Increasing the number of organ transplants

Professionalisation of organ procurement in Spain has increased donors

EDITOR,—The success of organ transplantation in terms of survival, quality of life, and the ratio of costs to benefits has been such that ever greater numbers of patients are being referred to transplant teams. The shortage of organs remains the main obstacle to the full development of these procedures. In 1992 we reported the initial results of several integrated actions accomplished since the creation of the Spanish National Organisation of Transplants¹ and proposed that this approach could be used to alleviate the lack of organ donors.

Three years later things do not seem to have got better. The number of organ donors per million population has remained stable in the United States (around 17-19 donors per million)² and western Europe (14.7 donors per million in 1993). Furthermore, preliminary data from several European countries for 1994 showed a dramatic decrease in the rate of organ donation, usually attributable to the impact of negative media issues on public opinion.³

The situation in Spain is just the opposite. The number of organ donors has risen continuously from 14.3 per million population in 1989 to 25 per million in 1994 (table). So far as we know, this is

Number of organ donors per million population and number of solid organs donated, Spain, 1989-94

	1989	1990	1991	1992	1993	1994
No of donors/million population	14.3	17.8	20.2	21.7	22.6	25.0
No of solid organs retrieved	1409	1930	2359	2554	2690	3026

the highest rate reached for a medium sized country like Spain with nearly 40 million inhabitants. Some regions, such as the Canary Islands or the Basque country, now have over 40 donors per million population, while others, such as Andalucía, still have only 18.

All organs for transplantation are obtained after informed consent has been obtained from the relatives. We have developed a network of medical doctors working part time as transplant coordinators after specific training.⁴ The quick and clear explanation of any problem and confusion about the transplantation process (for example, brain stem death or distribution of organs) to journalists and the maintenance of a telephone line operating 24 hours, seven days a week to answer

any doubt or question about organ donation and grafting have achieved a positive atmosphere for organ donation in Spain during the past years.

Efforts to improve organ donation should be focused on medical professionals, who are often faced with the responsibility of having to raise the question of donation with bereaved relatives without specific training for this difficult task. The Spanish experience emphasises the need for training and professionalisation of people who procure organs and for an organisation focusing on the promotion and facilitation of organ donation.

RAFAEL MATESANZ
National coordinator

BLANCA MIRANDA
Attached doctor
CARMEN FELIPE
Attached doctor

Organización Nacional de Trasplantes,
26029 Madrid,
Spain

- 1 Matesanz R. Organ procurement in Spain. *Lancet* 1992;340:733.
- 2 Suthanthiran M, Strom TB. Medical progress: renal transplantation. *N Engl J Med* 1994;331:365-76.
- 3 Cohen B. *Eurotransplant Newsletter* 1994;121:1.
- 4 Matesanz R, Miranda B, Felipe C. Organ procurement in Spain: impact of transplant coordination. *Clin Transplant* 1994;8: 281-6.

Opting out scheme for donors has support in Britain

EDITOR,—On 30 November 1994, 4874 patients were waiting for a kidney transplant. This was an increase from the figures of 4640 in September 1993 and 3847 on 31 December 1990 (J Warren, personal communication).¹ One reason is the fall in the number of deaths from road traffic accidents. In Britain these fell from 5934 in 1982 to 5217 in 1990 and 4229 in 1992.²

In an attempt to increase the number of transplants the government decided to computerise the register of organ donors. This development has had a mixed reception. Some people thought it a small step forward, while others said that it would prove just as ineffectual as the existing donor card system.³ A more active approach assumes people to be donors unless they opt out. We attempted to find out the views of the doctors involved on such a change.

In 1994 we sent a questionnaire to nephrology consultants at 42 units. We received replies from 38 (90%) units. The main question on the system of donation was: "The Kidney Patients Association is recommending a change in the donor system to one where people opt out if they do not wish to donate. Would you support or oppose such a change in the law?" Forty five of the 69 consultants who answered this question said that they would support such a change, nine that they would neither support nor oppose it, and 15 that they would oppose it. So nearly two thirds of the consultants who responded were in favour of such a change in the law and less than a quarter were opposed to it.

There also seems to be majority public support for opting out. At the request of the Kidney Patients Association, Gallup Poll asked a random sample of 1019 people: "Would you approve or disapprove if the kidneys of anyone who had just died could be used unless they had 'opted out,' that is, stated that this must not be done?" The interviews were carried out on 4-10 May 1994 and showed that three in five people (59%) would approve and just under a third (31%) would disapprove. The remainder said that they did not

know.⁴ So there is majority support for a change from both the professionals and the public.

We recommend that Britain should follow the example set by Belgium, which has implemented "weakened presumed consent." This has resulted in a doubling of the number of transplants available each year. The method works slightly differently from the normal method of presumed consent by allowing the family a veto. Even with this veto the improvement is considerable: when a person is shown to be brain stem dead it takes the hospital only five minutes to check the central register. Once a person is known to be a potential donor the hospital then informs the relatives that that person wished to donate his or her organs after death. Belgian doctors believe that the system is so effective because the question is asked automatically and everyone expects the request. For this reason, few relatives have made use of the veto. In fact, only 200 000 people have opted out of the system (2% of the population). Such a change could greatly improve the situation for those waiting in Britain.

