen three or four times throughout the night. The telephone exchange say that they cannot do anything as my night roster with four colleagues is not regular or constant. Clearly, changing my practice number is no solution, nor can it be intercepted unless it is left open constantly, even when I am not on duty for the practice.—P H SCHOFFER, general practitioner, Health Centre, Rodney Road, Walton-on-Thames KT12 5LB.