- 1 Martines JC, Rea M, de Zoysa I. Breast feeding in the first six months. *BMJ* 1992;304:1068-9. (25 April.)
- 2 Black J. Paediatrics among ethnic minorities. Asian families. II. Conditions that may be found in their children. *BMJ* 1984; 290:530-3.
- 3 Lee E. Asian infant feeding. *Nursing Mirror* 1985;160(21):S14-5.
- 4 Koramoa J, Lingam S. Feeding practices and problems in Afro-Caribbean children. *Clinic Talk—Milupia* 1992; No 5 (April): 8-9.

Gonad protection in young orthopaedic patients

EDITOR,—We agree with Nicholas Kenny and John Hill that gonad shields tend to be omitted or inadequately positioned in many radiographic examinations.¹ We can see a potential pitfall, however, in the authors' suggestion that gonad shielding should be used during radiographic assessment of congenital dislocation of the hip (developmental dysplasia of the hip).

In the initial assessment of children with developmental dysplasia it is important to exclude congenital lumbosacral abnormalities. There is also value in checking for correct alignment of the symphysis pubis. Our practice, therefore, is to perform the initial examination without a gonad shield, reserving this for subsequent studies. Dosimetry studies with a phantom have shown that we can reduce the radiation dose to the whole region by performing the examination with a fluoroscopic unit equipped with a 100 mm camera. The quality of these images is adequate for measuring the acetabular shape and assessing bony morphology. With a fluoroscopy time of five seconds and a single exposure, the radiation dose to the skin is roughly one sixth of that delivered during a standard radiographic examination. Using fluoroscopy increases the chance of correct alignment on first exposure and reduces the number of repeat films necessary.

In young patients the cumulative effects of ionising radiation are a concern, and we see no reason why magnetic resonance imaging should not be used for all examinations for slipped capital femoral epiphysis.

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- 1 Kenny N, Hill J. Gonad protection in young orthopaedic patients. *BMJ* 1992;304:1411-3. (30 May.)

Epidemiological aspects of travel related illness

EDITOR,—We agree with John D H Porter and colleagues about the need for appropriate surveillance systems, improving communication between health professionals, quantifying risks, facilitating targeted education, and a nationally coordinated computer database to combat the increasing problem of travel related illness.¹

Since 1978 a surveillance programme involving 13 816 travellers returning from abroad has been carried out at the Communicable Diseases (Scotland) Unit both to establish the pattern of travel related illnesses and in response to specific episodes of reported illness.² Comparative analysis of the data has enabled a risk profile to be defined³; this profile correlates with similar studies conducted in Switzerland⁴ and Finland.⁵ To broaden the epidemiological picture further, analyses have been made of hospital admission data,² the collated laboratory reports for infections imported into Scotland,^{6,7} deaths of Scots abroad,⁸ travellers attending a local clinic for immunisation against yellow fever,⁹ and travellers' immunity to infections that are preventable by immunisation.²

The availability of computer technology in primary care has considerable potential for travel medicine. For example, in Scotland one system is common to over 700 practices, covering 60% of the population.¹⁰ The possibility exists of conducting a data search for patients attending for health advice before travelling and, some months later, comparing this with an analogous search for those patients treated for a travel related illness.

There is logic in this approach in view of the general practitioner's role in giving advice both before travel and after return.¹¹ In recognition of the difficulties that the general practitioner may have in giving advice a computerised database (Travax) was established in 1982.¹¹ This nationally accessible database is freely available to NHS users with suitable hardware; it contains recommendations on immunisations for individual countries, advice on preventing malaria, and details about particular vaccines with information to help make a balanced judgment when indications are not clear cut. A recent development is the installation of a telephone networking system throughout the United Kingdom, enabling easier access by local telephone call from a suitable modem linked to a screen display. Much remains to be done, but progress has been made.

