Community hospitals

Many provide acute services

EDITOR.—Sam Ramaiah raises several relevant issues relating to community hospitals today.¹ The experience he reports from South Tees, however, focuses only on the non-acute aspects of care in such hospitals. His vision of an administrative centre with little acute medical activity is far removed from reality.

Many community hospitals are already adapting to meet the challenges of providing acute care. Day surgery and minimal access techniques are expanding the range of surgical activity currently suitable for such hospitals. The introduction of ultrasound imaging, gastrointestinal endoscopy, and desk top laboratories has greatly enhanced locality diagnostic services.

In the present climate in the NHS, specialists are increasingly aware of patients' preference to be seen and treated in their own community and of general practitioners' preference for this. The planned development of community based services with a 40% reduction in beds in district general hospitals; a considerable increase in locality based outpatient clinics; and the increase in the number of over 85 year olds, in whom care and not cure is practical, are likely to lead to an increased demand for beds in community hospitals.

Each community hospital continues to evolve uniquely to meet local needs and in today's competitive setting can still do so successfully. The identification and development of appropriate services are vital. Innovations in local care are legion, and several will be featured in the annual symposium of the Community Hospitals Association to be held in Hythe on 3-4 May. Those who doubt, or lack ideas, should book now.

DAVID POPE

Quarter Jack Surgery,
Wimborne,
Dorset BH21 1AP

1 Ramaiah S. Community hospitals in the new NHS. *BMJ* 1994;308:487-8. (19 February.)

Community hospitals not available to everyone

EDITOR.—Small hospitals come into and go out of fashion, as Sam Ramaiah says.¹ They have been described as cottage hospitals, general practitioner hospitals, community hospitals, and community care centres. One issue that is often overlooked is the equity of care that they provide. For some services (such as outpatient and casualty services) they may improve equity by bringing services to rural areas. But for other services such as general practitioner beds (particularly in urban community hospitals) inequity will arise if only a proportion of general practitioners have access to these beds. In practice (and leaving aside the problem that some general practitioners may not want to use community hospital beds) this seems inevitable since most small community hospitals can cover the patients of only 15 to 20 general practitioners.² In most districts it is inconceivable that enough community hospitals could be built to serve all patients.

One solution suggested in 1974 was to build larger community hospitals or to convert other hospitals into community hospitals.³ The concept was unpopular, and few units conformed to this plan.² The idea has resurfaced⁴ but may founder again if in some areas district general hospitals are downgraded to community hospitals, which is likely to cause considerable public opposition. Another reason for the lack of large community hospitals is that their small size is seen by many as a strength.

Another solution is to consider some of the "rival" institutions described by Ramaiah as complementary to community hospitals rather

than a threat. They may be used to provide services in areas where there is no community hospital cover. In Buckinghamshire, where there are five community hospitals covering half the population, we have been working closely with the social services department, which is developing its network of "resource centres" (part III homes with an extended and more flexible role). We hope to agree joint policies for certain services such as respite care to improve equity of access across the county.

DAVID CHAPPEL

Department of Public Health Medicine,
Milton Keynes Hospital Campus,
Milton Keynes MK6 5LD

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No one asked the patient

EDITOR.—I read M Heim and colleagues' debate on a difficult case with concern. Several doctors were asked how best to manage a 68 year old diabetic woman with a right below knee amputation and an infected ulcer on her left heel who presented with a fracture of her left hip. There were two schools of thought—to operate and not to operate—each of which had risks and benefits. Members of each school argued their case forcefully.

But no one asked the patient what she wanted. Surely in such cases of finely balanced clinical judgment it is the patient who, after the situation has been explained, should take the final, difficult decision. After all, the decision is more to do with the balance between risk and return than with medical knowledge. The job of doctors in such situations is to present unbiased advice and not to take decisions, based on their own values, on the patient's behalf. As well as being the right action for the patient this is the best option for the doctor. Who among us needs another difficult value based judgment?