COLIN FRANCOME
Reader in medical sociology

London NW4 4LH

CARYL BRYANT
Research assistant

London N10 2DG

MARIE DUNNE
Research assistant

Sudbury,
Middlesex HA0 2QF

- 1 United Kingdom Transport Support Services Authority. *Renal transplant audit*. Borden, Hampshire: Kidney Patients Association, 1993.
- 2 Department of Transport. *Statistics Great Britain 1994*. London: HMSO, 1994: 173.
- 3 Nuttall N. Transplant patients say new computer donor scheme is useless. *Times* 1994 Oct 7.
- 4 Gallup Poll. *Kidney doing*. London: Gallup Poll, 1994.

Establishing a minor illness nurse in a busy general practice

May reduce doctors' workload

EDITOR,—G N Marsh and M L Dawes show that it is possible to train practice nurses to see patients with acute minor illness.¹ They rightly ask whether the absence of waiting time for appointments may have resulted in more patients consulting with acute self limiting disease. No data on doctors' workload are included in their paper. It is unclear, therefore, whether this was affected by the introduction of this service.

We have introduced a similar system in our practice for children under 12, having found that this was the largest group requiring urgent appointments for minor illness. Six thousand patients are registered at Richmond Medical Centre, and in March 1994 there were 264 consultations with doctors for patients in the above age group. One of us (SM) analysed these consultations before setting up the nurse led children's surgery in July. We then reviewed the total number of consultations for this age group in March 1995. Two hundred and sixty eight children were seen: 230 in the nurse led surgery and 38 in doctors' surgeries because of either patients' preference or the unavailability of the nurse.

Even though our list size has increased by 2.2% since March 1994, the total number of children

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

seen per month seems to be similar. This implies that the introduction of a nurse led children's surgery has not increased the consultation rate. It has, however, greatly decreased the doctors' workload. Other general practitioners may be considering the introduction of such a service, and our experience seems reassuring. It is important, however, to assess the quality of these nurse led consultations.

ANITA CAMPBELL
General practitioner
MICHELLE HERDMAN
Practice nurse
Richmond Medical Centre,
Sheffield S13 8NA

NICHOLAS KEARSLEY
General practitioner
STEVE MARIC
Locum general practitioner

1 Marsh GN, Dawes ML. Establishing a minor illness nurse in a busy general practice. *BMJ* 1995;310:778-80. (25 March.)

Busy is a weasel word

EDITOR,—The technical editor's blue pencil must surely have hovered at least momentarily over the title of G N Marsh and M L Dawes's paper.¹ Like supermarkets that use the exhaust fumes from the in house bakery to make the entrance smell wonderful, every article's title should of course entice readers to go further. But doesn't the word "busy," even if it appeals to every general practitioner's Monday morning near paranoia that the floodgates of demand are about to open, belong more to advertising than to science? Busy, when hooked up to general practice, is a weasel word, to use the advertising industry's term, and is as meaningless as "farmhouse" attached to butter or "home baked" attached to cake: that hovering blue pencil should have struck it out, not moved on.

SIMON BARLEY
Former general practitioner
Wortley, Sheffield S30 7DS

1 Marsh GN, Dawes ML. Establishing a minor illness nurse in a busy general practice. *BMJ* 1995;310:778-80. (25 March.)

Preregistration house officers in general practice

Regulations limit approved institutions for training

EDITOR,—Joe Wilton's paper shows the considerable benefit of young doctors acquiring preregistration experience as house officers in general practice.¹ We believe that the arrangements for this should be extended throughout Britain so that there are more opportunities for such popular and profitable attachments.

Regrettably, such experience can be acquired only in an "approved institution," and section 12 of the Medical Act 1983 limits such approval to health centres. This we believe to be illogical for there are many excellent practices and would-be teachers who are not based in health centres and whose participation would enable preregistration experience to be readily obtained in general practice. It seems that a new Medical Act would be required before the necessary changes could be brought about. We are concerned at the reluctance of those involved, and in particular the General Medical Council, to move in this direction, and we urge that the necessary legislation be enacted as quickly as possible.

W MCN STYLES
Chairman of council
Royal College of General Practitioners,
London SW7 1PU

I G BOGLE
Chairman
General Medical Services Committee,
BMA,
London WC1H 9JR

1 Wilton J. Preregistration house officers in general practice. *BMJ* 1995;310:369-72. (11 February.)

Problems will arise over who pays

EDITOR,—None of the references cited in Joe Wilton's article on preregistration house officers in general practice dates from before 1987.¹ I have reported the experience of house officers attached to a practice in Runcorn, Cheshire, that was associated with a university in 1981 and 1982.² I described the basis for the scheme and the way in which the attachments worked, including components of learning and methods of supervision. I also raised the need for clarification of administrative aspects such as finance and terms of employment. The "Runcorn scheme" founded in 1982 after a promising start because of the predictable question, "Who pays the general practitioner house officer?" and implicit fears that a popular community scheme for preregistration house officers might in some way threaten the size of the pool of young doctors required to staff the hospital service.

