Kwitesafe trial

(1) *Title*
A 10-week open study to investigate the effect of Kwitesafe on the control of blood pressure in patients

(2) *Site*
In general practice.

(3) *Investigators*
Selected general practitioners.

(4) *Background*
Kwitesafe is a new antihypertensive agent with a unique effect (see enclosed literature). Trials have demonstrated effectiveness in the control of blood pressure in patients who are attending hospital as either inpatients or outpatients. It now seems logical to try the effect on patients in general practice.

(5) *Objectives*
(i) To determine the effect of giving Kwitesafe to patients with mild to moderate hypertension.
(ii) To assess the acceptability of Kwitesafe to both patient and doctor.

(6) *Patient entry*
(a) Patients of either sex aged between 30 and 70.
(b) Previously untreated patients or those whose treatment has been withdrawn two weeks before entry.

(7) *Patient definition*
All patients should have a diastolic blood pressure of between 95 and 120 mm Hg.

(8) *Concurrent treatment*
The concurrent use of other antihypertensive agents is not permitted.

(9) *Study design*
Each practitioner will recruit eight patients and will record the blood pressure on a standard form at two-week intervals over a period of 16 weeks. Drugs will be supplied to participants. At each visit the patient will be asked whether any side effects have occurred. These will be recorded.

(10) *Patient consent*
This should be obtained after a full explanation of the aims, methods, anticipated benefits, and potential hazards in accordance with the Declaration of Helsinki (attached).

Would you want to know about how much it cost, how many patients took it and for how long?

Does the information in *MIMS* give you what you need? Do you, for instance, add to or substitute existing treatment? What is the dose range? Are side effects dose-related? Are there any drug interactions?

There are many questions that might be asked about the trial. Has it been given approval by an ethical committee? What is an "open study" and what are its disadvantages? Is this trial capable of meeting its objectives? Are the criteria spelt out? What about the criteria for entry and the patient definition? Are there any exclusions—pregnant women, for example? Is two weeks a long enough period of withdrawal for previous treatment? Is it 4th or 5th phase blood pressure, standing or lying, left or right arm? What advice is given about withdrawals? Is it good enough to ask about side effects or should we be recording events that occur during treatment? Finally, is this really a trial or is it a concealed marketing exercise? Should doctors be concerned? Should doctors be paid for doing it? Why?

You may have realised that even with the information supplied from a wide variety of sources there's a lot you, and perhaps the manufacturers, still do not know about the drug.

Information on prescribing

How do you check that you are prescribing safely? Which of the following sources do you turn to for further information? You might arrange them in order of merit and note which you have used in the last month.

Audiocassettes
Consultants' recommendations
Discussions with professional colleagues
Drug company representatives
Medical societies
Unsponsored meetings at postgraduate centres
Sponsored meetings at postgraduate centres
MIMS
Non-subscription journals
Official Government publications
Other sponsored meetings
Papers and medical journals

When 200 general practitioners did a similar exercise, this is the order they came up with:

MIMS
Consultant's recommendation
Discussions with professional colleagues
Unsponsored meetings at postgraduate centres
Sponsored meetings at postgraduate centres
Papers and medical journals
Non-subscription journals
Drug company representatives
Official Government publications
Medical societies
Other sponsored meetings
Audiocassettes

But, of course, many of these sources of information are not available when you need them—in the surgery. There is no substitute for a well-developed sense of suspicion based on familiarity with the drugs and the patients who may need them.

This is the second of four articles on prescribing.

Clinical curio: human-hair paraphimosis

In Riyadh, Saudi Arabia, in 1977 I saw two small boys who had paraphimoses caused by long human hairs tightly wound several times around their penises at the coronal sulcus. The hairs produced oedema of the glans and obstructed the urinary flow. The members of the children's families were all unaware of the presence of the hair and did not know who had wound the hair, or where, or how. I was interested to see these two cases in Riyadh, in Saudi children, not only because the condition is rare, but also because I had already seen two similar cases in 1975 in Marj'uyun in Lebanon.

