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and alcohol; (ii) regular weighing; (iii) avoiding eating between meals—"nibbling" should be of fresh fruit or nuts; (iv) awareness of the relation between individual energy intake, expenditure, and storage (fat); (v) motivation.

Summary

- (1) There should be a simple, standard approach to diet.
- (2) The main task is to avoid obesity. Energy intake should be adjusted to maintain optimal body weight (as defined by life insurance statistics or calculation of body mass index).
- (3) Average sugar intake should be halved. This means cutting down on sweets, chocolates, puddings, soft drinks, and sweetened beverages.
- (4) Fat intake should be reduced to about 30% (from an average now of about 40%) of energy intake and the reduction should be of "saturated" fats. This means cutting down visible fats—for example, butter, margarine, cream, fat on meat, and fried foods.
- (5) Intake of fibre should be increased to about 30 g a day (from an average now of about 20 g), and this should be from whole grain cereals.
- (6) Salt intake should be halved. Adding salt should be discouraged.
- (7) Alcohol intake should be reduced to not more than two "units" (pints of beer/glasses of wine or spirits) a day.

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Free literature

Sample literature on diets. *Fat—what made it?* and *Fibre in your food* are available from the Health Education Council, 78 New Oxford Street, London WC1A 1AH, and from local health education units.

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titution has notified the authority of the danger, preferably in writing, he should be exonerated from liability if an accident does occur. He should, however, also follow up his letter to check that action was being taken by the authority. (Liability would fall on the authority under the Defective Premises Act 1972 and the Health and Safety at Work Act, since it is both the owner of the premises and those in control of maintenance who are responsible.) Similar provisions may arise where premises are rented from a private landlord. It may be advisable for a general practitioner to examine the licence or lease under which he holds the premises to clarify whose burden it is to maintain specific parts of the premises. The staff also have a responsibility to report any risks to health and safety.

A practice may not be exonerated of all responsibility for the safety of their premises, even if they are not the owners; they may be held responsible for hazards such as highly polished and slippery floors and unsafe electrical fix. But if the doctor is responsible for maintaining the premises he must concern himself with other parts, including, for example, the condition of steps and stairways, floors, and windows for a newer activity—retirement.

The Act also states that, as far as is reasonably practicable, the employer must provide and maintain a working environment for his employees that is without risks to health, with adequate provision for their general welfare. The wording appears to apply to more than just the physical environment of the workplace. Here a practice would be well advised to consider whether there is an adequate rest room, refreshment facilities, and toilet and washing arrangements, etc. Again, the extent to which this can be done must depend on the practice's resources.

Safety representatives and safety officers

Not all practices will have safety representatives and safety committees. These are normally appointed only when there are more than one employer, however—for example, health centres—they will normally be required. Employer safety representatives can inspect the workplace, investigate accidents, make representations to the general practitioner, and also insist on a joint safety committee being appointed. Safety representatives have the legal right to change an employee on all matters affecting health and safety standards in the workplace.

But the Health and Safety Commission have recommended that similar arrangements for safety committees and safety representatives should be made even if staff are not unionised. The Health and Safety Commission think that since both the employer and employee share a statutory duty to ensure the health, safety, and welfare at work of all an employer may find it helpful if employees contribute to the development and improvement of health and safety procedures. The Commission have therefore recommended that in non-unionised workplaces the employer should set up a safety committee drawn from both management and staff. This is hardly practicable in a small practice, so the general practitioner may prefer to nominate a member of his staff to serve as the "safety officer" and monitor standards. The practice manager could well undertake this duty. The "safety officer" should report to the general practitioner who is the "controller" of the premises.

This is the first of a three-part article on the Health and Safety at Work Act.

Law and the General Practitioner

Health and Safety at Work Act 1974: GP's duties to staff

ANNE CULLINAN, NORMAN ELLIS

For some time general practitioners could assume that legislation on health and safety at work simply need not worry them. But some general practitioners have been surprised by a visit to their premises by a health and safety inspector. The obligations laid down on the employer by the Health and Safety at Work Act etc are not onerous. Most general practitioners undoubtedly occupy premises that meet with the requirements of the legislation, and apart from a few mostly technical matters there is little in this new legislation that should cause concern. Nevertheless it may be helpful to explain the responsibilities laid on the employer, if only to forewarn general practitioners of some matters that an inspector may raise.

