GP trainees' views on hospital obstetric vocational training

SIR,—The views of general practitioner trainees with regard to hospital obstetric vocational training, highlighted by Lindsay F P Smith, are of concern in relation to hospital training and the future provision of intrapartum care by general practitioners.¹

As part of an initiative to encourage intrapartum care by general practitioners a community obstetric support group has been formed. It recently completed a postal survey of 235 principals in general practice in the Southampton area, to which a response rate of 84% (198 replies) was obtained. Although 52% of the respondents had the diploma of the Royal College of Obstetricians and Gynaecologists or a higher qualification and 89% had completed a minimum of six months' hospital obstetric training, we found, as in Smith's study, that current provision of intrapartum care was not related to completion of the hospital training post or possession of the diploma. The training, however, had increased perceived competence in that, for example, those who had completed it and had the diploma were less likely to report lack of confidence as being a factor in dissuading them from providing intrapartum care ($\chi^2=4.96$, $p=0.03$). Thus I agree that hospital training in itself fails to encourage general practitioners to use obstetric skills, although, interestingly, we found that younger doctors were more likely to report that encouragement from senior hospital colleagues would increase their involvement in intrapartum care.

It would be naive, however, to think that simply altering the nature of hospital training, needed though such changes may be, would provide an answer. In our study the main factors preventing general practitioners from increasing their involvement in intrapartum care were that it conflicted with surgery hours, daytime workload, and onerous on call rotas and that it adversely affected their social lives. Among the most cited comments medicolegal considerations were prominent.

General practitioner obstetrics probably provides a safe, cost efficient way of delivering care in low risk pregnancies² with the advantage of personal knowledge of the expectant mother. Besides educational and other initiatives such as the organisation of local rotas of interested doctors and encouragement from hospital colleagues, it should be encouraged by the government and family health services authorities, which should allow for it in the hours of availability criteria in the general practice contract and provide remuneration commensurate with the disruption that it often entails.

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1 Smith LFP. GP trainees' views on hospital obstetric vocational training. *BMJ* 1991;303:1447-50. (7 December.)

2 Campbell R, Macfarlane A, Cavenagh S. Choice and chance in low risk maternity care. *BMJ* 1991;303:1487-8. (14 December.)

Doctors in the making

SIR,—*Doctors in the Making*,¹ which Stephen Hunter discusses in an editorial,² suggests formalising an arrangement that has tacitly been the case for some time. In reality experienced sisters have taken the lead in supporting and advising junior doctors for many years, but in many instances they have had to play the so called "doctor-nurse" game as their lines of authority have not been clear. It is important that this interrelationship has been acknowledged.

Furthermore, it is the sister who has day to

day responsibility for the smooth running of the ward. It is unrealistic to ask someone to manage an environment if he or she does not have some degree of authority for the people working there. Acknowledging lines of accountability would go some way to making this task less complex as well as giving recognition to the skill required of a sister.

The report offers a valuable insight into the work of junior doctors and suggests pragmatic solutions. It should be welcomed by nurses and doctors alike.

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1 Dowling S, Barrett S. *Doctors in the making. The experience of the pre-registration year*. Bristol: SAUS Publications, Bristol University, 1991.

2 Hunter S. Doctors in the making. *BMJ* 1991;303:1415-6. (7 December.)

Rugby injuries

SIR,—In response to the editorial and correspondence calling for an audit of rugby injuries^{1,2} I would remind doctors of the service provided by the consumer safety unit of the Department of Trade and Industry. The home accident surveillance system, leisure accident surveillance system, and home accident deaths database are all run by the department and can provide data in the form of tables or case listings. The data for the home accident surveillance system and leisure accident surveillance system are taken from a sample of hospitals in Great Britain selected to represent the population as a whole. Information on the injuries and circumstances in which they occurred are collected from the patient by interview and from the medical records. Data for the home accident deaths database are collected from the Office of Population, Censuses and Surveys and area electricity boards and from death registration forms.