I am at a loss to explain the reasons behind this condition. I found no reference to similar cases, and I talked to several colleagues about it. But no one had seen, heard, or read about any such case, except Dr Marwan Hanna who recalled having once read in one of the biographies of Rasputin that Rasputin had done something similar to the Czar's son. But Dr Hanna could not recall the exact reference.

Who could do such a thing to a child? In searching for the possible culprit, the mother is the first suspect to come to mind. She may have been tired of washing diapers and sheets and may have attempted to lessen her burden by winding the hair around her son's penis. This is a distinct possibility, but three things militate against it. Firstly, maternal love, which although it may weaken in the face of adverse conditions and overwork remains a strong deterrent. Secondly, if the mother had wound the hair herself, she would be able to remove it and would not need to bring her son to the doctor unless because of oedema she could not find the hair. Thirdly, all the mothers were genuinely surprised when they saw the cause of the child's distress was a hair.

So, having excluded the mother, we have to look for another suspect. I presume that tying the penis of these children was done by some mischievous, psychopathic person out of jealousy, spite, vengeance, fear, or hate. The hair was in all cases 20 cm long and therefore probably came from a woman (unless it was from a long-bearded man like Rasputin).

I think that this condition has not been described before because the oedema is so pronounced that the hair becomes embedded in a deep groove and the doctor has great difficulty in noticing it. The treatment is simply removal of the hair: in all cases this was easy and curative. I will be interested to hear from anyone who has seen similar cases or who has any explanation as to why it should happen.—FARID SAMI HADDAD, chief of urology, Veterans Administration Medical Center, Phoenix, Arizona.

Organising a Practice

Do appointment systems work?

SARA ARBER, LUCIANNE SAWYER

Appointment systems in general practice are here to stay. They are one of several changes in practice organisation that have gathered momentum over the past 20 years. By 1977, 75% of practices were using appointment systems, compared with 15% in 1964.[1] Whether or not an appointment system is used is associated with the size of the practice. Our own research, based on interviews with a random sample of 1038 adults in Surrey and south-west London in 1977, showed that of doctors consulted by these patients only 38% of single-handed doctors had an appointment system, whereas 66% of doctors practising in partnerships of two or three doctors and more than 90% of larger partnerships and those in health centres had appointment systems.[2] Appointment systems formalise to some extent the contact between doctors and patients since arrangements generally have to be made in advance through a third party—the receptionist.

To have or have not?

The main advantages of an appointment system for the doctor are that the work load is spread more evenly among the days of the week and the times of the day, so that the doctor is better able to plan his or her time, and the patient's records are available in advance. The main advantages for the patient are a shorter average length of waiting at the surgery and being able to arrange visits to the doctor to fit in with other commitments. These advantages were shown by Bevan and Draper[3] and Cartwright[1 4] and were confirmed in our research.[2] Patients whose doctors had no appointment system reported that on average they had to wait nearly half an hour—that is, twice as long as patients attending by appointment—and nearly a third waited three-quarters of an hour or more compared with only 10% of patients with an appointment. Patients who attended practices with appointment systems were generally in favour of them: less than 20% thought that they had no advantages; 60% thought that the main advantage was shortened waiting time; and 10% said that the advantage was being able to plan appointments in advance. But about half of the patients who attended practices without appointment systems thought that appointment systems had no advantages.

A third of the patients who attended practices with appointment systems thought that a major disadvantage was that the patient may not be able to see the doctor when he or she wants to or needs to.[2] An appointment system "is all right if you know you're going to be ill in two days time." How a practice deals with this will bear on the advantages of an appointment system.