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- 1 Porter JDH, Stanwell-Smith R, Lea G. Travelling hopefully, returning ill. *BMJ* 1992;304:1323-4. (23 May.)
- 2 Cossar JH, Reid D, Fallon RJ, Bell EJ, Riding MH, Follett EAC, et al. A cumulative review of studies on travellers, their experience of illness and the implications of these findings. *J Infect* 1990;21:27-42.
- 3 Cossar JH, Reid D. Health hazards of international travel. *World Health Stat Q* 1989;42(2):27-42.
- 4 Steffen R, van der Linde F, Syr K, Schar M. Epidemiology of diarrhea in travellers. *JAMA* 1983;249:1176-80.
- 5 Peltola H, Kyröseppä H, Holsa P. Trips to the south—a health hazard. *Scand J Infect Dis* 1983;15:375-81.
- 6 Sharp JCM. Imported infections into Scotland, 1975. *CDS Weekly Report* 1976;76/26:v-vi.
- 7 Campbell DM. Imported infections into Scotland, 1986. *CDS Weekly Report* 1987;87/47:7-8.
- 8 Paixao MLTD'A, Dewar RD, Cossar JH, Covell RG, Reid D. What do Scots die of when abroad? *Scott Med J* 1991;46: 114-6.
- 9 Wacławski ER, Walker E. Yellow fever vaccination and business travel. In: Steffen R, et al. *Travel medicine: proceedings of the first conference on international travel medicine*, Zurich, 1988. Berlin: Springer-Verlag, 1989:238-9.
- 10 Milne RM, Taylor MW, Duncan R. An assessment of computing activity by GPASS users in Scottish general practice. *Health Bull* 1991;49:152-60.
- 11 Cossar JH, Reid D. Immunisation and health advice for travellers: the role of the general practitioner. *Health Bull* (in press).

Day hospitals for elderly people

EDITOR,—The results of the Bradford community stroke trial at six months¹ and of the Canadian² and New Zealand³ trials of day hospitals give little support to the use of day hospitals in rehabilitation, yet in recent decades geriatricians have tended to rate rehabilitation as the main purpose of day hospitals.⁴ This expensive service will be under intense scrutiny by those planning services for elderly people.

Rehabilitation is only one of the functions of day hospitals. In the early days of geriatric day hospitals their primary objective was stated to be the physical and social maintenance of frail and vulnerable people.⁵ In the 1990s this means keeping patients in their own homes and out of nursing homes. This previously unfashionable aspect of care in geriatric day hospitals has been less well studied but may become fashionable again in the wake of attempts to implement changes in the provision of social services.

In the studies from New Zealand and Bradford the patients were relatively young (average age

about 70) and the rates of admission to nursing and residential homes were not quoted. In the Canadian study the patients were considerably older (average 79), and a small, non-significant trend towards lower rates of admission to nursing and residential homes was seen in the day hospital group. Preliminary results from an elderly group (average age 79) in a randomised study in Nottingham, however, indicated that death rates and rates of admission to nursing and residential homes were lower in patients attending day hospitals than in those receiving domiciliary rehabilitation.⁶

The Bradford community stroke trial has shown that rehabilitation is better delivered at home than in a day hospital: this is a step forward for the care of patients with stroke. Some of these patients, however, need maintenance rather than rehabilitation, and day hospitals may best fulfil that role.

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- 1 Young JB, Forster A. The Bradford community stroke trial: results at six months. *BMJ* 1992;304:1085-91. (25 April.)
- 2 Eagle DJ, Guyatt GH, Patterson C, Turpie I, Sackett B, Singer J. Effectiveness of a geriatric day hospital. *Can Med Assoc J* 1991;144:699-704.
- 3 Tucker MA, Davison JG, Ogle SJ. Day hospital rehabilitation—effectiveness and cost in the elderly: a randomised controlled trial. *BMJ* 1984;289:1209-12.
- 4 Brocklehurst JC, Tucker JS. *Progress in geriatric day care*. London: King Edward's Hospital Fund, 1980.
- 5 Cosin L. The place of the day hospital in the geriatric unit. *Practitioner* 1954;172:552-9.
- 6 Gladman JRF. A randomised controlled trial of a domiciliary rehabilitation service for elderly stroke out-patients [abstract]. *Age Ageing* 1992;21(suppl 1):11.

