Geriatrics in the cottage hospital

SIR,- Approaches to Dr Andrew Grooters’s Personal View (29 February, p 519), would it not be better to ask what an enthusiastic GP working in a cottage hospital has to offer his long-stay geriatric patients than to state as he does that a local hospital whose beds have been allowed to become filled with elderly patients “has little to offer the enthusiastic GP”?

Medicine is a service, not a hobby, and what we have to offer was well put by Paré many years ago when he said “guérir parfois, soulager toujours.” I speak with feeling because my father has, for the past few months, been such a patient in such a hospital and we owe a great deal to our caring GP.

The great value of local hospitals is that they offer nursing care in their own community to patients who do not need the technology of the district general hospital, but do need their physical well-being looked after by professionals if they are to die in comfort and dignity.

JOHN A DAVIS
Department of Child Health, University of Manchester

Supervision of repeat prescribing

SIR,—As the astonished general practitioners concerned with the care of the patients who were the basis of the “attempted audit” by Mrs S M Shaw and Mr J L Opit (28 February, p 505) we would like to present some additional information.

The authors show that a small proportion of elderly patients on regular medication had evidence of diminished intellectual function, social isolation, and long intervals since the last consultation with their practitioner. However, the critical element in the authors’ argument hinges primarily on the “three patients who” might be suffering from drug toxicity.” The partners, in the presence of one of the authors, conducted a clinical audit of the actual cases.

The first of these was the patient whose biochemical profile “showed changes consistent with phenylbutazone poisoning.” It transpired that this patient was not receiving repeat prescriptions from the practice at all but was most probably receiving them from another practitioner privately. This raised many interesting subsidiary issues, including ethical problems, and was the basis on which the conclusions which the authors indirectly have drawn from this case.

Two more were thought by the nurses carrying out the surveillance to be showing signs of digitalis toxicity.” One of these patients (incidentally the father-in-law, who sees him almost daily) had been known for many years to have had an athletic basal pulse of 57/min. His pulse was now reduced to around 42/min, but this was attributed mainly to the therapeutic effects of beta-blockers which he was also receiving and not to digoxin. The second patient, some of the details of whose case have only come to light recently, was an elderly man with congestive cardiac failure well controlled on 0·0625 mg of digoxin daily. His pulse rate of 52/min had also been a feature for many years. One of the investigators decided that this was one of the cases of digoxin toxicity and the dose was reduced to alternate days. Within a few days the patient was finding difficulty in climbing stairs and in walking any distance. When he also developed ankle swelling the patient’s wife telephoned and asked us what was going wrong and put him back on his original dose of digoxin, with rapid improvement.

We give these clinical details for we find it surprising that the authors forbore to mention that, on review, there was no evidence of adverse effects attributable to the practitioners’ prescribing. However, if they had perhaps there would have been no basis for a “review.” On the contrary, that this has become turned into the serious accusation that these patients “might be suffering from drug toxicity” due to inadequate management by the practitioners is in our view laughable.

Mrs Shaw and Mr Opit also suggest that long-term drug treatment might have contributed to the reduced intellectual function which was found in a proportion of patients on regular medication. We would suggest that their own figures support the opposite view. The proportion of patients with reduced intellectual function among those on medication was 7/51, while the proportion for those not on medication was 7/47. For what it is worth, medication was not associated with any increase in the proportion with impaired intellectual function. Incidentally, this first time we have seen any of the data relating to intellectual deficiency and we hope that the authors will not mind our pointing out that the totals in tables II and III for patients with different categories of intellectual function do not agree.

The authors’ suggestion that one in seven (14 in 98) of a representative sample of elderly people over the age of 70 are demented would be hilarious if it were not so deadly serious. Common sense demands at least suspicion of the criteria used for defining dementia if not of the scoring system itself or the way it was used in this study. Of course many elderly people can become muddled and confused by complex and novel problems. On the other hand, once a ritual such as routine medication is established, most can meticulously follow it. Unchangingness of clinical practice is to be lauded.

In the circumstances we find the authors’ patronising comments, “Some concern is aroused by this deficiency in supervising partners” and “the study practitioners have been aware of these problems and are creating a filing system to ensure regular reappraisal of these patients on long-term drug treatment,” particularly obnoxious and irritating for yet other reasons. The automated system which the authors used was planned over three years ago to develop, among other things, surveillance systems for doing just this. We have always been prepared to be “examined under the microscope,” but our fee for this privilege is “feed-back” to enable us to improve our clinical management of patients. This has been sadly lacking. It was because of procrastinations and delays in this area that the partners set up a variety of manual surveillance systems. If the original programme had been implemented there would have been no basis for this so-called “audit.” We find it galling that there are resources in money and staff for the type of study reported here when the creative opportunities of the automated system are not being realised.

The manual system (which will be described in detail elsewhere), is essentially a monitoring and surveillance system which allows selective recall, at the practitioner’s discretion every six or 12 months, of patients receiving repeat prescriptions. The automated system incidentally does not include all consultations with patients and excludes elderly patients and important contacts with patients when they return for repeat prescriptions. We believe that the flexibility in the manual system is compatible with effective care and we have found no reason to change it since reading this paper.

The present repeat prescription monitoring system in use in the practice was the direct result of a previously reported audit of repeat prescribing by the partners carried out in 1970. We believe that all forms of audit, self-assessment, and critical reappraisal of clinical and operational performance where they are relevant must be an essential part of modern general practice. We also believe that service general practitioners need the help of their academic colleagues in developing this rationally. We are not convinced that the overzealous and misguided approach demonstrated in this paper will achieve these ends.

D L CROMBIE
C M GREEN
A J PEARCE
A BENN
ANTON DEWSBURY
Birmingham

Renal lesions in a case of septicemia

SIR,—The letter from Wing Commander T J Betteridge and Squadron Leader D J Rainford (28 February, p 522) provokes comment.

Firstly, let us give credit where it is due. Powell’s described the whole spectrum of renal lesions in staphylococcal septicemia, including focal and diffuse proliferative nephritis, and he drew attention to the disseminated intravascular coagulation of that syndrome.

Secondly, let us be clear that nephritis is a diagnosis based on clinical observation, urine microscopy, tests of renal function, and blood cultures, estimations of cryoglobulins, complement components, fibrinogen degeneration products, and even radioisotopic study. Since the patient had vasculitis she was very likely to have a serious nephritis, and lesions as shown might have been found in her kidneys.