PRACTICE OBSERVED

Overcoming Isolation

Fellowships in general practice in the St Thomas's district

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A survey of general practice in Lambeth in 1979 showed that many young general practitioners were isolated in a system of primary care that gave them little opportunity to review their work critically. So a new educational initiative was developed, funded by the Trustees of St Thomas's Hospital. The most important characteristic of this was that it brought time for young doctors by appointing them as clinical assistants for one half day each week for two years to the department of general practice. During this time they shared their experiences in general practice, learnt to look critically at their practices, and developed a project designed to improve their patient care. The course became known as the St Thomas's fellowship scheme. Three year courses have now been completed and it is time to review the results of this experiment.

What we have learnt

Six places were available on the first course and eight on each of the subsequent courses. Thirty general practitioners applied for places. Most of these came from Lambeth or Battersea. Five of the applicants had graduated outside the United Kingdom. Twenty two were appointed. With the exception of one doctor, who it was thought would be unlikely to fit into a group setting, those who were not recruited had, in general, misunderstood the objectives of the course.

The course was originally designed for doctors who had been in

practice for between three and eight years, but several doctors in their first year applied and four were appointed. It had been hoped that singlehanded doctors would be particularly interested, but they were underrepresented while several applicants came from group practices where peer support might have been assumed to exist. One important thing we have learnt from the course is that professional isolation is not peculiar to singlehanded doctors.

Each course started with a residential weekend, designed to develop a group identity. In the first course this was followed by 12 weekly sessions designed to train the members in certain epidemiological principles and research methods. This was criticised by the members of the first course who wanted to learn more about each other's practices. So several weeks were given over to visiting the practices of the members of the group. This proved such a fertile ground for new ideas and methods that it became the first group activity in the second and third courses. The bringing together of a multiplicity of practices and approaches seemed to animate the group towards a feeling of professional development based on a process of audit.

The formal package of research methods was dropped from the second course when various experts were invited to contribute when individual projects were being discussed. It was reintroduced in the third course but at a later stage.

The courses were evaluated in four ways. At the residential weekends members completed a multiple choice questionnaire, designed to measure research concepts and methods in general practice, and completed a semantic differential test to measure attitudes to several aspects of general practice and to research. The members of all three courses improved their marks in the multiple choice questionnaire at the end of the course, but the second course that had not been submitted to the formal teaching programme on research methods showed the greatest improvement, which may mean that such things are more securely learnt when applied to a specific project.

The semantic differential test on attitudes showed a negative shift in all the courses away from epidemiology although knowledge of that subject improved in the multiple choice questionnaire. This may reflect a recognition of the difficulties of carrying out epidemiological research in general practice which were not appreciated at the outset. An important attitudinal change detected in the semantic differential test was the attitude to partners. This showed changes in both a positive and negative way which were interestingly reflected in other evidence provided by members during the course. Short essay questions completed at the beginning and end of the course showed a shift from somewhat idealistic to more realistic views of general practice.

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As a measure of success the projects in terms of a full report at the end of two years were disappointing, despite the fact that many members made important improvements in their practices. One complete report was provided by the members of the first course, two at the end of the second course, and four at the end of the third.

Some benefits are difficult to measure objectively. Those who have taken part in the course are unanimous in valuing the contributions that it has made to their professional development.

Implications for postgraduate education in general practice

The number of young principals who joined the fellowship course seems to suggest that the vocationally trained doctor, currently entering general practice, has been nurtured in an atmosphere of group support and peer oriented development so that acceptance into a practice may suddenly seem an anticlimax. Instead of a steady evolution of interest and skill, the doctor may be faced with feeling alone and even discouraged from bringing initiative to bear on the problems of contemporary general practice. It would seem that the

concept of the fellowship course might become a logical and necessary step towards personal professional development after vocational training has led to appointment as a principal in general practice.

The essential requirement for this type of course is a method of buying time to allow young doctors entering general practice an opportunity to stand back from their day to day work and think about it in a disciplined way. In these courses the method used was to appoint the doctors as clinical assistants to the department of general practice. It is possible that the concept of the clinical assistantship might be transmuted at a national level to developing skills in general practice rather than to developing in the hospital setting.