Implementing patient's charter in outpatient services

EDITOR,—Charles Collins's editorial about implementing the patient's charter in outpatient services is mainly about outpatient appointments for those needing surgery.¹ For those visiting a rheumatology department who will never need surgery the position is entirely different. They need more than is apparently envisaged in the casual direction to explain any treatment, which is slipped in among all the other items suggested to be essential in 20 minute consultation. They need considerable help and counselling about how to manage their arthritis, and it is commonly accepted that those who receive adequate information are likely to make better progress than those who do not. Of course the consultant will not have time to do this, but there should be someone in the team who has.

Arthritis Care believes that the provision of a rheumatology practice nurse in every rheumatology department is essential and would welcome the BMA's support for this in any discussions about the patient's charter.

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- 1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;304:1396. (30 May.)

EDITOR,—In his editorial on implementing the patient's charter in outpatient services Charles Collins advocates the judicious use of telephone contact with patients.¹ Experience in genitourinary medicine indicates that this can be valuable, but it has staffing costs. Standard practice in most genitourinary medicine clinics has been to allow patients to telephone to learn the results of their investigations with the aim of avoiding unnecessary visits, and of course the results and advice may have to be amplified.

The use made of this facility was monitored in a

provincial clinic seeing around 4500 new cases a year. In two weeks 116 calls were made for results and 65 for advice (roughly 9000 annually). Most of these calls were dealt with by clerical and nursing staff, but to do so adequately they require experience and training. If telephone calls are to be used more their use should be included in routine statistics and the demand they make planned for.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;304:1396. (30 May.)

EDITOR,—The subheading of Charles Collins's editorial on implementing the patient's charter in outpatient services seems naive.¹ Perhaps more resources are needed? Perhaps many of those who, like me, practise mainly in outpatient clinics may be permitted a hollow laugh. I have no doubt that Collins is right in everything he says, but being right is not always practical, nor is it necessarily fair.

My new patients are booked at 10 minute intervals. If I adhered to Collins's standard of 20 minutes for a new patient I would have to cut my clinics in half, even without allowing spaces for emergencies. As over the past six weeks I have received about 25 referral letters weekly for my 18 clinic appointments this might be expected to increase the waiting time for a routine appointment—presently five months. It would also increase the number of patients who forget their appointment, and I would then sit twiddling my thumbs.

We should heed the lesson of the "rubber windmill"; unless there is a massive increase in consultant manpower quality must be sacrificed. In our unit the need for two obstetricians, an orthopaedic surgeon, and an anaesthetist is paramount yet unaffordable, so what chance do I have?

Of course the advent of fundholding practices will enable me to make contracts appropriate in quantity to my quality standards. I estimate that this would enable me to exclude from my clinics the patients of one half to two thirds of local general practitioners. Somehow I don't think this would go down very well. Which is better: to provide a reasonable service to all or a perfect service to a few? I have suggested before that patients prefer to have a half hour wait to be seen in a clinic than to suffer an extra delay for an appointment in the first place.²

It is also worth noting that the charter does not actually require patients to be seen within 30 minutes of their appointment time, only that a reasonable explanation is offered if they are not so seen. So far that has not proved a problem.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;304:1396. (30 May.)

2 Bamji AN. "No show" fines [letter]. *Times* 1989 June 20.

Trusts need local negotiating committees

EDITOR,—Hart refers to the urgency with which all trust hospitals and potential trust hospitals should set up local negotiating committees and to these committees' need for help and guidance from the BMA's regional industrial relations offices.¹ Hart also reports that the most successful region in this respect is Mersey, where all the trusts have local negotiating committees. This is largely due to

an active regional office and a conscientious industrial relations officer.

Hart states that provision has been made in the BMA's budget to expand the regional staff if required. Yet only this week I have learnt that the finance and general purposes committee is proposing that Mersey regional office should be closed. This does not seem to make any sense, and I urge a rapid rethink.

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1 Hart. Vigilance in the face of bullishness. *BMJ* 1992;304:1530. (13 June.)

BMA's view on generic substitution

EDITOR,—I must correct the information given by David Taylor in the first paragraph of his news item on generic substitution becoming law in the European Community.¹ He states that the BMA vigorously supported the Greenfield committee's recommendation that pharmacists could substitute a generic medicine for a branded one unless the doctor had specifically vetoed this. The truth is actually the opposite.

