"Mumbling the GP"

Few doctors were ever willing to sell prescriptions for dangerous drugs, and almost all have now been driven out of business, so that young persons who want drugs have been looking for an alternative source of supply. Since the imposition of restrictions on the prescribing of hard drugs outside the authorised clinics, the pill-takers have transferred their affections to the softer group, including not just barbiturates and other tranquilisers but also many other compounds which give some form of "lift." Some people are taking bronchodilators; and analgesics may also be abused—not all doctors realise that dihydrocodeine (DF 118) and pentazocine (Fortral) are also potentially habituating. Practitioners should be particularly wary of the patient who says "nothing else is strong enough to relieve the pain."

What is perhaps most disturbing is the frequency with which the drugs are obtained, not for personal use but to be sold to others who are less skilled in acquiring "legal" supplies. In a recently reported study Bewley et al asked 100 patients attending drug dependency clinics how they got prescriptions for psychotropic drugs from general practitioners. Apparently all had been able to do so at some time during the previous 12 months. Not surprisingly, the addicts found it easier to persuade a GP who was working under pressure to let them have prescriptions. Usually the doctor was in singlehanded practice and more likely to be nearer retirement than qualification. They consulted him at times when the waiting room was full, and registered themselves as temporary patients. Their problem, they assured the harassed doctor, was "easy and won't take a second." They were staying with friends in the district for a few days or weeks and unfortunately had left their pills at home. They were, they claimed, epileptic, depressed, sufferers from migraine, insomnia, and so on. All they needed was a repeat prescription to tide them over until they returned home and could go and see their regular doctor. Alternatively, a regular patient might say that she had had her handbag stolen and with it either the previous prescription form or the pills themselves: "May I have some more, please? You know I cannot be without them."

"Mumbling the general practitioner." Perhaps as these methods become more widely known, doctors may be better able to resist the attempts to con them into writing such a prescription. The fact that the patient fills in a temporary registration form is a type of inducement for the doctor, because he is paid an extra fee for each such patient. Even so, should he refuse to comply with the patient's demands, he will still get his fee. From time to time family practitioner committees supply general practitioners with the names of people who have been trying to obtain drugs under false pretences; very often these people use different names and frequently give a false address. Unfortunately there is no consolidated list so that it is not easy to check rapidly whether or not a particular person is listed.

GPs should always have a high index of suspicion when faced with a temporary patient who wants a repeat prescription, and in doubtful cases prescribe no more than a 24-hour supply. The more such prescriptions are written by an individual doctor, the greater will be the demand made upon him. Indeed, it may be said that every prescription of this type that is written is an invitation for further requests of the same kind.

High pressure medicine

The medical care of the 1000 divers working in the North Sea oilfields presents unique difficulties, as became clear at last week's meeting of the Society for Underwater Technology in London.1 The problem may be stated simply enough: divers working at depths of 200 metres live in a "saturation" state, returning to the surface in a pressurised bell and spending their rest periods in the pressure chamber on board the rig. Safe decompression from these conditions may take as long as a week and cannot be much speeded up no matter how grave the emergency. How, then, can divers under pressure be treated for injuries and emergencies such as appendicitis or a perforated duodenal ulcer?

In dealing with accidents the crucial factor is time. A man injured on the sea bed has to be manoeuvred back into the diving bell and brought to the surface before anyone other than his fellow divers can be of any help. If a doctor is summoned he may take three, four, or more hours to arrive. Anyone who enters the pressurised compartment has first to undergo compression himself (taking up to three hours for an inexperienced individual)—and once the doctor or rig medical assistant is there with the casualty, *Catch 22* operates and he will have to stay there for the full decompression period lasting several days. The effect of these restrictions is that the only person who can give any resuscitation in the vital early hours after injury is another diver: and the medical and diving experts at the meeting agreed that both first-aid and basic lifesaving procedures must, therefore, be included in the instruction of all divers. Familiarity with simple techniques can be an invaluable practical asset, too—a diver who can suture a relatively minor laceration saves himself and the rig medical assistant a great deal of inconvenience.

While first aid may be given by another diver, the rig medical assistant will be the only professional on the scene of an accident for several hours. Many of these men have a background as NCOs in the armed services; others come into the industry from the NHS; but they must have a high standard of first aid (possibly including the ability to carry out endotracheal intubation) and enough diving experience to make them familiar with pressurisation. During the vital early hours the assistant will be in contact with a doctor on shore by VHF radio or Telex; with the help of the diver inside the pressure chamber he will have to monitor the pulse, respiration, blood pressure, and other vital functions and decide whether or not to enter the pressure chamber himself to help in resuscitation.

Medical opinion is still divided on the best procedure once the doctor reaches the casualty—for the very good reason that so few medical emergencies have occurred in divers under pressure that there is hardly any practical experience to draw on. Pressures may be as high as 20 atmospheres, when conventional inhalational anaesthesia is unpredictable, as are the side effects of many drugs in current use. Under these conditions most surgeons would prefer to rely on local anaesthetics, with heavy doses of morphine if necessary. In theory there are
three possibilities: the sick diver may be given basic resuscitation while being decompressed as quickly as seems safe and then can be treated as an abnormal casualty; or the doctor may enter the pressure chamber on the rig and give treatment there; or the patient may be transferred to a lightweight pressure chamber, transported to the mainland, and then transferred to a large chamber for treatment at leisure.