The trustees of St Thomas's Hospital made this experimental course possible. In the absence of more permanent funding the fellowship course has died. A fitting epitaph is 22 young doctors who took part in the course are now making important contributions to undergraduate teaching in general practice, to the development of young doctors' groups, to vocational training, and to the care of patients in an inner city area.

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Practice Research

Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: dealing with the opiate misuser

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Abstract

Because there has been a substantial increase in the scale of drug misuse, general practitioners have become increasingly concerned in responding to this problem. Little is known, however, about how general practitioners manage drug misusers. The findings from a national survey carried out in mid-1985 of a 5% random sample of general practitioners in England and Wales show the extent to which various actions were undertaken by general practitioners who reported on the consultation with the opiate misuser whom they last attended. In more than half of the cases the opiate misuser had been under the care of the general practitioner for this problem for at least six months. The findings indicate that most general practitioners refer these patients to specialist drug dependence clinics or to general psychiatric services but rarely to other agencies. Opiate drugs had been

prescribed in nearly a third of cases. The rate of notification to the Home Office conforms with that in other studies and indicates a high degree of undernotification. More detailed study of general practitioners' activities in managing drug misusers is needed.

Introduction

The great increase in drug misuse in the past few years has brought general practitioners into the front line of response, both in terms of the demand for care by drug misusers and in terms of the government's emerging strategy to provide services for drug misusers. Some background to these developments and new data on the extent of the contact that general practitioners in England and Wales have with opiate misusers were described in a previous paper.

Concern has been expressed about the nature of general practitioners' treatment of drug misusers—that is, the wide differences in practice and limited awareness of the range of options for treatment that is available. The Department of Health and Social Security has recently issued *Guidelines for Good Clinical Practice in the Treatment*

of Drug Misuse. There is little information available on how general practitioners handle these patients, such as the use made of specialist medical services and social agencies for referral, the likelihood of prescribing opiates, and so on.

The findings presented here are from a national survey of general practitioners concerning their role in the treatment of opiate misuse and throw some light on these activities. The undernotification of addicts to the Home Office by general practitioners is also discussed.

Methods

Details of the methods have been published.¹ A postal questionnaire was sent in mid-1985 to a 5% random sample of general practitioners in England and Wales, which was stratified by regional health authority. A further three waves of questionnaires were sent as reminders to non-respondents. The general practitioner was asked to recall the most recent attendance of an opiate misuser, and with reference to this case to indicate for how long the patient had been under the care of the general practitioner for this problem, how many times the patient had been seen, and whether or not any actions in a list provided had been taken to date in managing the patient.

Over the four response waves, 845 (72%) of the 1166 general practitioners who were sent questionnaires returned usable questionnaires. The respondents resemble the national profile of general practitioners in terms of the average number of patients on their lists and the number of partners. Thirty one per cent of the respondents stated that they had "never" seen an opiate misuser, and the section of the questionnaire of concern here did not apply to these general practitioners. The remainder, 80% (384) completed the entire section, and the percentages in the text below are based on this group of respondents.

Results

The evidence from the responses of this sample of general practitioners suggests that many are treating opiate misusers and that this may extend over a substantial period of time. One fifth of respondents reported one contact only with the last patient attended, a further 30% had seen the patient two or three times, and 29% reported at least 10 attendances so far. The median number of attendances was four. The median duration of care to date in these cases was six months, with 31% of the general practitioners treating the opiate misuser for under one month, a further 24% for at least one month and up to six months, and 55% for at least six months.

The table gives the actions listed in the questionnaire and the proportion of general practitioners who reported having taken each action in dealing with the opiate misuser whom they most recently attended. Clearly, these actions must mutually exclude, and several actions will have been taken over the period of care. Eighteen per cent of the general practitioners had taken one action only, and most often this was an assessment of the patient by an interview and taking a case history (10%).

REFERRAL AND PRESCRIBING

Before assessing the pattern, the findings suggest that the most common response of general practitioners in dealing with opiate misusers is to refer them to specialist hospital drug dependence clinics or to general psychiatric services (table). Two thirds of the general practitioners made such a referral, including a few who referred the patient to both services.