SUSAN DICKIE

London NW3 4SJ

- 1 Heim M, Zievner Y, Nadorva H, Azaria M, Ruckley CV, Klennerman L, et al. Should an elderly diabetic woman with a right below knee amputation and an infected sore on her left heel be operated on for a fractured hip? *BMJ* 1994;308:517-9. (19 February.)

Mental health law

EDITOR.—We were interested to read Nigel Eastman's comments on the possible lack of knowledge of mental health law among doctors¹ and to learn that the Royal College of Psychiatrists and the Department of Health are considering action to remedy the situation.² The problem is not confined to a single jurisdiction. Recent work in Scotland has shown that junior psychiatrists at all stages of training have a patchy knowledge of the provision made in the Mental Health (Scotland) Act 1984 for emergency compulsory detention³ and that the same is true of general practitioners (M S Humphreys and A Ryman, unpublished data). This is obviously of concern in a country where the most common means of formal admission to hospital—in more than 3000 cases each year and for up to 72 hours at a time—is an "emergency recommendation." This may be made by any registered medical practitioner acting alone with, "where practicable," the consent of a relative or

specially trained social worker. The need for the continuing education of clinicians has been recognised, and, in collaboration with the Mental Welfare Commission for Scotland, we are producing an educational package for doctors who use the emergency powers of the act.

Further research into doctors' understanding and practice of the law in this and other areas is clearly needed. In our opinion, the problem is not just that doctors are ignorant of the facts. Ease of access to a process and superficial familiarity with it may lead to complacency. Important issues of civil liberties may be taken less seriously than they should be. A survey of psychiatrists working in the United States found that the rather dismissive and paternalistic attitudes adopted by participating practitioners towards the use of involuntary admission to hospital was of equal, if not greater, concern than their apparent lack of familiarity with the law.⁴

Until there is a more pervasive sense of concern for mentally disordered people it may prove difficult to effect change even among professionals. There are still those who might be prepared to condone the use of mental health legislation as an instrument of social control.⁵ We trust that they are in the minority.

MARTIN S HUMPHREYS

JOHN R GEDDES

Royal Edinburgh Hospital,
Edinburgh EH10 5HF

- 1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5. (1 January.)
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- 4 Affleck GG, Peske MA, Wintrob RM. Psychiatrists' familiarity with legal statutes governing emergency involuntary hospitalisation. *Am J Psychiatry* 1978;135:205-9.
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Acute renal failure associated with NSAIDs

EDITOR.—G W Smith and S B Cohen report on a 79 year old woman who was taking non-steroidal anti-inflammatory drugs and developed renal impairment and hyperkalaemia when a urinary tract infection was treated with trimethoprim.¹ They unreasonably dismiss the non-steroidal anti-inflammatory drug as a possible cause of the renal disease.

Non-steroidal anti-inflammatory drugs inhibit the normal tonic renal vasodilatation induced by prostaglandin. Loss of this tonic dilatation may be tolerated during health but not in unwell patients, particularly if there is volume depletion or a strong vasoconstrictive drive.² Many illnesses, including urinary tract infection, can result in enhanced renal vasoconstriction mediated particularly by the renin-angiotensin axis. In the absence of drugs these renal effects of angiotensin II are opposed by prostaglandins.³ Acute salt or volume depletion is sufficient to render even young health volunteers at risk of renal impairment induced by non-steroidal anti-inflammatory drugs,² and elderly people seem particularly susceptible to these effects.⁴

Thus an elderly patient who is well may have stable renal function while taking non-steroidal anti-inflammatory drugs; illness, however, may result in enhanced vasoconstriction which cannot be opposed by prostaglandins in the kidney and therefore results in a fall in the glomerular filtration rate. Hyperkalaemia is often severe and is a well recognised effect of non-steroidal anti-inflammatory drugs when renal function becomes impaired.²

