

the individual questions ranging from 90 to 94%. The results and response rates to the individual questions are shown in Table 1.

Of people responding to the question relating to the content of The Patient's Charter, 88% were unaware of its guarantees. When asked to interpret the term 'initial assessment' 67% of responders felt that 15 min or longer would be appropriate and 62% felt that it should be performed by someone other than a doctor.

Our follow-up study performed in January 1994 over a 48-h period was conducted in exactly the same manner. Of 173 patients attending during this period, completed data sets were collected for 134 (77%). Of these, 83% were unaware of the 'initial assessment' guarantee, 64% felt that it should be performed within 15 min or longer and 71% felt that it should be a nursing or non-medical task.

DISCUSSION

The Department of Health published The Patient's Charter amidst a blaze of publicity. Despite the Government's best efforts it appears that only 12–17% of patients in our studies were aware of the standard that they should be seen and assessed immediately on arrival in an A&E department. Moreover, when asked directly, approximately two-thirds felt that this term implied assessment within 15 min or longer. We imagine that this finding will be of interest to the NHS Management Executive who insist that 'immediate assessment' should be interpreted literally, with a maximum latitude of 5 min. However, our findings show that the suggestion by the NHS Management Executive that this assessment should be performed by a nurse accords with patient expectations.

These results have important implications for those providing A&E services. There have been several incidences around the country of A&E departments being fined, or threatened with fines, by purchasing authorities for not achieving these charter standards. It is the patients who should decide what standards they expect from A&E departments, rather than managers who claim to be acting on their behalf. The current Government obsession with achieving charter standards has obscured the more important aim of maintaining and improving standards of clinical care. It has caused hours of pointless debate and the production of massaged, often meaningless statistics. The immediate assessment exercise may be looked upon as 'window dressing' and, as such, it is surely of far less value than the

provision of good clinical care. The results of this survey indicate that our viewpoint seems to be echoed by the patients, the forgotten tribe of their own charter.

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Gilbert's syndrome during medical residency training

Gilbert's syndrome is defined as benign, inherited, mild, unconjugated hyperbilirubinemia in the absence of pigment overproduction and with normal routine liver tests. It affects some 2–5% of the population. Fluctuations in pigment levels are commonly observed, with peak values occurring in association with fasting, strenuous exercise, or intercurrent illness. Residency training involves multiple stresses, many of which could be potential causes of rising bilirubin levels in subjects with unrecognized Gilbert's syndrome, as the following cases illustrate.

Three healthy medical residents of the first level presented with scleral jaundice after being on duty in our Emergency Ward's Medicine Section. Extensive evaluation revealed chronic, mild, unconjugated hyperbilirubinemia — not because of haemolysis — and a diagnosis of Gilbert's syndrome was established by exclusion of structural or functional liver disease (Table 1).

A relatively high prevalence of Gilbert's syndrome during medical training was previously reported by Kornberg *et al.* in a group of healthy medical students.¹ The potential risk of Gilbert's syndrome during residency training is unknown, but the suspicion that there is an association between work-related stress and peak values of bilirubin levels is raised by the observations presented here. Residency training involves many stressful situations, many of which were not present, or were present to a

| Case No. | Sex | Age (years) | Speciality | No. of days on duty | Serum bilirubin* | |
|----------|-----|-------------|--------------------|---------------------|-------------------------------------|--------------------------------------|
| | | | | | Peak value ($\mu\text{M L}^{-1}$) | Basal value ($\mu\text{M L}^{-1}$) |
| 1 | M | 27 | Internal medicine | 10th | 35.7 (28.9) | 22.1 (15.3) |
| 2 | M | 26 | Intensive medicine | 5th | 40.8 (35.7) | 23.8 (16.8) |
| 3 | M | 26 | Haematology | 1st | 49.3 (38.9) | 20.4 (15.1) |

(*) Normal value range: $2-18 \mu\text{M L}^{-1}$. Numbers in parentheses indicate the value of unconjugated bilirubinaemia. Neither hepatomegaly or liver abnormal test was detected in these subjects.

lesser degree in previous years.² Some of this stress occurs during service in the emergency ward. Working conditions of medical residents when they are on-call include sleep deprivation, inordinate and inflexible time demands, excessive workload, fatigue and lack of appetite for extensive responsibilities and obligations. These problems are recognized as being factors that result in raised bilirubin levels in subjects with previously undiagnosed Gilbert's syndrome. Likewise, other metabolic disturbances have been observed in response to stressful stimuli. Recently Coeck *et al.*³ reported raised serum levels of cortisol and ACTH in a group of internal medicine residents at the end of their on-call period. Furthermore, it is well documented that some junior doctors cannot endure these stress factors and they have a negative impact on their residency training, frequently being responsible for impaired efficiency and performance.⁴

We feel that these cases, demonstrate a link between residency programmes and previously undetected Gilbert's syndrome, and that this disorder may be one of multiple abnormal responses to the stresses of residency training. Strategies for identification, prevention and reduction of stress are necessary for a successful adaptation to residency training programmes.

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Table 1. Professional and clinical characteristics of the three residents with Gilbert's syndrome

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Plaster checks: a waste of resources?

The majority of patients attending for a plaster check the day after application gain nothing from their visit. The aim of this study was to ascertain if there was a group of injuries or cast types that rarely received any intervention at the attendance and therefore reduce needless visits.

Details of 250 consecutive patients having a cast applied by plaster technicians or nurses were entered into a log book with details of their plaster, who applied it and the nature of any alterations made at the plaster check the following day. The accident and emergency (A&E) records were retrieved 1 month after the study to identify those who had attended outside their appointment time and any comments relating to their visit. In addition a postal questionnaire was sent to arrive 5 days after application of the plaster to assess the patients' perceptions.

Excluding the 14 patients who had follow-up arranged elsewhere, 89% returned for their check and 24% (51) had alterations made — 18 patient had plasters changed, 17 had them reinforced, 12 had them trimmed and four slabs were removed and replaced with a bandage at the patients' request. Alterations were made to all types of cast whether applied for soft tissue injuries or a variety of fractures — of the plasters changed there was an equal