Those concerned with rugby injuries may wish to know that in 1989 the leisure accident surveillance system recorded 2574 patients reporting to an accident and emergency unit with injuries sustained while playing rugby (a national estimate of 91 000). Further information (for example, type of injury, age of patient, length of inpatient stay) can be obtained from the consumer safety unit, Room 306, 10-18 Victoria Street, London SW1H 0NN (tel 071 215 3215). The unit can also supply an annual report on the three databases, containing the most requested breakdowns of data.

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1 Garraway WM, Macleod DAD, Sharp JCM. Rugby injuries. *BMJ* 1991;303:1082-3. (2 November.)

2 Correspondence. Rugby injuries. *BMJ* 1991;303:1401-2. (30 November.)

The health strategy

SIR,—David J Hunter is right to observe the need for intersectoral action at the central level of the Whitehall "village."¹ But this is only one of the levels at which policy can be formed, albeit an important one for matters such as tobacco taxation. He has failed to recognise the regional or sub-national level of activity that is of increasing importance both in the United Kingdom and throughout Europe.

The World Health Organisation's European regional office recently convened a meeting in Switzerland at which representatives from Lower Saxony, Catalonia, the canton of Geneva, Wales, and elsewhere came together to discuss the de-

velopment of subnational policies for health. The emphasis was on health, not health services, as the starting point in the analysis, and on local arrangements for participation in both the formulation of policy and the implementation of programmes. Wales has been following this approach since 1989² as it attempts to fold the principles of Health for All by 2000³ into the fabric of its health service. The Welsh protocols for investment in health gain are further evidence of a health focus, and each emphasises the need for intersectoral collaboration.^{4,7}

The fulcrum has been shifting for some time in many English regions and districts, and it is at these levels, rather than through central effort, that real differences will be made in terms of health status.

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1 Hunter DJ. The health strategy and the hole at the centre. *BMJ* 1991;303:1350. (30 November.)

2 Welsh Health Planning Forum. *Strategic intent and direction for the NHS in Wales*. Cardiff: Welsh Office/NHS Directorate, 1989.

3 World Health Organisation Regional Office for Europe. *European regional strategy for attaining health for all*. Copenhagen: WHO, 1981.

4 Welsh Health Planning Forum. *Protocol for investment in health gain—cancers*. Cardiff: Welsh Office/NHS Directorate, 1990.

5 Welsh Health Planning Forum. *Protocol for investment in health gain—cardiovascular diseases*. Cardiff: Welsh Office/NHS Directorate, 1991.

6 Welsh Health Planning Forum. *Protocol for investment in health gain—maternal and early child health*. Cardiff: Welsh Office/NHS Directorate, 1991.

7 Welsh Health Planning Forum. *Protocol for investment in health gain—physical and sensory disability*. Cardiff: Welsh Office/NHS Directorate, 1991.

SIR,—David J Hunter's proposal in his editorial that government departments are incapable of transcending their inherent rivalry in order to collaborate is reasonable.¹ He warns that the Department of Health's consultation document *The Health of the Nation* may fail as a result. He suggests that the Department of the Environment should lead on health issues and advocates a new interdepartmental mechanism to broaden the health debate. He comments favourably on the recent developments in New Zealand whereby public health services have been separated from personal health services. This mixed bag of remedies is highly questionable.

Firstly, the Department of the Environment has shown no evidence hitherto of working outside its brief towards a broader health strategy. Leadership on environmental control policy has come recently from the European Commission. Secondly, Hunter offers no evidence that a new cross departmental mechanism will have more success than similarly ill fated initiatives (the Department of Economic Affairs and central policy review staff).² Thirdly, his recommendation of a managerial separation of personal and public health services needs greater description and justification.

Is he recommending the creation of a new government department with a network of regional public health services? Such an arrangement seems unlikely to advance the development of a coherent health strategy. The Department of Health has received an overwhelming response to its consultation document. The process has a considerable way to go. Another reorganisation of the health system can only add to the "change fatigue" being felt by those in the NHS currently trying to implement an imported organisational model. We wonder, like McLachlan, whether an obsession with structure, based on managerial theory, may be an obstacle to formulating broad based health policy.³

Or is Hunter suggesting that the separation of services should occur within an administrative unit responsible for a population similar to that of New Zealand (3.3m), such as an NHS region or Wales? The integration of a wide range of services for health at a regional level has attractions for the

future. The development of a coherent strategy across all sectors following a health lead has been shown to be possible in Wales.⁴

NHS regions in the United Kingdom may have the option of looking towards Brussels rather than Whitehall for health policy in the longer term. The mere suggestion of this may be enough to get Whitehall departments collaborating more effectively to fill "the hole at the centre."