The timing of the renal impairment in the case reported fits with that of the urinary tract infection (which was severe enough to merit admission to hospital) and its effect on a kidney deprived of

vasodilatation induced by prostaglandin, just as readily as it fits with the use of trimethoprim. Once the patient was well again, non-steroidal anti-inflammatory drugs would not be expected to cause problems, and thus rechallenge with the drug would be of no discriminatory value in this case. It seems unnecessary to propose an unusual effect of trimethoprim when the case is readily explained by the known and commonly observed effects of non-steroidal anti-inflammatory drugs,

C A O'CALLAGHAN

Renal Unit,
Guy's Hospital,
London SE1 9RT

- 1 Smith GW, Cohen SB. Hyperkalaemia and non-oliguric renal failure associated with trimethoprim. *BMJ* 1994;308:454. (12 February.)
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New roles for general practitioners

GPs frustrated by restricted access to investigations

EDITOR,—Stuart Handysides's article on new roles for general practitioners states what is reasonable but obvious to most practising general practitioners.¹ The limitation on medical responsibility in general practice is not so much general practitioners' ability to do the work but the limitation imposed by hospital investigative departments which will carry out certain tests only when the request is in the name of a staff consultant. This is all very well, but probably most of these requests are issued by junior doctors, generally on their own initiative and generally correctly. There is nothing more frustrating than to leave a post as a senior house officer or registrar and to enter general practice and be told that you cannot request a barium enema or endoscopy, let alone computed tomography or magnetic resonance imaging, other than through a hospital outpatient clinic.

Much of this policy is traditional rather than based on the results of audit. Schemes in which open access exist, and "supervised" review of referrals for specific investigations, work well and are popular with specialists, general practitioners, and patients as they save them all time. Additionally, there is a saving to the hospital as general practitioners are inevitably more experienced than the clinics' senior house officers and request only specifically required tests, requesting a batch of secondary investigations only when positive results are obtained. Becoming a "general practitioner physician" is well within the capability of all but a few general practitioners, particularly if initiatives were set up locally.

NIGEL DE KARE-SILVER

London NW2 7RX

- 1 Handysides S. New roles for general practitioners. *BMJ* 1994;308:513-6. (19 February.)

General physicians not a thing of the past

EDITOR,—Stuart Handysides states that "the general physician in hospital practice is a thing of the past,"¹ quoting a speculative article written some 10 years ago. Neither the statement nor the speculation is correct. Most posts advertised for consultant physicians, even though a specialty is specified, require the appointee to attend general medical outpatients and to look after patients admitted as medical emergencies. Despite the

caption of the photograph in Handysides's article it would be difficult to see how general practitioners can "take on the role of hospital general physicians" in charge of such conditions as upper gastrointestinal bleeding, myocardial infarction, overdoses, and diabetic ketoacidosis. To do so would add an impossible burden to their already heavy clinical load. Moreover, acquiring the necessary knowledge additional to that already required by a general practitioner would tax even the most agile and retentive brain. Furthermore, it is difficult to envisage a general practitioner, working predominantly in the community, teaching medicine as practised in a hospital.

Although Handysides is right to be concerned about the dangers of the "Calman recommendations" squeezing out general medicine, negotiations to enable most trainees to be certificated in both general internal medicine and another specialty without unrealistic prolongation of the period of training are well advanced.

While the welfare of the patient is best secured if care is shared between the physician and the general practitioner, standards would be unlikely to be maintained if general practitioners took on the role of hospital general physician.

D R LONDON
B L PENTECOST

Royal College of Physicians,
London NW1 4LE

- 1 Handysides S. New roles for general practitioners. *BMJ* 1994; 308:513-6. (19 February.)

