

LETTERS

GP workload in nursing homes <i>Robert A Andrew</i>	501	Management of angina <i>Manish M Gandhi and David A Wood</i>	504	Teenage sexual health <i>Trevor Stammers</i>	506
Delay in cancer diagnosis <i>John B Williamson</i>	501	Fourth national morbidity study <i>Roy Carr-Hill and Nigel Rice</i>	505	GPs' low morale <i>Bill Reith</i>	507
Pneumococcal sepsis in a splenectomized patient <i>E L C Ong, et al</i>	502	Immunization: precautions and contraindications <i>George Kassianos</i>	505	Art of communication <i>David Williams and Jacquie Williams</i>	507
Warfarin in stroke prevention <i>Stephen Morgan and David Mant; Kieran Sweeney, et al</i>	503	Urinary tract infection in children <i>Darryl Tant</i>	506		
Acute myocardial infarction <i>John Rawles</i>	504	Complementary medicine — a definition <i>E Ernst, et al</i>	506		

GP workload in nursing homes

Sir,
An extended study from 1984 to 1991 confirmed the findings of my original study that general practitioner consultation rates among 42 residents in a nursing home for elderly people were about 40% higher than consultation rates among other practice patients aged 65 years and over.¹ There are 10 separate nursing homes in the same geographical area. In 1987 I took over the medical care of another similar sized nursing home in the complex and pooled the statistics from the two homes for a workload study from 1987 to 1991.

The workload generated by nursing home residents and other practice patients is shown in Table 1. The 15 nursing home residents in the 65–74 years age group had a mean annual consultation rate which was 83% higher than that for practice patients in the corresponding age group while the consultation rates for the 75 years and older cohorts were approximately the same. The mean annual consultation length per patient is a useful index of practice workload and showed that the younger nursing home residents required

91% more work than their equivalent practice age group. The rates for those aged 75 years and over were the same. The younger nursing home residents were referred for hospital services approximately twice as often as practice patients in the same age group.

Between 1987 and 1991, the prescribing rates for 10 nursing homes and one residential home cared for by the practice varied from 36 to 68 items annually per patient. This compared with 21 items for practice patients aged 65 years and over. The mean annual prescribing rate per patient for the whole practice excluding residents in the nursing homes and the one residential home was seven items.

Increased workload has been reported from practices with large numbers of nursing home residents.² From the present study it seems that the increase is in the younger age group of patients (65–74 years). My impression is that these patients suffer from severe forms of degenerative disease and dementia and are receiving nursing home care because they are unable to manage or be cared for in their own home. They require a considerable input of medical care. The problems for those in the older age group (75 years

and over) may be the result of exaggerated ageing processes and less virulent forms of disease, including the dementias, which synergistically become sufficiently severe to require assistance with everyday existence, especially if living alone. These patients may require nursing care rather than medical care.

ROBERT A ANDREW

2 Wansfell Holme
Windermere
Cumbria LA23 1LS

References

- Andrew RA. Analysis of a general practitioner's work in a private nursing home for the elderly. *J R Coll Gen Pract* 1988; **38**: 546-548.
- Green PA. General practitioners' workload in nursing homes [letter]. *J R Coll Gen Pract* 1989; **39**: 173.

Delay in cancer diagnosis

Sir,
A degree of delay is inevitable between the development of a cancer and its diagnosis. The general practitioner has an important role in keeping this delay to a minimum.

A study was undertaken looking at the second phase¹ of cancer diagnosis in general practice, that is, between the patient's first presentation with symptoms of malignancy and the general practitioner making a referral. The aim was to look at the factors that contributed to a delay in cancer diagnosis.

In a Suffolk practice of 10 800 patients, the computerized database was searched to identify all patients with a history of cancer. Their notes were reviewed to identify episodes of delay of more than four weeks' duration between presentation and referral. Reasons for the delay were noted and categorized by J W.

A total of 376 patients in the practice had a history of cancer and had notes suitable for analysis. Inspection of the notes revealed 53 cases of delay; the associated factors are shown in Table 2. In many cases several delay factors were identified.

Table 1. Workload generated by residents of nursing homes and other practice patients, 1987–91.

Care group	Mean annual consultation rate per patient	Mean length of consultation (minutes)	Mean annual consultation length per patient ^a (minutes)	Mean annual referral rate per patient
65–74 years age group				
Nursing home residents (<i>n</i> = 15)	8.4	8.9	74.8	0.5
Other practice patients (<i>n</i> = 248)	4.6	8.5	39.1	0.2
75+ years age group				
Nursing home patients (<i>n</i> = 68)	7.6	8.9	67.6	0.4
Other practice patients (<i>n</i> = 160)	7.9	8.5	67.2	0.4
Practice patients aged <65 years (<i>n</i> = 2344)				
	3.2	8.5	27.7	0.1
Whole practice population (<i>n</i> = 2835)				
	3.8	8.6	32.7	0.2
Practice excluding nursing home residents (<i>n</i> = 2752)				
	3.6	8.5	30.6	0.2

n = mean number of patients each year. ^aConsultation rate x consultation length.