Proportion of general practitioners who took an action in dealing with the patient whom they most recently attended for opiate misuse

Action	Percentage who took action n = 384
1. Assessment by interview and taking a case history	10
2. Referral to specialist drug dependence clinic	31
3. Referral to general psychiatric services	34
4. Referral to a primary health care team	9
5. Referral to local authority social services	11
6. Referral to voluntary organisations dealing with drug misuse	12
7. Prescribing opiate drugs for the short term (2 weeks)	13
8. Prescribing opiate drugs for the longer term	17
9. Screening or arranging for screening of urine for evidence of drugs	17
10. Notification to the Home Office	12
11. Other	12

recently described by Teeling Smith, where he cites drug abuse along with cancer as cases for the specialist: "The general practitioner cannot be a jack of all trades... Only the most cavalier of general practitioners would expect to handle such cases on their own."²

On the other hand, a substantial number of general practitioners prescribe opiate drugs, and the extent to which this is done independently of specialist advice is unknown. Thus the DPHSS guidelines might be of considerable value in defining good practice in this respect. Also, given the finding of the rather narrow referral activity, it may be useful to give general practitioners information about the range of services available to deal with drug misusers.

This provides only initial descriptive information on the pattern of general practitioners' activity in responding to opiate misusers. In the light of the scale of the contact that general practitioners have with these patients and the policy of the government in encouraging such contact further investigation is required into the quality and outcome of general practitioners' management of opiate misusers.

I thank Professor Brian Jarman, St Mary's Hospital Medical School, and Dr Paul Williams, Institute of Psychiatry, for valuable discussion during the planning of the study. Professor Griffith Edwards, Colin Taylor, Betty

Although a comparison may be misleading when the two numbers are so small, there appear to be some wide differences between regional health authorities in the pattern of referrals by general practitioners. These differences are likely to be an effect of characteristics of regional provision of services and policy. The lowest rate of referral to a specialist drug clinic (13%) and the second highest rate of referral to general psychiatric services (47%) are in the South Western Regional Health Authority, where regional policy is "Health Service provision for drug misusers... based on the general psychiatric service... No special clinics have been established and none is currently planned." Furthermore, just one district in the region is served by a drug treatment centre established under the DHSS General Funding Initiative. The highest rate of referral to a specialist clinic is in Mersey Regional Health Authority (71%), where the largest financial outlay on a single project under the General Funding Initiative has been committed to a new outpatient clinic for drug dependency. The region with the highest rate of referral to general psychiatric services in North Western (62%), where the development of "satellite clinics" within district psychiatric services has been fostered, aiming at offering easier referral of drug misusers than to the regional specialist unit.

Other potential sources of care appear to be used less often by general practitioners. Few in this sample had referred the opiate misuser to other members of the primary health care team (9%), and referral to local authority social services (9%) or voluntary organisations concerned with drug (11%), was also done infrequently (table).

Few of these general practitioners reported that they had undertaken or arranged for screening of urine for drugs (9%). This may reflect difficulties of access to appropriate facilities. On the other hand, a substantial proportion of general practitioners had prescribed opiate drugs, and, as the table shows, was equally likely to have been for the short term (up to two weeks) or for the longer term. It cannot be determined from these data how much of the prescribing was part of a withdrawal programme or how much was for maintenance treatment until the patient could be seen by a specialist. Taking into account a small overlap between the general practitioners who prescribed for the short term and those who prescribed over the longer term, the findings suggest that nearly a third (31%) who had had contact with opiate misusers prescribed some form of opiate, and 22% prescribed and did not refer to another agency.

NOTIFICATION

Notification of certain categories of addicts to the Home Office is a legal obligation for doctors under the Misuse of Drugs (Notification and Supply to Addicts) Regulations of 1973. It has been suggested that limited awareness of this statutory responsibility results in extensive undernotification. Among this sample of general practitioners one third had notified the Home Office of the opiate misuser who had most recently attended (table). Since the definition of a case for inclusion in this section of the survey is a person attended for "problems associated with misuse of heroin or other opiates" it would not necessarily be appropriate to make a notification under the regulations which define an addict in terms of "an overpowering desire for administration of the drug."