The 1974 Health and Safety at Work Act is not just another Factory Act. It lays down a new approach to occupational health, safety, and welfare, and it applies to many premises that are not covered by previous legislation, including laboratories, hospitals, and general practice surgeries. Although the occupiers of these

premises already owed their visitors the "common duty of care," as laid down in the 1957 Occupier's Liability Act, this duty only required reasonable precautions to be taken for their wellbeing and was far less onerous than the duties of many employers to their employees as specified in Factory Acts, the Offices, Shops, and Railway Premises Act, and the Mines and Quarries Act. The new Health and Safety Act, combining the Factory Inspectorate and other central Government inspectorate, is responsible to the Health and Safety Commission. Local authority environmental health officers inspect premises and enforce the legislation in the non-industrial sector, and they follow guidance from the Commission. Because general practitioners' premises are grouped with hospitals and laboratories in the category of "health services" it is the Health and Safety Executive that inspects their premises.

The Act lays down new duties on employers (including the self-employed) to provide and maintain a safe place of work. It establishes new powers and penalties to enforce safety laws, and its aim is to make all employers and employees aware of the need for safety at the place of work. Although much of this legislation is concerned with employers who already recognise trade unions—there is a requirement to appoint union safety representatives and establish a safety committee if requested to do so—even general practitioners who have only a few employees and do not recognise trade unions have duties to fulfil.

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Seaside Practice

Bexhill: retirement haven

J H EMMANUEL

Bexhill-on-Sea is a seaside town on the south coast, nestling quietly between the more celebrated resorts of Eastbourne and Hastings. In its Victorian heyday it was a fashionable resort in its own right. Now, however, its clean air, benign climate, and flat, wide promenade make it famous for a newer activity—retirement. The imposing seafront hotels that once accommodated the rich and famous at what have now been converted to house permanently elderly residents, most of them widowed and far from any other members of their families. This is surely the capital of the "Costa Geriatrica." Like all good graffiti, the oft-quoted slogan "Dover for the Continent, Bexhill for the Incontinent" contains a sharp but cruel ring of truth.

This predilection for retirement to Bexhill has led to appreciable age imbalance in the town, and therefore in the practice. Of my personal list of 2800 patients, 34% are over 65 years of age (more than twice the national average). Almost half of these are 75 years or older. Just these few statistics point up the potential problems for the general practitioner who has to organise primary medical care for his patients.

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Some difficulties

Several features distinguish geriatric practice from practice among a predominantly younger population. Firstly, some medical conditions are almost unique to the elderly—polymyalgia rheumatica, Stokes-Adams attacks, and brain failure, to name a few. Secondly, the elderly patient frequently presents with disease or degenerative changes in several body systems. Thus, a chest infection may lead on to mental confusion, incontinence, and heart failure; the patient deteriorates from a functioning, independent citizen to a major management problem within 48 hours. The elderly patient with arthritis will soon start falling about as if her Parkinson's disease or cataracts are allowed to develop too far without timely medical intervention. Finally, social isolation is extremely prevalent in this sort of population and commonly has a devastating effect on the patient's ability to lead a fulfilling, independent existence. This factor is exacerbated by the popular dream of retiring to a bungalow by the sea. Sadly, so many couples find that having achieved this long awaited ambition they miss their life-long friends and family, and find it difficult to make a new social life. If one spouse soon becomes ill or even dies, one has the makings of a social catastrophe.

In summary, the elderly patient epitomises the need to consider what Marinker calls "the triple diagnosis," for in this

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General practitioner's duties to his staff

The most important duties laid down in the Act are those of an employer to an employee. (The general practitioner has an ancillary staff who are employed by a health authority have other lesser duties.) The Act states: "It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety, and welfare at work of all his employees." Thus the general practitioner is required to do all that is reasonably practicable to ensure the safety of his employees. Any proceedings that may be taken under the Act are criminal. An employee can report a breach of the employer's statutory duty under the Act to the Health and Safety Executive, who may bring criminal charges. Although the Act does not in itself confer a right of civil action on the employee, it does not prevent the employee, if injured, suing the employer for being in breach of his liability as an employer or for negligence under the common law.

What is reasonably practicable?

In assessing whether it was reasonably practicable for a general practitioner to avoid a specific hazard or risk of injury a court may well look at the cost of any preventive measures, particularly if the general practitioner's resources are limited, and weigh this against the risk of personal injury and its likely severity. Thus, a larger practice may have a heavier burden imposed than one with fewer resources.

The Act requires that all equipment and systems of work must be safe and without risk to health. This includes waste-bins, sterilisers, photocopying machines, electric fires, electric typewriters, furniture, fire extinguishers, plugs, and any other potentially hazardous equipment. Importance is attached to the maintenance and renewal of equipment, and inspectors are particularly concerned about the arrangements for regular servicing. Attention is also paid to the age, reliability, appropriateness, and position of equipment.

Safe systems of working must be understood and used by all persons. Obvious examples include ensuring that staff do not lift heavy weights without help if there is a risk of back injury; that arrangements are made for the safe disposal of clinical waste, and that care is taken in storing flammable liquids, materials (such as paper), and drugs.