In its response to the Greenfield report the General Medical Services Committee proposed that the prescriber should have to make a positive indication on form FP 10 when generic substitution by a pharmacist was acceptable.² At all other times the medicine should be dispensed as written. The GMSC has not changed its policy and continues to believe that a positive opt in is safer and more appropriate than an option by default.

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1 Taylor D. Generic substitution may become EC law. *BMJ* 1992;304:1529. (13 June.)

2 General Medical Services Committee. *Annual report*. London: GMSC, 1983:appendix VI.

Consultants' communications with general practitioners

EDITOR,—Graham Read raises an important issue.¹ As a result of the new Access to Health Records Act can general practitioners and consultants still communicate honestly by letter? Patients may ask for access, see the information (including results), and become worried.

There is evidence accumulating from around the world that record access is safe. Denmark has allowed access since 1989 without problems² and, in both the United States³ and Europe, with outpatients⁴ and inpatients,⁵ and in general practice,⁶ record access does not lead to fear and trauma for patients. The reason is simple: those who request access want to know. They want to know the bad news as well as the good.

In our practice for the past six years we have allowed access in a more liberal fashion than the act currently allows: patients are handed their notes in the waiting room and have time to read them if they wish. We have found that patients welcome this move, find it reassuring, and think that it enhances the doctor-patient relationship. About 40% choose not to read their records but are satisfied with this arrangement.⁶ Most people are well able to decide for themselves.

Read is reluctant to expose his patients to the truth because he is concerned that it may hurt them and, in the process, risks offering too little information to the general practitioner so that the care of the patient is jeopardised. This approach, although well meaning, is essentially patronising to

the patient, apart from being risky. If patients choose to have information about themselves and to go through the barriers the act puts in their way, then they are entitled to that information. The doctor's job is to translate the technical information and put the results into perspective, as Read shows he could ably do.

The act gives us an opportunity to relate more honestly to patients and to demystify medicine to some extent. We should take that opportunity, not avoid it. The answer to Read's dilemma is to carry on writing the letters he always wrote. Both patients and the system will cope admirably.

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1 Read G. Consultants' communications with general practitioners. *BMJ* 1992;304:1248. (9 May.)

2 Andersen T. Danish experience of statutory right of patients to access hospital records. *Lancet* 1988;ii:1428.

3 Golodetz A. The right to know: giving the patient his medical record. *Arch Phys Med Rehab* 1976;57:78-88.

4 Hertz C. Patient participation in the problem-oriented system: a health care plan. *Med Care* 1976;xiv:77-9.

5 Steven D. What happens when hospitalised patients see their own records? *Ann Intern Med* 1977;86:474-7.

6 Baldry M, Cheal C, Fisher B, Gillet M, Huet V. Giving patients their own records in general practice: experience of patients and staff. *BMJ* 1986;292:596-8.

EDITOR,—I cannot agree with Graham Read's comments regarding passing information concerning the extent of severe illness and its prognosis to general practitioners.¹ General practitioners are often asked to explain what has occurred at hospital clinics, where anxiety and bewilderment are likely to interfere with full comprehension of what has been said. Often we are asked for advice about future management, and, though we are unlikely to be experts in oncology, we may have an overview and a better understanding of a patient's particular position. We need the information on what has been found and disclosed by the specialist team and may also need to prepare ourselves for future management.

Read expresses a concern that patients may wish to see the letter and be upset by what they read. If patients wish to see the letter this suggests that they want to discover the truth. Though they may be upset initially, patients are often better able to handle reality than the doctor may conceive. Ley quotes several studies which showed that over a third of patients considered that they had not been given enough information, though he comments that telling patients in itself is not enough.² They have to be told in ways they can understand and remember. As communicators, doctors need to learn how to explain "residual thickening" or "slight nodal enlargement" without causing unreasonable alarm. If a patient wishes to remain ignorant written evidence will not be requested. There may be exceptions, but that is for the general practitioner to decide at the time of the request.

If we expect patients to trust us we should not cheat, and we should trust patients to make their own judgments about how far they seek for the truth. There is no place for a letter that requires a doctor to read between the lines.

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1 Read G. Consultants' communications with general practitioners. *BMJ* 1992;304:1248. (9 May.)

2 Ley P. *Communicating with patients*. London: Croom Helm, 1988.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.