

# Are you being served?

## A survey of the opinions of general medical practitioners who refer patients to Bristol Dental Hospital

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We recently carried out a survey of general medical practitioners regarding their opinions of the service they receive for patients whom they refer to Bristol Dental School and Hospital (BDH).

### METHOD

Anonymous questionnaires were circulated in Spring 1987 by the Family Practitioner Committee to 523 general medical practitioners in the Avon Family Practitioner catchment area (Table 1). Questions were posed as to the frequency of referral, the departments or units to which patients were referred and the practitioner's general opinion as to the service provided. A section was also devoted to eliciting specific criticism of the service provided, if any.

### RESULTS

Replies were received from 334 medical practitioners (63.9% response) (Table 1).

**Table 1**  
 Details of survey

	General Medical Practitioners	
	No.	%
No. of questionnaires	523	
Replies	334	63.9
Practitioners referring patients to BDH	210	62.9 of replies

Medical practitioners who referred patients to BDH accounted for 210 (62.9%) of the respondents.

From Table 2 it can be seen that the vast majority of referrals from medical practitioners is on an 'occasional' basis only.

**Table 2**  
 Frequency of referral

	No.	%
Weekly	—	—
Fortnightly	1	0.5
Monthly	9	4.3
Occasionally	200	95.2

Table 3 shows that most departments receive referrals, the exception being the 'Preventive'. The Oral Medicine and

**Table 3**

#### Units or departments to which patients are referred

	No.	%
1. Oral Surgery	136	64.8
2. Casualty/Diagnosis	99	47.1
3. Oral Medicine	96	45.7
4. Periodontology	9	4.3
5. Prosthetics	7	3.3
6. Conservation	6	2.9
7. Orthodontics	6	2.9
8. Children's	4	1.9
9. Preventive	—	—

Oral Surgery units receive the biggest share of referrals.

Nearly all practitioners referred patients to more than one department which accounts for the overall total of 364 departmental or unit referrals by GMPs.

Table 4 shows the overall opinion of practitioners as to the service provided. Some three quarters of referring GMPs (75%) ranked the service as "good" or "excellent": nearly 18% ranked it "excellent". Some 15% felt the service was "average". Only 5 out of 193 (2.6%) GMPs who expressed an opinion, were dissatisfied, in general terms, with the service provided.

**Table 4**  
 Overall opinion of BDH service

	No.	%
Excellent	37	17.6
Good	121	57.6
Average	31	14.8
Poor	3	1.4
Bad	1	0.5
Not stated	17	8.1

Table 5 shows the numbers of complaints and the main categories in which complaints were made.

Further analysis showed that 22 of the medical practitioners who were otherwise reasonably satisfied, felt strongly enough to register 25 complaints about particular fields of service. Together with the 5 who considered that the service was 'poor' or 'bad' overall (4 complaints), this amounts to a total of 26 GMPs (12.4%) who registered 29 causes for complaint. No opinion as to the overall standard of service was given by 17 GMPs (8.1%).

**Table 5**  
 Main areas of criticism of BDH service

	No.	%
Long appointments' waiting list	6	2.9
Long operations' waiting list	—	—
Presence of students	1	0.5
Unhelpful staff	—	—
Poor telephone communications	2	1.0
Patient not seen by consultant to whom referred	1	0.5
Unsatisfactory correspondence	4	1.9
Miscellaneous other*	16	7.6
* Includes comments about		
No emergency service provided		(12)
Insufficient knowledge of departments		(2)
Too frequent recall		(1)
Inadequate supervision of students		(1)

The usual reasons given by the 124 practitioners who did not refer patients to BDH were that:-

- they were unaware that the service existed
- there were no weekend referrals
- they referred patients elsewhere

Only 2 did not refer patients to BDH because of some past dissatisfaction. Both of these were stated to be because of a lack of after-hours service.

## CONCLUSION

Whilst most practitioners who expressed an opinion were more than satisfied overall with the service which they receive from BDH, the incidence of certain criticisms shows that there are a number of important areas where improvements in the service can be made.

A new telephone exchange is currently being installed for 1988 and this, together with new Consultant clinics and a new Primary Care Unit, as well as improved organisation should help communications and reduce waiting lists for appointments—two of the major problem areas. Practitioners should, however, appreciate that there has been chronic shortage of medical secretaries and records staff and that

there are increasing cutbacks in funding of many acute services in the country. In 1982 BDH was run on 1.5 medical secretaries, though this is now 4. The total number of outpatient attendances is about 105,000 per year.