Capture-recapture as a tool for programme evaluation

EDITOR,—The capture-recapture technique described by Ronald LaPorte¹ may be particularly useful in studying marginalised or inaccessible groups to assess the size and characteristics of the target population and the proportion in contact with services. For example, Fisher *et al* used a capture-recapture analysis of individual patterns of contact with homeless agencies in north east Westminster to estimate the total number of homeless people.² They also used the data to determine use of services and concluded that, during the study, almost two thirds of the homeless people in the area did not contact the statutory or voluntary agencies involved in the study.

We recently used capture-recapture analysis to estimate the numbers of sex workers meeting clients at bars in Mutare, Zimbabwe, and to assess their levels of contact with the Mutare HIV Prevention Programme (D Wilson *et al*, VIIIth International Conference on AIDS and STDs, Amsterdam, 1993). This programme was founded in 1991 and is run jointly by Mutare City Health Department and Family AIDS Caring Trust with technical support from the University of Zimbabwe. The study was conducted over four nights on two weekends at a weighted random sample of bars in the city. On each night programme workers held structured interviews with women reporting involvement in commercial sex. Because prostitution is illegal and stigmatised we did not try to use names to distinguish individuals. Instead, each night different gifts were given to each woman interviewed. We used information collected about items received on previous nights to assess on which nights sex workers had been contacted during the survey. To assess programme coverage, 204 sex workers were also interviewed about their contact with the programme.

Each night, 600-800 sex workers were interviewed. A preliminary capture-recapture analysis of the patterns of contact indicated that about 1600-2000 women were selling sex from bars over the two weekends. A more accurate estimate that accounts for different work patterns and move-

ment in and out of the population is being determined. Programme coverage was found to be extremely high, with almost all sex workers reporting contact with the prevention programme, 83% reporting seeing an AIDS lecture that month, and 93% reporting obtaining condoms from the programme.

These examples illustrate the potential uses of the capture-recapture technique as a tool for programme evaluation. Such information can be used to assess local needs and help guide programme planning and management.

CHARLOTTE WATTS
ANTHONY ZWI

Health Policy Unit,
Department of Public Health and Policy,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

DAVID WILSON

Department of Psychology,
University of Zimbabwe,
Harare, Zimbabwe

SIMON MASHABABE
GEOFF FOSTER

Mutare HIV Prevention Programme,
Mutare, Zimbabwe

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Management of cutaneous T cell lymphoma

EDITOR,—We agree with Paul A Bunn that multi-centre prospective randomised trials in patients with properly staged cutaneous T cell lymphoma are urgently needed to define the optimal topical or systemic treatment.¹ We also agree with his comments regarding the combination of psoralens and ultraviolet A treatment and interferon, which may produce a higher complete response rate than either agent used singly; we have useful experience of this.

We have successfully managed an 89 year old woman with tumour stage cutaneous T cell lymphoma with this combination. She presented with cutaneous plaques and ulcerated nodular lesions, which had relapsed after treatment with localised kilovoltage radiotherapy. There was no evidence of systemic disease on clinical examination or investigation. Cutaneous T cell lymphoma was confirmed on skin biopsy. Treatment was started with 3 million units of interferon alfa-2a subcutaneously three times a week and psoralens and ultraviolet A treatment twice a week, initially as an inpatient as she lived a considerable distance from our hospital. Within four weeks of the start of treatment there was a partial response (greater than 50% clearance of cutaneous lesions), which continued over the next month, when she was treated as an outpatient.

Psoralens and ultraviolet A treatment was then stopped at the patient's request because she found travelling difficult. Although treatment with interferon was continued, there was evidence of progression of disease at review a month later. The superiority of combination treatment was confirmed on two occasions over the next six months, with clearance of cutaneous lesions during inpatient treatment with both interferon and psoralens and ultraviolet A and gradual relapse during outpatient treatment with interferon alone.

Three studies have highlighted the combination of interferon and psoralens and ultraviolet A as a promising new treatment.^{2,4} The combined data from the 31 patients treated in these studies give a complete remission rate of 71% (22 patients) and a partial remission rate of 26% (eight patients). Patients with all stages of disease and those extensively pretreated with other modalities have