improving prison health care would be to employ more fully trained nurses and give better training to those discipline officers who become hospital officers. Again Dr Kilgour agrees with recruiting more fully trained nurses. Sixthly, the prison doctors themselves deserve better training—both within and outside the prisons.

Finally, there needs to be better provision within the service for the mentally abnormal. It will never be possible to separate out all the mentally abnormal and remove them from the prisons: the service will always be left with many prisoners who have mental health problems.[18] In England Grendon Underwood, the psychiatric prison, may come to contribute much more to managing the mentally abnormal in the system, but this will not be enough. The lessons learnt in Grendon and other experimental prisons need to be applied in all prisons so that they can become much more humane places. The present is gloomy within the prisons, but it need not always be so.

RICHARD SMITH

Assistant Editor,
BMJ

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The breathless farm worker

Farm workers are popularly supposed to lead healthy, open air lives. Nevertheless, occupational hazards lurk in the farming environment, and several of these are important causes of lung disease. The breathless farm worker may therefore present a diagnostic challenge to the doctor.

Agricultural workers were recognised by Ramazzini in the early eighteenth century as becoming breathless on handling grains or after exposure to noxious gases arising from grains,[1] while in modern times farmers' lung, a form of allergic alveolitis, was described in the 1930s[2] and silo fillers' disease, a toxic pneumonitis due to nitrogen dioxide, was described in the 1950s.[3] More recently, attention has been directed again at the frequency of asthma in farm workers, associated with exposure to grain, fungal spores, or mites in stored hay.[4-6] Much less commonly, respiratory problems may arise from exposure to agricultural chemicals—for example, absorption of paraquat through the skin[7] or inhalation of antifungal sprays.[8]

The doctor consulted by a farm worker who has become short of breath should bear in mind the three most common occupational causes. Occupational asthma is usually recognised by the patient as being associated with particular activities; commonly it starts shortly after he enters a barn or byre. It may occur in up to 15% of farm workers and is often associated with rhinitis or lachrymation.[6] Attacks may last an hour or more but not infrequently recur later in the day or night. A careful history should suggest the diagnosis, which may be confirmed by lending the patient a mini peak flow meter and getting him to record flow rates serially over a week or two, noting down related activities in a diary. Skin tests may be useful in tracking down a cause—commonly one of the mites that live in hay[5 6] or fungal spores from grain.[4] The asthma normally responds to standard treatment, but efforts should be made to prevent it by changing farming practices and if necessary by using a respirator. A full face helmet respirator is ideal for this purpose as it will also protect the eyes and nose from allergens.

Farmers' lung, which may be seen in up to 5% of farm workers,[9] typically presents as an acute attack of fever, malaise, and breathlessness four to six hours after handling mouldy stored hay. Inspiratory crackles are heard in the lung, and the chest radiograph shows a pattern resembling that of pulmonary oedema. Precipitating antibodies to thermophilic actinomycetes are frequently found in the blood, though their absence does not exclude the diagnosis.[10] Unfortunately, by no means all episodes are typical. Very acute, severe, and prolonged attacks may occur with absent precipitins after heavy exposure to fungal spores (sometimes called mycotoxicosis[11]), while minor episodes may cause general malaise and more persistent breathlessness but with a radiograph that is almost normal. If the diagnosis is missed the patient may develop chronic disease with pulmonary fibrosis, though the disease does have a tendency to resolve if exposure ceases.[10] The diagnosis is made from the history and by finding crackles on auscultation supplemented by chest radiographs and testing for precipitating antibodies. Challenge testing and lung biopsy are required only rarely to distinguish atypical cases from other diseases causing diffuse pulmonary infiltration. The chief difficulty arises in distinguishing acute attacks from atypical pneumonias.[12] Treatment of farmers' lung in the acute stage usually requires corticosteroids, though attacks are self limiting in the absence of continued exposure. Prevention is best achieved by changing from the use of hay to silage and by educating the farmer in handling and laying down hay. Appropriate oronasal and full face respirators with filters approved for use against fungal spores give good protection—but these must be worn whenever exposure is likely to occur and must be properly maintained.[13]

Silo fillers' lung occurs after exposure to oxides of nitrogen from the top of an unventilated silo. Cases occur sporadically owing to carelessness or lack of education of farm workers. The gas is not particularly irritant, so that the initial exposure may hardly be noticed, but cough and breathlessness increase over several hours, eventually progressing to frank pulmonary oedema.[3] Sometimes apparent recovery may be followed several weeks later by progressive breathlessness due to an obliterative bronchiolitis.[3 14] This may even occur if the initial attack was quite mild; deaths have been reported in both stages of the disease. There is anecdotal evidence that corticosteroids are useful in treating the condition. Prevention is by proper safety education of farm workers.