Any offences under the Medicines Acts, the Poisons Acts, or the Misuse of Drugs Act 1971, lie outside the remit of the Health and Safety at Work Act. So any unauthorised access to drugs is more likely to be of interest to the Home Office than the Health and Safety Executive.

Misuse of drugs

Since there may be some overlap of the work of these Government bodies, brief reference should be made to the Misuse of Drugs Act 1971 and its regulations. Most general practitioners can expect to encounter drug abuse in one form or another. This Act aims to restrict the availability of certain specified drugs of dependence. The following safety precautions apply to such drugs. They must be kept in a "locked receptacle" which can be opened only by the practitioner or a person authorised by him. This does not mean that your duties are absolved if you simply hide the key of the receptacle in a drawer or some other "secret place," since this could be the first place where an unauthorised person might search. Also, the courts do not accept a "locked car" as a "locked receptacle" within the meaning of the regulations, so emergency bags, if they have to be left in cars, should also be locked.

In large dispensing practices, where substantial quantities of controlled drugs may be stored, the advice of the local crime prevention officer on appropriate security precautions should be obtained. Both the police and inspectors of the Home Office

Written statement of safety policy is required

The general practitioner should provide information, training, and supervision to ensure the health and safety of his ancillary staff. Specifically, unless he employs fewer than five ancillary staff he must prepare a written statement of his general policy "with respect to the health and safety" of his employees and the organisation and arrangements for carrying out this policy. For example, any safety rules that apply to potentially hazardous operations undertaken by medical and nursing staff—the dangers of homologous serum jaundice and "High Risk Specimen" warning stickers required under the Howie Code of Practice for the Prevention of Infection in Clinical Laboratories and Post-Mortem Rooms by all Pathological Laboratories and the immediate action required by staff in respect of accidents and mishaps that might occur. He should consult his employees about its form and provide a copy of it to each employee. A small practice to give everybody a copy of this written statement may be advisable to do so. A group practice may easily overlook a change in their legal obligation when the number of employees changes. The statement should be signed by the general practitioner, and if the general practitioner wished to show that it had been drawn to everyone's attention it is advisable to give everyone a copy. Once the requirement to provide a written statement is established—that is, you have five or more employees—it should cover all persons working on the premises.

The statement should be simple and avoid excessive wording that may detract from its impact. But the safety rules should be as comprehensive as necessary so that both the general practitioner and the safety inspector can ensure that the procedures are adequate. For example, all staff should be reminded to report immediately to the safety officer any incident that might cause a risk to health or safety. The written statement could be included in each employee's contract of employment. The statement might be as follows:

Health and Safety at Work

The practice's policy on health and safety at work is to provide a safe and healthy working conditions as possible and to enlist the support of its employees towards achieving these aims. While the overall responsibility rests with your employer, all staff have a legal duty to take reasonable care to avoid injury to themselves or to others by their work activities and not interfere with or misuse any clothing or equipment provided to protect health and safety.

The main hazards that staff should be aware of are: (i) medical infections, etc., in the context of nursing, etc., (ii) bicycles, etc., (iii) any accident to a member of the staff or a member of the public should be reported to the doctor in charge as soon as possible. You must record in writing any actual statement covering to the fullest possible extent all the circumstances of the accident at the time so that any necessary action may be taken to prevent a recurrence.

Maintaining the building

The general practitioner, "so far as is reasonably practicable as regards any place of work under (his) control," must ensure that the building is maintained in a safe condition, without risks to health. He must provide safe access to the building for all his staff. But if the health centre is under the direct control of a health authority the general practitioner can only do what is reasonable on his part, and any blame may ultimately lie with the authority. For example, if there is loose guttering which the health authority is under a duty to maintain according to the licence between it and the practice, so long as the general practitioner

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age group above all, the physical, psychological, and social factors in the illness often assume equal importance, and successful management of the problem may hinge on getting all these factors right.

Surprisingly, and contrary to my initial expectations, the practice statistics show no evidence of the increased work load that a geriatric population is claimed to generate. My patients consult in surgery at the rate of 2.3 contacts per year, and home visits are requested at the rate of 0.9 a year. Both figures are close to the national average.¹ It is evident, however, that even though the quantity of the work appears average, the quality of the work is certainly extraordinary in both its scope and the demands it makes upon the caring practitioner and his team. The truth of this assertion is soon grasped by any trainee, incoming partner, or visitor to the practice—sometimes even as he enters the waiting room. Commonly a surgery of some 25 consultations does not include anyone under 65 years of age. The consultation itself requires important skills that can only be learned by practical experience and not from textbooks. The patient with arthritis may need assistance to reach the consulting room safely. When inside the hearing aid may need to be adjusted to allow communication to proceed. A shopping list of symptoms or problems, written in a tremulous hand, is often produced and has to be patiently read. Should cardiovascular or abdominal examination be required there may be layers of tightly applied corsets to be removed first, and reapplied afterwards. As mentioned before, several systems may need checking. The plan discharges may require contact with other members of the team, or other agencies. Finally, treatment must be explained to the patient, and it is important to ensure that he has understood. So much for "six minutes for the patient." This type of medicine cannot be hurried, and the implications for ensuring enough time within the appointment system are obvious. Home visits are often more time-consuming because the patient is obviously more handicapped, and relatives need explanations and help.

