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GPs' attitudes towards drug users

Sir,

General practitioners have long been exhorted to involve themselves in the management of patients with drug problems.[1,2] Unfortunately, for the drug user, there is a wealth of research pointing to a poor doctor–drug user relationship. Bewley warned doctors about deception and manipulation by drug users,[3] and more recent research[4] depicted drug users as unreliable and unrewarding patients.

A study by McKeganey and Boddy stressed that the lack of established individual and practice policy creates confusion and enables drug users to manipulate the service.[5] The authors recommended that strategies be developed which maintained continuity and consistency in treatment. The advent of community drug teams ushered in the era of shared care. This 'integrated model of care'[6] implied collaboration between drug workers and general practitioners.

Following a seminar in May 1991 on addiction, attended by doctors in Worthing, 65 West Sussex general practitioners completed a postal questionnaire (81% response rate) canvassing their attitudes to treating drug users, especially the provision of methadone for opiate addicts. Their responses indicated continued distrust of this patient group, 59% of respondents agreeing with the statement that intravenous drug users were a threat to general practice, and 89% of respondents agreeing that given the chance, intravenous drug users exploit doctors. Hardly any general practitioners (6%) favoured injectable methadone, and short term reduction programmes were preferred to longer term maintenance (60% versus 34%, respectively). Harm reduction was seen as a legitimate treatment goal by 81% of respondents, with the vast majority of respondents (90%) favouring needle and syringe exchange schemes and education in safer drug use (72%).

Half of the sample of general practitioners (44%) were aware of intravenous drug users on their lists. One fifth (21%) would not accept a new patient with a known history of addiction, while the remainder would take them on a permanent or temporary basis. Importantly, most general practitioners had no explicit practice policy on accepting addicted patients (65%) or treating existing patients (66%). The majority (73%) saw the acquired immune deficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) as a greater threat to public health than the individual health issue of drug addiction but only half (51%) had altered their attitude to drug treatment as a consequence.

The data from this attitudinal survey present a more hopeful view of shared care, with 60% of the sample of general practitioners expressing a willingness to engage in the medical management of opiate dependency. This may be an indication of successful partnership between general practitioners and the community drug team.

General practitioners are faced with difficult and challenging decisions. Although many doctors have overcome their reluctance to get involved with treating drug misusers, the effectiveness of this involvement is hampered by the negative attitudes of both doctors and drug misusers and the lack of common, negotiated and explicit policies within and between practices. The sound advice in the government's *Guidelines on clinical management*[2] should encourage improved collaboration between general practitioner and drug abuser.

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Cost effectiveness of minor surgery in general practice

Sir,

The paper by O'Cathain and colleagues compared the cost effectiveness of minor surgery in general practice.[1] We have few doubts about the abilities of properly trained general practitioners to perform technically adequate surgery, though the high incidence of inadequately excised lesions (5%) in this study indicates that the desire to make small excisions often overrides the surgical necessities.

O'Cathain and colleagues list the conditions treated in both settings[1] but it is not clear whether they were all excised. In many cases excision may not have been appropriate. Certainly there are better ways of treating many of these lesions, but choice of an appropriate technique requires an accurate diagnosis. In addition, 44% of specimens sent for histopathology examination from general practice had an incorrect diagnosis[1] and there is no reason to believe that those not sent were diagnosed any more accurately. Other studies have found similar problems.[2-4] Many of the lesions mentioned, if accurately diagnosed on clinical grounds, require no treatment at all.

It has been recommended that all lesions removed by non-specialists, or where the diagnosis is uncertain should be sent for histopathological examination,[4-6] and we would agree with this. This obviously has cost implications, but nothing is more expensive than unnecessary treatment. The advantage to patients of the general practitioner performing their minor surgery is of little value if their lesion did not require excision.

Unsightly scarring and poor cosmetic results were reported more frequently by patients who had received treatment in hospital than in general practice, but as the authors point out, the case mix in the two settings was significantly different.[1] The removal of more seborrhoeic warts, moles and other lesions would inevitably lead to a less satisfactory cosmetic result than the treatment of skin tags and warts.

The cost of excision by the general practitioner was 25% cheaper than in hospital (£33.53 versus £45.54).[1] Most of the additional cost in hospital was explained by the initial outpatient visit and the higher cost of follow up, which may not be re-