Appointment systems in general practice cannot be run the same way as those in other walks of life—for example, to see a bank manager, a school teacher, or a hairdresser—simply because by definition the person with an acute illness cannot plan in advance to be ill. Once a decision to consult is made the patient generally wants to see the doctor as soon as possible. Two things are needed: flexibility in the way the system is organised and a minimum time-lag between requesting an appointment and getting one. There is evidence, however, of severe problems, which affect from a third to a half of patients. Cartwright and Anderson[1] found that 63% of patients said that they could usually get an appointment within 24 hours when they wanted to see their doctor at the surgery as soon as possible, but 15% said that it usually took three days or more. When we asked patients how easy it was for them to see their own doctor at the surgery on the same day more than half said it was a problem: fairly difficult 25%, very difficult 22%, impossible 9%.[2] This suggests that in a great many practices it is a problem to see the doctor in cases of acute illness.

Types of appointment systems

Appointment systems are sometimes discussed as though everyone understands exactly what they mean, yet, as with other aspects of general practice, there are many different ways to organise them. Therefore, before one can assess the advantages or disadvantages of appointment systems it is worth discussing the types of appointment systems. There are four dimensions that need to be considered when assessing how well appointment systems are organised to deal with acute illness.

(1) The method of organisation. Consultations may be arranged (*a*) all by appointment; (*b*) some by appointment and some by "waiting in turn"—a partial system; (*c*) none by appointment.

(2) The method of coping with patients who do not have an appointment but who wish to see the doctor as soon as possible. The main alternatives are: (*a*) the patient is given the next available appointment; (*b*) a proportion of appointments are left free, to be filled only by patients requesting an appointment that day; (*c*) the patient is "fitted in" between scheduled appointments; (*d*) the patient is seen at the beginning or the end of surgery; (*e*) the patient is seen by one specific (duty) doctor.

(3) The criteria on which a decision is based if patients can be seen before the next available appointment. Here the most restrictive criterion may be only "medical emergencies" and the least restrictive for "any condition." A rough continuum might be: (*a*) medical emergency; (*b*) patient in severe pain; (*c*) worrying symptoms—anxiety about cause or prognosis; (*d*) patient in some pain; (*e*) condition would benefit from early treatment; (*f*) any condition.

(4) Who makes the decision that patients with a particular condition should be seen early? (*a*) The patient; (*b*) the doctor; (*c*) the nurse; (*d*) the receptionist or secretary.

These issues are rarely discussed in general practice yet are crucial in assessing the adequacy of appointment systems.

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In many cases, dealing with acute sickness leads to lack of continuity of care. This is explicitly built into systems where a "duty" doctor sees unbooked patients. In other cases which doctor is seen will depend on whether the patient's own doctor has a surgery that day and the relative pressure of work for each doctor. A doctor who works faster or is less popular may see more unbooked patients. But is continuity of care less relevant when treating acute sickness than either long-term illness or preventive health, both of which may be more easily planned in advance? Our research found that the majority (61%) of patients who had been asked to see another doctor when making an appointment were willing to do so. Many qualified this willingness, however, by saying that they knew, or liked, the other partners in the practice. A further 13% were willing but only if they needed medical care urgently. The remainder were willing though dissatisfied or would prefer to wait for their own doctor. This suggests that most patients are happy to see any doctor when they need urgent medical attention but that they prefer a doctor they know. Interestingly, patients thought that the main advantage of larger group practices and health centres was that a doctor was available, if necessary, all day.

General practitioners frequently accept that urgent cases can be "fitted in" or seen at special times. Thus, the crux of the issue when evaluating an appointment system is the definition of "urgency." Who determines what is "urgent" and by what criteria? Field[5] said: "*Urgent* is clearly a subjective description and it could be argued that any patient who says he needs to be seen the same day has by definition an urgent problem." We agree that the definition of urgency should be left to the patient. This is the opposite of Cartwright and Anderson's finding that 91% of patients said that the decision about how soon they could get an appointment was made by the receptionist.[1] Receptionists are the ones who have to run the appointment system specified by the doctors in that practice. They are in the unenviable position of either bearing the brunt of negative criticism from patients who cannot get an appointment as soon as they want one, or the wrath of doctors who want to finish their surgery on time rather than having a series of patients fitted in or seen after surgery hours. The receptionist is therefore subject to conflicting pressures. If she acts more as a barrier to patients this is likely to reflect practice policy in terms of the definition of urgent and the way of dealing with urgent cases. Nearly 20% of our sample of patients thought that the receptionist was more of a barrier between them and the doctor than a help, and over a quarter said that they sometimes had to insist on having an urgent appointment when talking to the receptionist. Parents consistently mentioned more unsatisfactory experiences with receptionists. More of their contacts with the surgery were requests for a child—for example, for urgent appointments or home visits—at which times the receptionist's role in controlling access is likely to be more apparent.

