

Previous studies of tamoxifen on physiological gynaecomastia

	Tamoxifen dose (daily dose in mg)	Duration (months)	No of patients	Success No/ total (%)
Ting <sup>6</sup>	20	3	23	Lump: 18/23 (78) Pain: 19/23 (82)
Parker <sup>7</sup>	10	2	10	Lump: 7/10 (70) Pain: 4/4 (100)
McDermott <sup>8</sup>	20	2-4	6	Lump: 3/6 (50) Pain: 5/6 (83)
Alagaratnam <sup>9</sup>	40	2	61	Lump: 49/61 (80) Pain: 49/61 (80)

placebo,<sup>5</sup> but adverse effects such as weight gain limit its application in general use.

The use of tamoxifen for gynaecomastia has been studied previously in several centres. The table shows the various published studies on the use and efficacy of tamoxifen for physiological gynaecomastia in the English literature.<sup>6-9</sup> Only two of these studies<sup>6,9</sup> have more than 10 patients and both showed resolution of lump and pain in 80% of cases. A recent study from our own unit in 36 cases confirms this figure (83% resolution of lump).<sup>10</sup> Ting et al also found tamoxifen to be more efficacious than danazol.<sup>6</sup> Importantly only minor and reversible side effects were reported. This confirms findings that tamoxifen used in male breast cancer

appears to have no serious side effects.<sup>11</sup> Tamoxifen appears to be successful, safe, and avoids operation and on present evidence should be regarded as the first line treatment of gynaecomastia.

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## General practitioners and occupational health professionals

*Consensus statement to improve interaction is timely and welcome*

**O**ccupational Medicine (the journal of the Society of Occupational Medicine) recently published a consensus statement on the interaction between general practitioners and occupational health professionals in their roles in vocational rehabilitation.<sup>1</sup> This was derived by using a Delphi technique to solicit the views of interested and influential individuals from industry, insurance, academia, representative organisations, government departments, and universities.<sup>2,3</sup> The statement emphasises the potential benefits of work and the importance of vocational rehabilitation in restoring an optimal lifestyle to individuals recovering from illness and injury.

Anecdotally, examples of excellent communication between general practitioners and occupational health professionals exist, but poor or non-existent communication is common. At times the relationship may become adversarial, with the patient unable to understand the respective roles. This has an impact on patients' rehabilitation to useful work. Poor communication is not restricted to the United Kingdom and has been shown to act as an impediment to rehabilitation elsewhere.<sup>4,5</sup> The consensus statement implies a role for occupational health professionals as case managers, coordinating efforts from healthcare providers, employers, and other agencies in facilitating a return to work. It ends with an exhortation for better communication from all to help establish interdisciplinary collaboration for the ultimate benefit of patients.

Vocational rehabilitation is an important issue. In Britain it is estimated that some 2.7 million people are currently economically inactive and receiving state incapacity benefit.<sup>6</sup> The issue has recently received increased attention from several organisations,<sup>7,8</sup> and all in health care have seen the damage that ensues from losing a job and income as a consequence of ill health. Successful vocational rehabilitation has the ability to promote health and limit the financial burden on the state and pension funds. It is important that it is done well.

General practitioners have an important role. They exercise an enormous influence during the treatment and recovery of their patients, but their role in assessing fitness for work and facilitating return to work may be handicapped by a limited knowledge of their patients' work and a lack of access to workplaces and managers. There is often an apparent conflict between the general practitioner's role as a patient's advocate and the requirement to provide objective information to an employer while maintaining patients' confidentiality. General practitioners act successfully as case managers for their patients in so many areas, but loyalty to patients can be perceived as potentially affecting their impartiality when considering employment and benefit entitlement.

Occupational health professionals, who do not have continuing responsibilities for family care, may be better placed to adopt an objective and proactive approach to vocational rehabilitation. Occupational

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health professionals have a better knowledge of the workplace. They are also motivated and ethically bound to help their patients.<sup>9</sup> Unfortunately large sections of the United Kingdom's population do not have access to an occupational health service.<sup>10</sup> Thus at present occupational health professionals are too few in number to adopt the role of case manager or certifier of ill health and disability for all who require this help. Better communication between general practitioners and occupational health professionals has to be the way forward in the short term to facilitate improvements in vocational rehabilitation.

Notable barriers to this communication remain. Occupational health is not a well understood specialty, occupational health services are many and varied, and confusion remains about their role and position in a modern healthcare system. There is much unfounded suspicion about the impartiality of occupational health services. Occupational health professionals are often employed by the "business" and may be perceived as biased in favour of their paymasters. This perception is not restricted to workers and their representatives. Managers may also anticipate a certain opinion, but they will be disappointed if they expect only an opinion that is helpful to the business to the neglect of an employee's health and welfare.

The inadequate and unequal development of occupational health services in the United Kingdom and the confusion over their role has inevitably led to difficulties in communication between occupational health professionals and other healthcare professionals. Acting as case manager in vocational rehabilitation is a legitimate and worthwhile role for occupational health professionals, and improving communication between a general practitioner and occupational health professional is essential to this process. There are good reasons for general practitioners to participate. Returning to work is a part of many patients' complete recovery, and there is evidence to indicate that primary

care doctors who participate in minimising their patients' disability achieve better health outcomes as well as greater patient satisfaction.<sup>11</sup> The consensus statement is a timely reminder of the importance of both the issue of vocational rehabilitation, and the quality of communication between different healthcare providers, and should be applauded.<sup>1</sup> The worthwhile objectives in the consensus statement will require considerable change in resources, attitudes, and systems before they are optimally achievable.

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## Speak up!

*Can patients get better at working with their doctors?*

A mother brings her daughter to the general practitioner with a chest cold. She is mainly seeking reassurance that the infection will go by itself. She hopes to avoid antibiotics unless they are absolutely necessary. Her general practitioner assumes she is there for a prescription and so writes one out for amoxicillin. The mother assumes the prescription means that the infection is serious and so keeps her preferences quiet. After the consultation the general practitioner acknowledged suspecting from the mother's body language that she was unhappy about taking a prescription for antibiotics. He admitted they were unnecessary.

This consultation would have gone so much better, you might say, if the doctor had simply explained what he was thinking. This is true, but the cliché about communication applies even in medicine—it is a two way street. If the mother had said what was on her mind,

things might have turned out differently. "Easier said than done," say patients. This is a guiding assumption behind "Working with your Doctor," an online course we have designed for patients to complement *Best Treatments*, the BMJ Publishing Group's website for US patients and doctors.<sup>1</sup> The course teaches patients simple things to do before, during, and after a visit to their doctor to help them get what they want from the consultation.

The antibiotics scenario described above is true. It comes from a qualitative study of patients' unvoiced agendas in consultations with their general practitioner.<sup>2</sup> Researchers asked patients about their ideas, concerns, and expectations for their visits. After the consultation only four of the 35 patients had managed to raise all the issues they wanted to when face to face with their doctors. Nearly half of the 35 consultations had "problem outcomes" such as major misunder-