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- 1 Hunter DJ. The health strategy and the hole at the centre. *BMJ* 1991;303:1350. (30 November.)
- 2 Hennessy P. *Whitehall*. London: Secker and Warburg, 1989.
- 3 McLachlan G. Public health at the crossroads. In: Holland WW, Detels R, Knox G, eds. *Oxford textbook of public health*. Oxford: Oxford University Press, 1985:50-9.
- 4 Welsh Health Planning Forum. *Local strategies for health: a new approach to strategic planning*. Cardiff: Welsh Office, 1989.

Doctors convicted of manslaughter

SIR,—Several correspondents, writing after two junior hospital doctors were convicted of manslaughter,¹ have drawn attention to the inadequacies of training in drug administration that is given to recently qualified medical staff.² None of these correspondents have attempted to quantify the problems that exist.³

Before the circumstances of the recent tragedy were published we carried out a preliminary survey of 34 of the 37 preregistration house officers in a teaching hospital six weeks after the start of their first house job. Equal numbers of surgical and medical staff were interviewed by telephone on a single day. After determining whether or not each doctor had administered intravenous ranitidine (chosen because there had been publicity about the potential danger associated with its use⁴) we asked them how the drug should be administered. Only three of the 15 doctors who had used the drug gave correct responses (diluting each 50 mg in 20 ml and giving the injection over at least two minutes), and only one of the 19 without personal experience of administration gave an appropriate answer.

These preliminary data highlight the need for a comprehensive review of the practical training offered to junior staff in the use of intravenous treatment. Widespread deficiencies seem likely, and unless these are both recognised and addressed urgently we fear that unnecessary tragedies will continue to occur.

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- 1 Dyer C. Doctors convicted of manslaughter. *BMJ* 1991;303:1157. (9 November.)
- 2 Correspondence. Doctors convicted of manslaughter. *BMJ* 1991;303:1399. (30 November.)
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- 4 Hart AM. Cardiac arrest associated with ranitidine. *BMJ* 1989;299:519.

AIDS campaigns: putting the message across

SIR,—“Don’t die of ignorance” was the message of the first AIDS awareness campaign in Britain. Since its launch there have been many other attempts to put the message across throughout the British Isles,¹ although the incidence of HIV infection has continued to rise. We have been investigating the spread of AIDS in Greenland, particularly in relation to the effectiveness of the anti-AIDS campaigns initiated by the Danish and Greenland health authorities. Our findings on

the success of campaigns applied cross culturally may be relevant to Britain: does the anti-AIDS campaign ignore the cultural, economic, and ethnic diversity that characterises modern Britain?

Native peoples who inhabit the Arctic experience high levels of sexually transmitted diseases.² The first cases of HIV infection in Alaska, Greenland, and Canada were diagnosed in 1987 and 1988. Subsequently, several deaths from AIDS have occurred among indigenous people. In Greenland now there are 15 HIV positive people³; the first person to die of AIDS in Greenland, in 1989, was a 26 year old bisexual man who had contracted the disease in Denmark. Danish doctors now fear that HIV may be endemic in Greenland’s population (55 000 people).⁴ Originally, the doctors hoped that early diagnosis and an AIDS campaign could contain transmission of the virus.

The AIDS campaign in Greenland, called “STOP-AIDS,” was introduced by the Danish and Greenland health authorities in 1986-7. Reducing the number of sexual partners and safe sex were the major issues. The message had been designed and tested in Denmark and was therefore specific to Danish culture; little was addressed to Greenland’s cultural conditions.