Furthermore, we must provide the service in those areas not the remit of general dental practitioners. We provide a 24 hour Accident and Emergency service for serious problems such as trauma, haemorrhage and infection. Provision of a 24 hour toothache service is explicitly not the function of the hospital dental service and it would only be justified on the grounds of the contribution to undergraduate training. Indeed, the rise in personal violence is already throwing an increasing burden on these services (Shepherd et al., 1986).

## REFERENCES

SHEPHERD, J. P., SHAPLAND, M., IRISH, M., SCULLY, C., LESLIE, I., PARSLOE, P. *et al.* Higher rates of assault in the unemployed. *Lancet* *ii*: 1038, 1986.

# Pancreatic Transplantation

## 8th Marjorie Budd Lecture

Delivered by Professor Peter Morris

Nuffield Professor of Surgery, University of Oxford, 4th February 1989 at Bristol Royal Infirmary.

Though the introduction of insulin in 1922 immediately transformed the management of diabetes, allowing diabetics to survive with their disease, the microvascular complications of the disease became increasingly evident with time. Thus insulin-dependent or type 1 diabetes is the fifth major cause of renal failure, the major cause of blindness, and coronary heart disease is a major cause of death in these patients. Evidently insulin is not the whole answer to diabetes and it was hoped that pancreatic transplantation might provide normal control of glucose levels throughout a 24 hour period, and so completely correct the metabolic abnormality in the diabetic patient which, in turn, might cause regression or failure of progression of these microvascular complications of disease.

Lillehei, in 1966, was an early pioneer in pancreatic transplantation; most of his attempts failed but he did have one patient who survived for one year completely insulin-independent before being killed in a car accident. Since the advent of cyclosporin pancreatic transplantation has 'taken off'; the average 1 year success rate is 40%, but some units have achieved a 70–80% one year graft survival rate recently.

However pancreatic transplantation, whether segmental or whole organ, is a major operation with a 30% complication rate and an average hospital stay of 6 weeks. Moreover, it has not been shown that either neuropathy or retinopathy regresses probably because surgery at present is done at an end-stage of the disease. If transplantation of pancreatic endocrine tissue is to succeed it should be done at an early stage, but such a hazardous operation cannot be offered to diabetics soon after their onset of their disease, or soon after the first evidence of microvascular complications. Thus it looks as though it will never be an option except in late cases who also need a renal transplant and hence immunosuppression.

The search is now on to find a means of transplanting isolated pancreatic islets by a simple safe, non-operative, injection procedure. A successful method of isolating islets

was developed in rats which gave rise to early optimism. Rats made diabetic by streptozotocin (a  $\beta$  cell toxin) can be cured by injection of a suspension of their own islets into their portal vein, spleen or beneath the kidney capsule and 'live happily ever afterwards'. Allografts in rats, however, are rejected promptly and it has proved difficult to achieve prolonged survival with a variety of immunosuppressive protocols, including cyclosporin, but progress is being made to overcome this problem.

However, the techniques used in the rat for the isolation of islets was unsatisfactory for large animals or man. The development of a technique in Oxford for the preparation of islets from a human pancreas using collagenase at 39°, injected directly into the pancreatic duct, has allowed good yields of human islets to be obtained. The monkey has proved a good preclinical model for testing the technique in that the pancreas resembles very closely that of man and it is possible to prepare islets using the same technique and implant them in totally pancreatectomised recipients and show that autologous grafts will survive for up to 3 years.

Cautious clinical trials are planned in the near future but there are many problems still to be overcome. If a safe successful technique can be found the supply of islets from cadaver pancreas will never meet the demand. Suspensions must be used fresh but may be kept in culture for a limited time, perhaps up to 7 days. There is still so much to learn about the physiology of normal islets as well as diabetes. For example, we do not even yet know why the islets are situated in the pancreas, perhaps the surrounding exocrine pancreatic cells have some important relationship with the islets. We must hope not!

This lecture was a fascinating insight into the important research in the treatment of a common and sometimes devastating disease. It was particularly appropriate as an update on the 4th Marjorie Budd Lecture given in 1985 by Sir Roy Calne on 'Liver and Pancreas transplantation'.

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