Doctors working in agricultural areas are often well aware of these conditions. Those less familiar with them would be wise to seek expert medical help; this can be obtained from

the Health and Safety Executive's local employment medical adviser, while colleges of agriculture are able to give advice on appropriate changes in farming methods.

ANTHONY SEATON

Director,
Institute of Occupational Medicine,
Edinburgh EH8 9SU

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Doctor to doctor

In his preface to a booklet on writing and talking about patients recently published by the Nuffield Provincial Hospitals Trust Sir John Walton writes: "While communication between doctors on the one hand and patients and their relatives on the other is clearly a fundamental aspect of clinical medicine in all its branches, there is no doubt that communication between individual doctors often leaves much to be desired. Stories about misunderstandings and mistakes caused by careless clinical requests, notes, and letters are often recounted by doctors when they meet and talk 'shop' and are attributed, with some merriment, to curious idiosyncrasies of other doctors from which the gossipers feel themselves to be free. The fact that it is usually the patient rather than the doctor who may be most inconvenienced or even harmed by these mistakes is often overlooked."[1]

Despite its obvious importance little research has been done or published on this subject. The time is now ripe for its further consideration because, within the current economic plight of the health service, united as a profession we may stand but disharmonious (in our planning and delivery of effective health care) we will fall. Given our obvious personally vested interests, how may we as individuals analyse and solve what is now a corporate problem? The simple but unhelpful answer is: with difficulty. Doctors are commonly very conscious of the errors made by their colleagues—but they are frequently unaware of the problems that they make themselves and, though this is forgivable, it does not allow progress.

Much of the problem may be traceable to attitudes acquired in medical training and then hardened during the stresses of daily medical practice. The need for prompt decision making commonly demands irreversible, snapshot judgments. This is an essential part of the immediacy of clinical practice, but it may be disadvantageous to the development and maintenance of amicable working relationships with colleagues—and especially if ill considered attitudes, mixed with too quick thinking, produce lingering prejudices that smoulder resentfully as unforgiven hurts. How, then, do we find a solution which will facilitate the healing of old wounds and foster the continually fresh growth of positive intraprofessional relations? We need to answer three questions.

Firstly, how does poor communication occur between doctors? The accounts of diverse personal experience so well presented in the excellent essays in the booklet clearly show the importance of courtesy among all parties.[1] They also underline the need for clarity in written communication and, when referring a patient to a clinical or diagnostic department, the necessity for not only understanding the function of that department but also defining clearly the patient's problems and the questions to be answered. For the dialogue between colleagues to be effective an additional essential requirement is for the response to be equally legible, concise, relevant, and prompt. The value of face to face contact or telephoned conversation cannot be overemphasised.

Secondly, why does poor communication occur between doctors? A professional façade of social politeness can obscure the real answer. It is contained in these four words: attitudes, prejudices, resentment, and unappeasability. When I was a medical undergraduate one of my then respected (but, now I realise, obviously uninformed) medical teachers pronounced that general practice was the lowest form of clinical medicine. The damage that he and generations of his followers have done has spilled over to affect such apparently minor specialties as traumatic and orthopaedic surgery ("any general surgeon worth his salt can join two bones together"), psychiatry (you have to be mad to work there"), community medicine and mental handicap ("ha! ha!"), and even my own specialty of geriatric medicine ("I congratulate you on obtaining such a sinecure"). Thus lack of mutual esteem in this and other ways is one of the reasons why we have a problem.

Thirdly, what can be done about it? The solution is simple, but, because it requires an equally positive response, its application may be difficult—namely, despite blatant stupidities and provocations, forgive readily and strive to begin as a new person with each fresh encounter. This has, of course, 2000 years of authority behind it[2] but there may be those who prefer an apparently modern approach.[1 3]

BRIAN LIVESLEY
Consultant Physician

Department of the Health Care of the Elderly,
Dulwich Hospital (North Wing),
London SE22 8DF

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