A badly organised appointment system may act as a rationing device, providing a barrier to general practitioner care. But there is no evidence that this results in a reduction of trivial or unnecessary consultations. Cartwright and Anderson found that 40% of patients who usually had to wait three or more days to get an appointment said they had been put off going to see the doctor on some occasion in the last 12 months because of the need for an appointment.[1] In our study 41% of those who said that it was impossible to see their own doctor on the same day had on a previous occasion been discouraged from seeing the doctor.[2]

Making it work

The reality of appointment systems may vary from the extremes of serenity to chaotic, neither being satisfactory from the point of view of patients or doctors. In the serene surgery nothing disrupts the ordered flow of prebooked patients, who never see the doctor more than a few minutes late. The doctor's work is well ordered and predictable, and patients with appointments are happy. Frustration and anxiety, however, are likely to occur outside the surgery among patients who have difficulty getting an appointment to see a doctor. In the chaotic surgery patients are continually being fitted in even though the surgery session is already full, with the consequent problem that patients in the surgery have to wait a long time, and the doctor's work day cannot be planned effectively.

The best appointment system would allow the patient to define "urgency" but maintain predictability for the doctor—that is, let him know about how many patients are seen during any particular surgery. Unpredictability may be minimised by continually monitoring the number of patient requests for both urgent and non-urgent appointments on different days of the week. The arrangements for making appointments would need to be changed until an optimum balance was found, which itself may vary at different times of the year. Thus, the ratio of prebooked to unbooked appointment times would vary among days of the week and times of day, depending on the number of patients who wish to see a doctor urgently at each of these times—for example, there may be no, or very few, prebooked appointments for surgeries on Monday morning. Such a system will result in better organised doctors, more contented patients, less irate receptionists, and fewer patients who do not seek medical care when they think they need to because of the difficulty of obtaining appointments.

Other aspects

The potential disadvantage of not being able to see the doctor easily for acute sickness may therefore be overcome if sufficient attention is paid to organising an appointments system. But there is another disadvantage of an appointment system that cannot be dismissed: some people have difficulty in making appointments. Only 54% of households in England and Wales had a telephone in 1976,[6] and the proportion is much lower among elderly people and those in the lower social classes. The problems of telephoning for appointments when the surgery telephone is engaged for long periods, or when the receptionist asks the caller to hold on while another patient is seen to, were mentioned by several respondents. Such delays are especially frustrating for patients who have to use public call boxes to make appointments. The alternatives to public telephones are asking a neighbour to use the phone or going to the surgery to make the appointment. The difficulties for elderly patients are particularly great if they do not have a telephone. In our study only 20% of patients phoned to make an appointment themselves, compared with over 80% of the elderly who had telephones; 25% asked someone else to telephone; a third went to the surgery themselves—and so had the inconvenience of making two trips to the surgery each time they wanted to see the doctor; and one-fifth asked someone else to go to the surgery to make the appointment for them. Patients without telephones may therefore be discouraged from using general practitioners or may go to the surgery more often without an appointment.

