Discussion

These results show that Lomotil ingestion is a cause of serious poisoning in young children, especially those aged under 5. It is always hard to assess the dose in patients suffering from poisoning, but it seems that young children may develop pronounced symptoms after taking only one to five tablets.

Doctors should be aware of this risk and warn parents, particularly about the hazards of leaving tablets within reach of children. Safety packaging would seem to be imperative. A further deterrent might be to increase the tablet size, currently 5.6 mm in diameter and 2.5 mm thick, to reduce the likelihood of a child swallowing many at one time. A person suspected of taking an overdose of Lomotil should be admitted to hospital and observed for at least 24 hours, as the atropine may delay the

onset of symptoms. Treatment should consist of intensive supportive treatment, and, if necessary, administration of a narcotic antagonist such as naloxone.

We thank those doctors whose co-operation, by contributing information, made this survey possible.

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Collaborative care of hypertensives, using a shared record

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Summary

A shared hospital-GP record for control of hypertension was studied in a sample of 60 patients. Over 80% of patients brought the record to hospital duly completed. Two-thirds of GPs, and the hospital staff, assessed the record as a useful aid in the care of hypertensives. It is still employed enthusiastically, three years after its introduction.

Introduction

Union of the three branches of the NHS in April 1974 was hailed as an opportunity for integrating medical care, but progress has been unimpressive. At a conference held under the

auspices of the Royal College of Physicians of Edinburgh in 1976 to stimulate new approaches¹ there was general agreement that patients with severe hypertension were ideal subjects for integrated care. The general practitioner would take most of the responsibility for controlling treatment, while the hospital staff did most of the time-consuming physical and laboratory investigations at long intervals. At the same conference, however, an experiment in shared hospital-GP care of diabetes was reported as having had only limited success, despite careful planning. Fears were expressed that shared care of hypertensives would fare no better and that the portable record would be lost, forgotten, badly completed, or illegible. We therefore report our experience in collaborative care of hypertensives.

Methods

CLINIC PRACTICE

For the past three years essential hypertensives without complications have been returned to the care of GPs after initial investigation and control of hypertension. Those with grade 3 or 4 retinopathy, cardiac failure, renal damage, and primary renal disease have attended hospital for long-term follow-up at intervals determined by their primary disease and complications. They are issued with a blood pressure record (see figure), which they carry to the hospital and the surgery and on which all BP readings are recorded. The information

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Name.....

Record Number.....

Date	Time	Hours since last dose	Blood pressure				Drugs and dosage			
			Lying	Sitting	Standing	Exercise				

Hypertensive record used in survey.

is duplicated in the hospital notes (and no doubt in some surgery notes) in case the record is lost. The GP is left to decide the intervals at which he will see the patient, the postures in which he will record the blood pressure, and the BP level at which he will take action.

THE SURVEY

Over a three-month period 71 patients issued with BP records were due to attend our clinic. Eleven failed to attend, and 10 had forgotten their records. The record sheets of the remaining 50 patients were examined to see how often they attended their GP's surgery, how the blood pressure had been recorded, and whether alterations in treatment had been carried out when indicated. We had left the last decision to the GP but we applied an arbitrary rule that more than two diastolic readings of 105 mm Hg or above between two hospital visits called for a change of treatment by the GP.

The 50 patients were under the care of 44 GPs. We sent to each GP a questionnaire asking his views on the clinic's policy (which had not been discussed with GPs before being implemented) and the value, or nuisance value, of the shared record; we received 39 replies.

Results and discussion

The records of these 50 patients showed that 46 (92%) had the blood pressure recorded by the GP in person, 44 (88%) had the blood pressure recorded in two or more postures, 42 (84%) had details of time and interval since the last dose of drug recorded, 42 (84%) needed no change in treatment, 6 (12%) had necessary change in treatment, 2 (4%) needed a change, which had not been carried out, and all saw the GP at intervals of 7-60 days (mean 30).

Do the record sheets fulfil their purpose?

A high default rate is to be expected when largely asymptomatic patients, suffering more from their treatment than their disease, are asked to attend hospital at long intervals, without reminders, for many years. We regard the attendance rate of 85% as satisfactory. All the 11 patients who missed their appointments were recalled and re-attended after one or two reminders. The success of this hospital recall system, which is not duplicated in many general practices, is our main reason for retaining a share in the treatment of severe hypertensives.