Anticipatory care

What should the general practitioner's priorities be in caring for a predominantly aged population? Certainly most of one's time is spent diagnosing, reassuring, and treating, or mobilising specialised resources so that patients with difficult problems can receive adequate support to remain in the community. It is also important to remember the enormous potential for preventive medicine in the elderly. In this age group true anticipatory care is primarily intended not to prolong the life-span, but to prevent conditions that cause disability and dependence on others. For example, arranging attendance at a day hospital for assessment and rehabilitation of Parkinsonism or disabled patients before they go completely off their legs and require hospital admission; effective management of risk factors such as hypertension, transient ischaemic attacks, arrhythmias to prevent heart disease; careful supervision of the diabetic patient with stasis ulcers, cataracts, or vascular disease—any of which could rob him of his independence if this possibility is not anticipated.

Such is the challenge of practising in this town. What resources are required to meet the challenge effectively? They are threefold—the GP himself; his primary health care team; and the geriatric hospital services. Firstly, the practitioner himself must be an enthusiast who can establish and maintain a caring relationship with a patient in the face of chronic disability, degenerative disorders, and multiple pathology. In my experience this is not as difficult as many of my colleagues from other areas appear to believe. Most of my patients are less demanding than their younger counterparts, and usually present their complaints in a humble and apologetic manner, often with the preface, "I know it's my age doctor, but..." There is always an element of self-blame for these patients, and the doctor who shelters his indifference behind such phrases as "What can he expect at his age?" or "You

were born too soon" is therapeutically bankrupt and would probably be happier in another type of practice.

Secondly, the members of the primary health care team must be equally resilient. In the surgery the receptionists need to be particularly patient and understanding. On the district one needs not only excellent nurses, but also other specialists in the community care of the elderly. The diabetic patient with a leg ulcer may require daily attendance by a district nurse to administer insulin, monitor blood glucose concentrations, dress the ulcer, and assess the need for aids to daily living. In addition, the health visitor may be required to support the spouse, liaise with social services to obtain financial entitlements, arrange home help or meal on wheels, and, where necessary, arrange short-term admission to a nursing home to relieve the strain on the partner. Another common problem is when a patient develops dementia, possibly the cruellest of long-term geriatric problems. The spouse has to be supported heavily while the life-long partner gradually changes into a confused, aggressive, unskinted individual who cannot be left alone. In this common situation a community psychiatric nurse for the elderly can be invaluable to monitor the progression of the disorder, give appropriate treatment, arrange short-term social admissions so that the spouse can have a holiday, and eventually help the spouse through the guilt that supervenes when the patient's condition requires admission to the long-term psychogeriatric ward.

Thirdly, the overall community management of this population is made easier by enthusiastic and forward-looking consultants in geriatric medicine and allied services, such as day hospitals, short-term assessment wards, occupational therapists, and medical social workers. (Incidentally I should reveal at this point that here the department of geriatric medicine caters only for patients aged 76 and over. Younger fry remain the responsibility of the general medical firms!) In this town we are blessed with such a set-up, and life would become very difficult without them. Furthermore, the management of patients with brain failure was revolutionised by the appointment of a consultant in psychogeriatric medicine. The icing on the cake for us is the availability of GP beds in our community hospital. Patients appreciate its informality and its accessibility compared with that of the district general hospital six miles away. We general practitioners appreciate the superb quality of nursing care provided there and the stimulation of managing our own cases. Unfortunately, the predominance of degenerative joint disease stretches the resources of the orthopaedic unit to the detriment of elderly patients with painful arthritis and the younger population with more routine surgical problems.

I have perhaps belaboured the problems of the elderly because this is the main feature of medical care in this particular seaside town. We do have some holidaymakers in summer, with the usual problems of medication left at home, sunburn, and other summer ailments. There are canoe clubs and sailing clubs, and consists of foreign students attending language schools and boarding with local families. This can tax one's linguistic skills, non-verbal communication abilities, and knowledge of foreign languages. Further along the coast at Rye, where there are caravan parks and holiday camps, my friend and his colleagues have to cope with a doubling of the population during the summer months—a startling increase in work load, but profitable in temporary rent fees.

Apart from the clinical challenge there are personal compensations for practising here—a pleasant environment for one's children and family, a quiet pace of life compared to that in "the big city," and lack of traffic jams and parking problems. After 10 years here I can thoroughly recommend it.

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