The rate of notification by general practitioners in this study is, however, similar to that for heroin users attending a Scottish general practice (34%), and higher than that for addicts referred by general practitioners to their own practice (26%). In the latter study it was suggested that some factors may be under the mistaken impression that only those for whom they prescribe need be notified. This is supported in the present study, where 60% of the general practitioners who prescribed opiates also made a notification to the Home Office compared with 30% of those who did not prescribe ($\chi^2 = 61.65, 1 d.f., p < 0.001$).

Discussion

These findings derive from a national survey of general practitioners. As part of the survey general practitioners who have had contact with opiate misusers reported on the action that they took in dealing with the opiate misuser most recently attended for this problem. The actions listed in the questionnaire were, however, limited in scope. For example, the role of the general practitioner in treating medical problems associated with opiate misuse, or in providing advice or counselling to these patients, is not covered. The picture that emerges, however, is that general practitioners most often responded to these patients by referring them to a specialist drug dependence clinic or to general psychiatric services after having assessed them. This approach conforms to the "diagnostic" model of the role of the general practitioner.

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This is the second of three papers.

Audit Report

Factors influencing the routine recording of blood pressure

The records of 100 men and 100 women over the age of 40, selected at random from each of the 14 training practices in a vocational training scheme, were examined by the trainees to see whether the practices had recorded the blood pressure in the previous five years. Patients who registered during the study period and those with conditions that required that their blood pressure was taken regularly were excluded.

Altogether, 89.2% of the patients had been seen during the five years, with 24% having attended five to nine times and 40.4% 10 times or more. Half of the records of those seen contained blood pressures recorded by the trainees in that time. The frequency of its being recorded rose from 30.5% in patients seen on average once a year to 65.1% in those seen twice a year or more ($p = 0.001$). When examined as a group there was a significant difference ($p = 0.0019$) in the way the practices performed: best 65%, worst 34%, although there was no significant difference in the attendance rates. The last size of the principals (average 1600 patients) did not influence their

performance negatively. Unexpectedly, the five practices which their own nurse recorded a similar percentage (49.5%) to the nine practices employing one (50.3%).

Although the most striking feature of this study was the participation of all the practices in a training scheme, the most important finding must be the apparent failure of the practices to delegate to the practice nurses the recording of blood pressure. In an Israeli study of 100 000 patients there was a marked improvement in detection and a massive improvement in the management of hypertension when nurses worked in the programme. Why are we not using the skills of our own nurses more fully?—PHILIP GORRY, general practitioner, MEDWYN WILLIAMS, trainee, 23 Castle Street, Conwy, Gwynedd, and the Gwynedd Vocational Training Scheme. *Accepted 16 July 1986*

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100 YEARS AGO

The ill-effects of the excitement and turmoil of a general election are not, by any means, confined to fluctuations in the stocks, or a temporary lull in trade, or the curtailment of the London season. The extra strain thrown on to the shoulders of a number of individuals, many of whom are well past their prime, inevitably results in the collapse of a certain number, whose enfeebled heart or brittle arteries are not equal to the extra load. Already, we hear from different localities, of persons who, after having been in the habit of, or would be members, or their more energetic partisans; and, before calm is re-established, others will doubtless succumb. It would be interesting to tabulate the deaths occurring on the eve of, or during, a general election, and to ask whether it is not altogether an easy one, if offers a good field for work for individuals gifted, or plagued, with the "bump" of statistical inquiry. One might suppose, a priori, that the more accurate methods of living of the candidates with more advanced views would secure them a certain immunity

from mishap. Figures alone can tell us whether this assumption has any foundation in fact. Certain it is that the combat material influences the chances of individuals in the matter of longevity, even when no physical violence is factor not to be overlooked at political meetings) intervenes to complicate the risks. So far as the latter contingency is concerned, the spectators, or rather auditors, have at least an equal chance with the candidates and their supporters. An inoffensive member of the profession was enabled to corroborate this statement, at a meeting last week, when he was his ill fortune to be belaboured with the leg of a chair, while endeavouring to stem to Mr. Richard Chamberlain—(not to be confused with the very substantial weapon, when skilfully wielded, as it appears to have been on this occasion). We are pleased to note, however, that person, without the option of a fine, might suppose, a priori, that the more accurate methods of living of the candidates with more advanced views would secure them a certain immunity from the present election. *British Medical Journal* 1886; ii: 30.