

doctors will normally seek the clinical notes and radiographs as well as themselves assessing the patient clinically, radiologically, and functionally.

A doctor who strongly believes that an employer has been negligent may find it difficult to resist the temptation to suggest that the patient sues. It is better to advise the patient to consult a trade union or a solicitor and offer to provide medical support for any claim. The patient will then get proper advice on negligence and the legal obligations of employers, matters with which doctors are usually unfamiliar. With pleural plaques it is mischievous to do other than tell the patient of the presence of harmless shadows in the radiograph and to explain that they carry no implications for health other than those arising from the known exposure to asbestos. Anxiety in such patients is iatrogenic and can be prevented by competent medical advice.

Finally, what should the doctor do when a patient suffering from asbestos related disease dies? In England and Wales deaths from industrial diseases should be reported to the coroner, who will hold an inquest, usually after a necropsy. In Scotland there is a similar requirement to report the death to

the procurator fiscal, but it is not commonly observed. Even if a death is reported there may be no necropsy, and a more efficient system would be for doctors to encourage the relatives to agree to postmortem examination, leaving the pathologist to inform the procurator fiscal when a relevant diagnosis is confirmed. After necropsy the lungs should be preserved for further examination in case of litigation, as detailed analysis of their asbestos content may be a useful indicator of past exposure.^{4,5}

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Three types of erythromelalgia

Important to differentiate because treatment differs

The term erythromelalgia was first used in 1878 by Mitchell to describe a syndrome of red congestion and burning pain in the hands and feet. He distinguished it from the painful red limbs seen in some patients with gout or rheumatoid arthritis.¹ Some confusion was introduced when Smith and Allen suggested changing the name to erythermalgia in order to emphasise the symptoms of painful inflammation and warmth. They also showed that in their patients aspirin promptly relieved the burning pain for about three days.² Recently erythromelalgia and erythermalgia have been used indiscriminately as synonyms—and to confuse matters further both have been described as primary or secondary, erythermalgia often associated with polycythaemia vera.^{2,4} There are, in fact, three syndromes of erythromelalgia that need to be distinguished for effective management.

The most common variant is erythromelalgia associated with thrombocythaemia. The clinical features of this syndrome are readily explicable by platelet mediated arteriolar inflammation and thrombosis—whether the thrombocythaemia is isolated or is associated with polycythaemia vera or myelofibrosis.³ The long lasting clinical relief given by aspirin is due to its irreversible inhibition of platelet cyclo-oxygenase activity.^{6,8}

The burning distress in the feet or hands of patients with thrombocythaemia is linked with local symptoms of redness, warmth, and swelling.^{5,8} Warmth aggravates the symptoms, but cold relieves them only slightly. More substantial relief is given by absolute and continued rest with the arm or leg raised. The redness is usually most obvious in the ball of the forefoot or one or more toes or both. In the arm the lesions are usually in the palm and finger tips. One hand is affected more often than both; when the lesions are bilateral they are asymmetrical. The picture may progress from a dull dusky mottled redness to dark purplish acrocyanosis and even peripheral gangrene.^{5,8} The histopathological findings are fibromuscular intimal proliferation and occlusive thrombosis of arterioles and digital arteries.⁷ Thrombocythaemic

erythromelalgia is frequently not recognised because clinicians are unfamiliar with its typical appearances, but it may be common. In our series of 50 patients with thrombocythaemia 30 had erythromelalgia, but of 73 such patients from eight general hospitals in The Netherlands it was present in only 17. The relief of pain for several days after a single dose of aspirin is a reliable therapeutic test for this type of erythromelalgia.

By contrast, primary erythermalgia is rare. Instead of the asymmetrical or unilateral localisation of thrombocythaemic erythromelalgia in the forefoot, toes, and fingers in adults,^{5,8} primary erythermalgia begins in childhood or adolescence as bilateral symmetrical burning distress in the feet, ankles, and legs.⁹ There is a sparing of the toes and no progression to peripheral ischaemia or gangrene. The burning distress of primary erythermalgia is easily elicited by exposure to warmth and by exercise—to such a degree that patients need to find some way of cooling their legs. The disorder occurred in more than one member in five families, suggesting some genetic basis.⁹ Six criteria are required for the diagnosis to be made^{9,11}: firstly, attacks of local red vasodilatation and congestion with increased local skin temperature and burning pain; secondly, the disorder is bilateral; thirdly, the attacks may easily be provoked and aggravated by exercise and heat; fourthly, cold, rest, and raising the affected limbs provides relief; fifthly, there must be no primary or associated disease; and, lastly, the condition is refractory to drug treatment. Only 13 case histories of primary erythermalgia satisfying these criteria could be collected from published work.^{9,10}