Medical opinion was unanimous that the first of these approaches would be preferable in most circumstances—appendicitis, perforated ulcer, and many other "emergencies" may be treated conservatively for several days with a high probability of success. Only when life is threatened by a condition such as intra-abdominal haemorrhage is surgical intervention vital; and, since a patient in that condition would almost certainly be unsuitable for transport by helicopter in a small pressure chamber, his best chance would come from operation in the cramped facilities on the rig.

In fact, there is as yet no combination of helicopter and lightweight chamber that could be used for the transport of casualties under pressure. The Association of Offshore Diving Contractors has been working on the project and within a few months two lightweight chambers should be available (one holding one man, the other four men). Nevertheless, their prime purpose is the rescue of divers under pressure should a rig have to be evacuated in an emergency. These chambers will be available for transport of casualties, and there is a compatible shore chamber at Dundee: within a year or two there will be another at Bergen in Norway. Theoretically, therefore, it will soon be possible to offer the medical services all three choices in dealing with sick divers; but unfortunately their co-ordination is still far from ideal. While the big pressure chamber is at Dundee, the surgical teams who are on call for diving emergencies are based at Aberdeen—and they are drawn from university staff with a research interest in hyperbaric surgery. Both the NHS authorities and the Government have insisted that their responsibilities for medical care do not extend out to sea, and they have played no part in providing medical services for divers under pressure. Thus, on the few occasions hyperbaric facilities have been needed, the equipment used has been borrowed from the Royal Navy, a diving contractor, or a research institute.

The size of the North Sea operation and the depths at which the divers are working have made the medical challenge more obvious than anywhere else in the world, and indeed nowhere else is there a really efficient medical service for the treatment and evacuation of diving casualties. The specialist services must be provided by the NHS, for no one would expect the oil industry to build its own hospitals in Britain, as it has done in other, more remote, parts of the world. There is an opportunity here for research to be done to establish the best management of surgical emergencies under pressure, but formal arrangements must be made to co-ordinate the specialist medical and engineering services concerned. Anxiety at the meeting about this state of affairs was somewhat allayed by the news that a voluntary co-ordinating committee is being set up from the medical and commercial interests. This should complement the working party chaired by Admiral John Rawlins which is examining the problems for the Department of Energy. So far we have been lucky, and dramatic medical emergencies have been seen only on the TV series Oil Strike North. No one, however, can tell when the need will be genuine. Time is not on our side.

1 The problem of hyperbaric rescue in the North Sea and its possible solutions. Society for Underwater Technology, 1 Birdcage Walk, London SW1H 9J.

Tests on overseas doctors

TRAB. Isn't that something to do with seeing if immigrant doctors can speak English? Isn't the failure rate rather high? These popular half-truths both distort and underrate the task that the Temporary Registration Assessment Board has faced in principle since 1970 and tackled in practice six times since May 1975. The board was set up to test the clinical and English language competence of overseas doctors with qualifications for which the General Medical Council has no reciprocal recognition. Because the candidates' own countries will not allow examinations to be taken there, up to 3000 candidates a year may have to be tested in Britain, in perhaps twelve tests per year, taken at three centres. The General Medical Council turned for help to the three non-university licensing bodies, and each of them appointed two representatives to the new board; Dr T C Hunt was elected the chairman, and he co-opted expert advisers, including language experts from the University of Lancaster. The board agreed that clinical examinations were out of the question—and in any case this aspect was covered by the DHSS's clinical attachment scheme. Indeed, even with the new examination, a satisfactory testimonial from the supervising consultant remains a condition of employment in the NHS, quite apart from registration by the GMC.

As it has emerged, the test has four parts and occupies two days. Firstly, the 60 multiple-choice questions test medical knowledge. Secondly, recorded voices are used to test whether the candidate understands spoken English, including the meanings conveyed by intonation and stresses. Thirdly, there is a modified essay question—replying to a general practitioner, answering a patient, or giving instructions to the ward sister as part of an unfolding case history. Lastly there is a 20-minute viva, in which two examiners consider whether the candidate can sustain a sensible conversation with doctors, paramedical workers, and lay people on medical matters. So far there has been a reasonable correlation between a candidate's marks and a 50-60% pass in each part; though the overall pass rate for all the parts together has been around 30%.

Most of the problems of overseas doctors—their integration, training, and service contribution—have fallen on the staff of peripheral hospitals. Thus the 296 postgraduate medical centres and their clinical tutors are deeply concerned, and at the annual meeting of the National Association of Clinical Tutors at the Royal College of Physicians on 25 November the tutors cross-examined the President of the GMC, Sir John Richardson; the secretary for overseas affairs to the GMC, Mr Robert Beers; and the chairman of TRAB, Dr Hunt. The authorities regarded the language testing as satisfactory and even exciting—while, contrary to expectation and popular myth, they reported that it was seldom the sole cause of failure. On the other hand, the tutors regarded the clinical testing (done without the traditional tests of clinical skills) more sceptically, though the large number of examiners (120-130) needed were said to be experienced.

Later in the meeting the tutors had the unusual experience of trying to answer an MRCP paper, which must have made them realize some of the difficulties faced by the overseas doctors in taking this examination. One obvious question is how long can the high failure rates in the TRAB examination continue before clinical standards have to be lowered merely to staff the NHS? That question was asked by the tutors, but could not be answered by Sir John—though he was able to reassure the meeting that the DHSS had not made any difficulties about introducing the tests. Nor could he say how those doctors who failed managed until they could resist the