Do GPs use the sheet as intended?

Patients were seen by GPs at surprisingly short intervals, implying a high level of conscientiousness in the control of blood pressure. Although many of the practices have attached nurses or health visitors, 92% of the readings were taken by the doctor himself and 88% were recorded in two or more postures. Only in eight of the records was a change in treatment called for by the criteria we employed and in six of these the GP had taken appropriate action.

Does the shared record help hospital staff and GPs?

Hospital staff have welcomed it. In the past letters were sent to GPs after each hospital visit but information rarely flowed in the opposite direction after the first referral letter. Changes in treatment by the hospital are now based on many more BP readings, usually taken without the anxiety of a hospital visit.

GPs had less to gain from the new system but 26 of the 39 who replied to our questionnaire said that they found the record a help in managing hypertensives. Presumably a tabulated record is more convenient than the usual mixture of GP records and hospital letters.

Thirty-six of the 39 doctors approved of the subdivision of work between hospital and general practice. Two thought that all essential hypertensives, including those with malignant hypertension, should be managed entirely by the GP.

Could the record sheet be improved?

Ten of the 39 doctors replying to our questionnaire had suggestions for improving it. The column for "hours since last dose" was included

at a time when many patients were taking short-acting drugs. Although there is a trend towards using longer-acting agents, we think that the column should be retained since it makes the doctor inquire about the last dose. This has disclosed that about 5% of patients attending hospital have forgotten to take their morning dose in the rush of getting to the clinic or have omitted it intentionally to avoid hypotension, drowsiness, or diuresis on the journey. It is clear from the record sheet that this occasionally happens also before visits to the GP. The column for postexertional blood pressure is virtually never used by general practitioners and has lost some of its importance with the declining popularity of sympathetic blockers. It could be replaced by a column for pulse rate now that beta-blockers have become first-choice antihypertensives.

Are we all measuring the same thing?

Shared care of hypertensives can work only if doctors trust one another's readings. Our questionnaire therefore inquired about technique. Thirty-six of the 39 respondents took the blood pressure with the cuff at heart level or with the arm at an angle of about 45° when the patient was sitting or standing, which gives much the same result. Twenty recorded fifth phase diastolic pressure, 14 fourth phase. Surprisingly few admitted sharing our difficulty in distinguishing either fourth or fifth phase in some patients. Broadly, it appeared that technique was similar except in one important respect: 27 doctors claimed to record blood pressure to the nearest 5 mm Hg; but readings on the record sheet show a definite digit preference for 0, as in many previous studies. In practice, therefore, BP is often recorded to the nearest 10 mm Hg. Only 11 doctors followed the hospital staff in recording to the nearest 2 mm Hg. We attach some importance to this practice since it encourages the observer to lower the mercury slowly and reduces errors arising from the fall in mercury between heart beats (important in patients with bradycardia from beta-blockers) and from the creation of a partial vacuum in the tube when the mercury falls rapidly.

Confidence in the system would be greater—and more firmly based—if all doctors agreed to measure blood pressure to 2 mm Hg and record fifth phase diastolic pressure.

Are our findings universally applicable?

In a city the size of Tyne and Wear a GP can send his hypertensive to any of 20 or more hospital physicians or manage him entirely from the surgery. No doubt he selects a consultant physician whose practices suit his own tastes. One would expect our clinic to be patronised by GPs interested in hypertension, keen to manage most patients themselves but conscientious in ensuring full investigation. They would inevitably answer favourably to the questionnaire we sent them. The patients in this survey, however, were a selected group on long-term management; half had reached us by emergency admission or referral from other consultants. Only nine of the GPs work in the designated catchment area of our hospital: the remainder are scattered over north-east England. We therefore believe that they are close to a random sample of GPs in the region and that our findings should be reproducible elsewhere.

Conclusion

Shared care of hypertensives, with the aid of a record carried by the patient, has proved successful over a three-year period and is acceptable to most hospital staff and GPs. The records are kept legibly and conscientiously. The knowledge that one's case records will be scrutinised by colleagues in hospital or general practice seems to concentrate the mind wonderfully.

We are grateful for the help of our colleagues in general practice who share the care of the patients we studied and who gave us an 89% response to yet one more tedious questionnaire.

Reference

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