The third and final variant is secondary erythermalgia, described in association not only with gout, systemic lupus erythematosus, rheumatoid arthritis, cryoglobulinaemia, endarteritis obliterans, thromboangiitis obliterans, polyarteritis nodosa, and arteriosclerosis but also with diabetes mellitus, neurological conditions, vascular diseases, and secondary to vasoactive drugs.¹²⁻¹⁸ In none of these conditions has any platelet dysfunction been shown, and aspirin has no

effect on the symptoms, which are best relieved by treating the underlying disorder.

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General practitioners' workload

Studies need to take account of part timers' characteristics

Picture a middle-aged man who has not troubled to keep up with developments in his continuously changing profession since he qualified 20 years ago. He sees clients for two or three brief periods each week, spending the rest of his time on the golf course.

This was how the *Economist* began an editorial entitled "Let doctors compete" in 1987.¹ The public image of the general practitioner on the golf course is tenacious. Even hospital doctors sometimes wonder what it means when they hear that the general practitioner is "on his rounds." General practitioners have fuelled these misconceptions by using terms like "part time" in a pejorative way to describe the work of women practitioners, those concerned with teaching and organisation, and almost any doctor other than themselves. Surveys of workload have added numbers to the confusion.² What is the reality?

General practitioners contract to be responsible for providing care for their patients continuously (168 hours each week).³ About 6% of doctors do work and remain on call for 130 to 168 hours a week, but most general practitioners work less than the theoretical maximum.⁴ They have reduced their working hours by forming groups and negotiating about their share of practice income and the hours they are prepared to contribute in return. Each group of doctors determines the hours of work rewarded by a maximum or full share of profits and the part share of profits corresponding to shorter or more convenient hours of work.

This process has allowed women with young families and people past normal retirement age to continue practising. Such doctors may work fewer hours than their full profit sharing partners—and earn less—though this may be acceptable to doctors in two income families or to those receiving a pension. This does not, of course, necessarily leave these doctors with more free time; young mothers who are also general practitioners are likely to work long hours.⁵

The public relations problem with studies of workload is that they have tended to focus only on hours rather than the income work package. This may have been partly because the Department of Health study provided data used for the

doctors' pay review and investigators wanted to avoid circular thinking. Or it may be that researchers feared that questions about income would reduce doctors' willingness to respond or the reliability of the data. But recent surveys by Leese and Bosanquet⁶ and Hooper^{7,8} suggest that doctors are willing to provide information about income and that income varies a great deal.

Hooper found that about half of the women general practitioners who responded received a maximum or full share of practice profits—but that half received less than a maximum partners' income and worked fewer hours.^{7,8} There was some dissatisfaction with earnings among part sharing general practitioners, which may reflect lack of consensus within groups about the share of profits that should be attached to longer hours and night and weekend work.

The Department of Health's study of workload found that the average general practitioner divided up the working week into 20 hours with patients in the surgery; 10 hours visiting patients in their homes; eight hours organising and doing administration; five hours doing work (not counted as general medical service) such as continuing medical education, committee work, or teaching undergraduates; and 30 hours on call. The average of 38 hours spent on the first three activities actually represented a conflation of the hours worked by doctors with maximum shares and part sharers who worked fewer hours. General practitioners who worked fewer hours (and were likely to be part sharers) were more commonly women or over 60 years old. Yet it surely is illogical to add the hours worked by full timers with those of part timers, divide the sum by the number of workers, and present the product as an average workload. Nevertheless, when this is done the average partner worked a 73 hour week—twice the normal working week in Britain and an underestimate of the time worked by full timers.

Those who do not take responsibility for sick people at night and at weekends tend to focus discussion on the figure of 20 hours spent in the surgery or the 38 hours spent on the first three activities. This total is no more than a normal working week, but focusing on this discounts and devalues the extra 35 hours spent on activities such as teaching, learning, commit-