

PostScript

LETTER

Frequent attenders to ophthalmic accident and emergency departments

The issue of recurrent attenders to eye casualties has received little discussion in the ethics and health policy literature. As many ophthalmology departments offer a walk-in emergency service, protocols need to be in place to ensure appropriate use of this resource and also to identify potential psychiatric comorbidity in such attenders. We illustrate the problem with a recent case.

A 42-year-old woman self-presented 14 times over a 4-month period to the same ophthalmic accident and emergency (A&E) unit. On each occasion, she complained of a recurrent eye infection or requested removal of bandage contact lenses and instillation of topical fluorescein. Corrected visual acuity was 6/6 in each eye. The eyes were white and not infected or inflamed and no contact lens was found at any visit. It is likely that she was also co-attending a separate ophthalmic A&E unit.

Ophthalmologists are perhaps unique in the UK in providing a casualty service distinct from the main accident and emergency department. This service is often "walk-in" and "free at the point of delivery" so that the normal gate-keeping mechanisms within the NHS are bypassed. Whether a walk-in service is right or wrong remains a contentious issue and is closely linked with patient empowerment and the recent drive toward a patient-centred health service. The need for an ophthalmic opinion is also fuelled by the general lack of specialist ophthalmic knowledge among general practitioners, casualty officers and other colleagues due to limitations in the undergraduate curriculum.

The patience of both staff and fellow patients is often tested when such clients attend in an inappropriate and recurrent manner. It has been shown that increasing attendances are positively associated with older age, male gender and living locally, and inversely associated with being married.¹ Additionally, psychiatric illness has been shown to be twice as frequent among frequent attenders than controls.² To address this issue, appropriate hospital information systems and continuous departmental audit should be in place to allow early identification of such patients. Ophthalmology trainees should be competent in recognising common psychiatric syndromes, performing a mental state examination and be familiar with the Mental Health Act 1983 and associated law.³ In particular, a psychiatry liaison service is an expanding and invaluable resource⁴, and early referral will result in better meeting the true needs of the patient and more efficient utilisation of ophthalmic A&E units.

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- 3 Royal College of Physicians and Royal College of Psychiatrists. *The psychological care of medical patients – a practical guide. Report of a joint working party of the Royal College of Physicians and the Royal College of Psychiatrists*, 2nd ed, 2003.
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BOOK REVIEW

Medicine and the market – equity v. choice

Daniel Callahan, Angela A Wasunna. Baltimore: The John Hopkins University Press, 2006, \$35 (hardback) ISBN 0-8018-8339-3, pp 321.

In this book, the authors' aim is to assess the evidence for the positive effects of market practices in healthcare and to provide an ethical evaluation of these market practices. It is clear from the beginning that the authors are not setting up a simple, and thereby false, dichotomy between market provision and equity in healthcare, but that they are genuinely interested in exactly what elements of market practices are useful and ethically acceptable. They argue convincingly that in order to provide such an analysis it is necessary to look in detail at a wide range of healthcare systems – systems that differ both in attitudes towards market competition in health care and in the resources available. One of the book's strongest points is that it

moves away from an analysis focused almost exclusively on the USA, Canada and the UK, and provides evidence from many different healthcare systems in Europe, Central and South America, Africa and Asia. By widening the scope of interest, it becomes possible to see that market practices that are ethically acceptable in some circumstances may have such severe distributional effects in other contexts that they become unacceptable. What we have to ask therefore is the specific question: will the introduction of this market approach in this healthcare system have generally positive effects? In most cases, the authors answer this question in the negative, as could probably be predicted from Daniel Callahan's previous work, but they always provide extensive arguments to back up their assessments. The authors' most severe criticism is levelled at those on both sides of the argument who propose or oppose market practices purely on theoretical or ideological grounds.

This is an excellent book and very reasonably priced. It should find a place on the shelf of everyone seriously interested in resource allocation in healthcare and in the design of healthcare systems. My only criticism is that it could probably have been around 10% shorter. Some of the material concerning individual healthcare systems could probably have been cut, or the number of healthcare systems analysed curtailed to some degree.

Søren Holm

CORRECTIONS

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An error occurred in the abstract of a paper published in the July issue (Denny CC, Grady C. Clinical research with economically disadvantaged populations. *J Med Ethics* 2007;33:382-5). The sentence "The economically disadvantaged are thought of as "venerable" to exploitation, impaired decision making, or both, thus requiring either special protections or complete exclusion from research." The word "venerable" should read "vulnerable". The journal apologises for this error.

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An error occurred in the author names of a paper published in the May issue (Do-not-resuscitate decision: the attitudes of medical and non-medical students. *J Med Ethics* 2007;33:261-5.) The correct names are as follows: CO Sham, YW Cheng, KW Ho, PH Lai, LW Lo, HL Wan, CY Wong, YN Yeung, SH Yuen, AY Wong.