Another disadvantage associated with appointment systems is that more practices with appointment systems have curtailed their surgery hours within the normal working day. Evening surgery finished at 6 00 pm or earlier for nearly half the patients who attended a practice with an appointment system, but this was so for only 11% of those attending practices where they waited in turn. This was reflected in the proportions who said that they usually had to take time off from work to go to the doctor—41% compared with 26%. This affects the lower income groups to a greater extent since they are more likely to lose pay by seeing the doctor during working hours.

What other aspects should we consider when evaluating appointment systems? Appointment systems themselves may influence the reasons for consultations and the types of clientele. Appointment systems may lead to a relative growth in consultation for some types of care—for example, preventive health care, long-term illness, and return visits—and a relative decrease

in consultations for acute sickness or for conditions that can only be adequately dealt with that day. When appointment systems are badly organised more people may cope on their own with short-term, self-limiting illnesses because of the feeling that by the time they get an appointment to see the doctor in two or three days the condition will have cleared up. The findings of Morrell and Kasap,[7] though based on a study of only one practice before and after an appointment system was introduced, support the thesis that appointment systems benefit those with chronic conditions most, while leading to a fall-off in consultations for acute conditions. Our study did not specifically investigate this, but the results suggest that for each age group of patients those last consulting the general practitioner for chronic conditions were more in favour of appointment systems than those last consulting for acute conditions, and were more likely to feel that their appointment system worked well.[2]

The relative use of general practitioners by different social groups may also be influenced by an appointment system. As well as favouring those groups who are more likely to consult general practitioners for preventive care and care for chronic conditions it may favour the more articulate patients, those who are more used to coping with bureaucratic procedures, and those who are more familiar with using telephones. Morrell and Kasap found that introducing their appointment system reduced the consultation rate in social class V and increased it for classes I and II.[7] Our study did not investigate this. If, however, appointment systems do facilitate the use of general practitioners by classes I and II while discouraging use among the lower classes this would further increase health inequalities. The Black Report showed that the lower social classes have greater morbidity and higher mortality rates and therefore have a greater need for primary health care,[8] yet, appointment systems *may* act as more of a barrier for these groups.

The introduction of appointment systems has been the major reason for the growth in the number of receptionists. It is no longer relevant to talk about general practice in terms simply of the dyadic doctor-patient relationship, since the first stage of seeking a consultation requires an encounter between the patient and the receptionist. Many general practitioners see the receptionist as a kind of "colourless sounding board" who simply acts as a passive intermediary between patient and doctor, but we maintain that receptionists have varying amounts of informal power—they are able to influence who sees the doctor, when and where. So, with the expansion of appointment systems, the receptionist's function becomes more prominent.

Conclusions

Appointment systems are now an accepted feature of general practice, providing many benefits to both doctors and patietns. There is one potential major disadvantage of appointment systems: patients with acute symptoms may not be able to see a general practitioner when they want to. This can, however, be successfully avoided in practices which run appointment systems that are sensitively organised and allow for flexibility in bookings and allow the patient to decide when he or she needs to see the doctor.

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Innovations in London

Great Chapel Street Medical Centre

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The Great Chapel Street Medical Centre for the young homeless opened in January 1978. It was designed as an experiment to provide general medical services to the young people who drift about the West End of London, often without fixed abode, and who have difficulty in obtaining acceptance by or are reluctant to go to local general practitioners.

The events that led to its inception date to some years before and reflected a growing concern about the medical and social welfare of this kind of patient. A report from an ad hoc conference pinpointed the needs of such patients to the Department of Health and Social Security. Negotiations were initiated by the Campaign for the Homeless and Rootless (CHAR), the West End Coordinated Voluntary Services (WECVS), with the help of the Kensington, Chelsea and Westminster Area Health Authority. The DHSS agreed to finance the project and to earmark funds for evaluation. Various charities contributed funds. The centre was initially run by a management committee representing the agencies that set it up. Since April 1981, when the DHSS funding stopped, the centre became a branch surgery, with supplementary financial contributions from the district health authority and the management committee became an advisory body.

My work with the centre came about through several fortuitous circumstances. A few years earlier I had resigned my

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