It is widely believed that the Inuit (Eskimos) are promiscuous because of a greater tolerance of sexual freedom. The campaign urged the Greenlanders to limit their sexual activities to fewer people and to use condoms. Our research suggests that the AIDS awareness campaign needs to be re-evaluated; it should show an understanding of Greenland’s values and sexual norms rather than denounce “promiscuity.”

With this in mind, we wonder whether British AIDS campaigns should be re-evaluated to ensure that all sections of the population are being targeted efficiently—as attitudes to sexual behaviour and risk vary among socioeconomic and ethnic groups. Essentially, is a national AIDS awareness campaign appropriate to the whole population? AIDS poses a threat to everyone; is the message being put across?

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- 1 Johnson AM. Out of the shadows. *BMJ* 1991;303:1484. (7 December.)
- 2 Nuttall M. AIDS in Greenland. *Anthropology Today* 1990;6(5):25.
- 3 Statsministeriet. *Gronland arbeg*. Copenhagen: Statsministeriet, 1990:224.
- 4 AIDS-ertut nunaat marluk. *Sermisig* 1990 February 9:38.

Wasted drugs in HIV infection and AIDS

SIR,—By 31 March last year 4454 cases of AIDS in the United Kingdom had been notified to the World Health Organisation. A recent report on the use of designated funds for the care of those with HIV infection raised the issue of appropriate allocation and gave several opinions.¹ We believe that modifying prescribing practice and reducing the wastage of drugs may lead to considerable savings.

Increasingly, people affected by AIDS and HIV are being cared for in the community. Centres are facilitating this in various ways in an attempt to provide maximum support at home when inpatient care is unnecessary. Bloomsbury and Islington District Health Authority provides a community care team linked to the Middlesex and University College Hospitals to support the primary health care team in managing symptomatic late and end stage disease.

After a patient’s death drugs that have been prescribed are collected from the patients home by

a community care team worker and returned to the pharmacy department at the Middlesex Hospital. The drugs are destroyed in accordance with guidance obtained from the Royal Pharmaceutical Society of Great Britain, which maintains that dispensed medicines intended for one patient should not be reused for another. This relates to the Consumer Protection Act 1987.

As large amounts of expensive drugs were being returned we decided to monitor this wastage. For the 13 months from 1 August 1990 to 31 August 1991 the value of drugs returned was £26 504. Returns from 15 patients were itemised individually after their death and the average cost of excess drugs found to be £721 per patient. Drugs contributing most to this figure included zidovudine, ganciclovir, fluconazole, foscarnet, acyclovir, and pentamidine. This wastage may be due to over-prescribing or, more probably, to duplicate prescribing by clinicians in different departments and general practitioners concerned in the shared care of patients with disease related to HIV infection. The possible national cost of this problem is considerable.

To address this issue we are evaluating a patient held medication record card for patients with disease related to HIV infection. Such a card ensures that a history of medication and dispensing record are immediately accessible to patient, doctor, and pharmacist. The cards are cheap, and anecdotal experience of paediatric and obstetric practice suggests that patients are receptive to them.

The expense of drugs used to treat patients with HIV infection and AIDS and the requirement for long term maintenance treatment make it essential to address the issues of rational prescribing and communication between prescribers. This will provide the best in medical care combined with responsible use of resources. Many other specialties prescribe rapidly changing regimens of expensive drugs, and an examination of this practice may lead to substantial savings in those specialties too.

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- 1 National Audit Office. *HIV and AIDS related health services*. London: HMSO, 1991.

Women in general practice

SIR,—Charles A West complains about the inequitable treatment given to female general practitioners, who can have up to 40 weeks’ voluntary absence from work on account of pregnancy. If West could sort out his anatomy many of us would be delighted for him to have the baby and the leave. On the other hand, perhaps he should join those who negotiate on his behalf. Many organisations, ours included, allow paternity leave and adoption leave. But of course the staff are salaried.

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- 1 West CA. Women in general practice. *BMJ* 1991;303:1205. (9 November.)

Bureaucratic record?

SIR,—I have been asked to provide 17 copies of my curriculum vitae with my application to join the orthopaedic registrar rotation at St George’s Hospital, London. Is this a record?

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