I wonder whether these aspects have been addressed effectively enough to make a nationwide scheme realisable in the foreseeable future.

B W MCGUINNESS
Professor of primary health care

Department of Primary Health Care,
University of Keele School of Postgraduate Medicine,
North Staffordshire Hospital,
Stoke on Trent ST4 7QB

1 Wilton J. Preregistration house officers in general practice. *BMJ* 1995;310:369-72. (11 February.)
2 McGuinness BW. A house officer attachment in general practice. *Practitioner* 1982;226:1216-7.

Training in general practice is also important for postregistration doctors

EDITOR,—We were encouraged to read Joe Wilton's description of the progress made in including general practice as part of the preregistration year at St Mary's Hospital Medical School.¹ His results confirm that general practice provides many educational opportunities, including increased clinical activities and longer teaching times compared with those for house officers based in hospitals. It is disappointing that this is the only established preregistration rotation in England. One wonders why this valuable experience is neglected elsewhere and why its development is not given a higher priority.

A similar situation exists with training at senior house officer level, with calls by many bodies to develop attachments in general practice for fully registered junior hospital doctors.^{2,4} Unfortunately, there is no evidence that progress in this has been any better.

We are in our second year of evaluating the benefits of linking an established senior house officer rotation in hospital medicine based at Newcastle General Hospital to a general practice post with the Northumbria vocational training scheme for general practice. This rotation provides young doctors who are either intent on a career in hospital medicine or undecided about a career with an opportunity to sample and learn from general practice. This has required much planning and coordination by a steering group comprising consultants, trainers in general practice, and course organisers for the vocational training scheme. A joint appointments committee selects trainees, who undertake three posts each of four months' duration, one of which is in an established training practice. A curriculum is fashioned in the general practice post to suit individual trainees' needs, with an emphasis on communication skills, teamwork, prescribing, record keeping, and the psychological and social aspects of patients' problems. Educational aspects include protected teaching time, attendance at the vocational training scheme's academic course, and an emphasis on formative assessment and feedback.

It is good to see some progress with the pre-

registration year, but we believe that innovation is long overdue in the education and training at senior house officer level. The way forward must be through experimentation with, and evaluation of, different models of training. Only then will progress be made in ensuring that these doctors receive training and education that have appropriate breadth and depth.

BILL CUNNINGHAM
BRIAN TOMS
Course organisers, Northumbria vocational training
scheme for general practice
PADDY HARRIGAN
Associate postgraduate dean

Postgraduate Institute for Medicine and Dentistry,
University of Newcastle,
Newcastle upon Tyne NE2 4AB

JULIAN TURNER
General practice trainer
DAVID MORGAN
General practice trainer

Ridley Medical Group,
Blyth,
Northumberland NE24 1DX

1 Wilton J. Preregistration house officers in general practice. *BMJ* 1995;310:369-72. (11 February.)
2 Council for Postgraduate Education in England and Wales. *On the provision of experience in general practice for intending hospital specialists*. London: CPEEW, 1987.
3 Royal College of Physicians of London. *General professional training—the Royal College of Physicians guide for trainees and trainers*. London: RCP, 1994.
4 Department of Health. *Report on the working group on specialist medical training. Hospital doctors: training for the future*. London: DoH, 1993.

Posts are purely educational

EDITOR,—The evident success of the preregistration rotation in general practice based at St Mary's Hospital over the past decade¹ is a tribute to its originator, Harris,² and to the dedication of subsequent teachers both in practice and in hospital. This training opportunity has always been educationally attractive, and I have often been asked why it is not more widespread. Some of the reasons were discussed when Coles and I reported the original scheme in Southampton in 1982.³ In particular, there is no essential service role for a preregistration house officer in general practice; the post is therefore purely educational, and the teaching needs to be paid for. It is interesting that Joe Wilton, in his account,¹ makes no reference to the costs or how they are met. I understand that both the regional health authority and the special trustees of the medical school contribute. When a trainer in general practice takes a trainee he or she gains a training grant (currently £4840 a year) as well as a (so called) free pair of hands from a competent young doctor who wants to make his or her way in general practice. I believe that to make preregistration attachments more generally feasible a considerably greater financial incentive for the trainers may be required.

The traditional service role for hospital preregistration house officers is the main obstacle to progress. As long as this persists and only lip service paid to education a general practice option is bound to seem expensive with its greater emphasis on education. Now that postgraduate deans have direct financial control over all junior hospital posts the time is surely ripe for a more flexible approach to apprenticeship in the preregistration year. General practice could play a much enhanced part. This could be a training path for a large proportion of junior doctors, whether they ultimately make careers in general practice or in hospital. Let there be no mistake, though: we must face up to the funding issues in concert with the educational benefits.

GEORGE FREEMAN
Professor of general practice

Charing Cross and Westminster Medical School,
Chelsea and Westminster Hospital,
London SW10 9NH