basis in Northern Ireland for several years now, no attempt has as yet been made to implement this policy. This has led to the current situation where the Western Health and Social Services Board is estimated to be around £9 million underfunded according to the Department of Health and Social Security's own figures for Northern Ireland. While we are well aware of the relative poverty of staff and service in the hospital and community sectors which this underfunding has produced, it is obvious from the results of Birch and Maynard's paper that there is bound to be a significant hidden impact in the general practitioner services, especially in light of the view that 'the ability of patients to express needs as demands is conditional upon the availability of services'.

I am sure your readers can well imagine the impact upon their own services if RAWP had not been implemented in England and can sympathize with their colleagues in general practice in the western part of Northern Ireland.

C.A. HAMILTON

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Thyroid disease follow-up

Sir,

We read with interest the report (News, November *Journal*, p.524) by Drs Jeremy Jackson and Peter Baxter of a framework for thyroid follow-up in general practice. Hypothyroidism is one of the few conditions which entitles a patient to life-long exemption from prescription charges. If form C-P 11 is completed by the patient and a doctor, and sent to the family practitioner committee, an exemption certificate will be granted to the patient. Some patients are not aware of this.

From the records of serum thyroxine and serum thyroid-stimulating hormone estimations carried out between June 1983 and March 1985 in the Department of Biochemistry at Northampton General Hospital, 1555 patients with hypothyroidism were identified. Of these 843 were already exempt from charges because of their age. Of the remaining 712 patients 140 were selected, as they were from eight training practices willing to cooperate, or under the care of the consultant with a special interest in hypothyroidism. We asked the doctors for permission to write to the patients — 15 patients were excluded at their general practitioner's request, and no reply was received concerning a further 15 patients.

A questionnaire was sent to 110 patients and 86 replies were obtained from patients eligible for an exemption certificate. Twelve of these patients did not have an exemption certificate. Of those who did, 46 had been informed by their general practitioner and the remaining 28 by other sources.

We recommend that informing patients of their right to free prescriptions should be included in the framework for management of hypothyroidism.

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Sex and health promotion

Sir,

Like Professor Clarke (December *Journal*, p.555) I deplore the adverse consequences of present day sexual behaviour with epidemics of sexually transmitted diseases, cervical cancer and abortion. In recognizing the need for a new primary care initiative I feel that all primary health care team members (in particular general practitioners) must warn those who are sexually active and using contraceptive measures, especially those under the age of 20 years, of the risks they run. For such initiatives to be effective all contraceptive advice and care should be centred on the primary health care team.

The organization 'Life' offers a national resource for competent pregnancy testing and advice regarding unplanned pregnancies, in addition to post-abortion counselling. The address of 'Life' is 118–120 Warwick Street, Leamington Spa, Warwickshire CV32 4QY (tel. 0926-21587/311667) and the telephone numbers and addresses of all local offices are available on request.

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Promoting better health

Sir,

With the knowledge of what has happened in the hospital service over the last few years I think it is naive to welcome the promises contained in the government's white paper with such unreserved enthusiasm (January *Journal*, p.1). Of course there are some elements in the proposals that are laudable and demand our support; it would be remarkable if there were not after all the debate. But there are others that are far from laudable. It is rightly pointed out that much of the document is vague and that much detailed work is now needed.

There is an arrogance inherent in the philosophy of the College that general practitioners can do anything, which at the best of times I find distasteful; in the current climate it is positively suicidal. I agree that general practitioners should be promoting health, improving information systems, educating, managing better and generally aiming to improve their services — but it has to be put in context. The hospital service is falling to bits. This has been acknowledged in public by the Royal Colleges of Physicians, Surgeons and Obstetricians and Gynaecologists. The services provided by the local authorities are ever diminishing and we are increasingly being asked to pick up the pieces. If we are to be able to meet the expectations of our patients and of government, and fulfil our own hopes we will need a lot more than what is on offer in the white paper. And it is not just a question of money.

There are many issues which are not thought through and as an inner city general practitioner one that alarms me is the issue of list sizes. After considerable debate it is now widely accepted that reducing list size is an important way of improving quality and moving to a more preventive approach, especially in areas of deprivation. A recent editorial in the *Journal* (November *Journal*, p.481) supported this conclusion. And yet there are several proposals in the white paper encouraging larger list sizes.

To improve the services we offer our patients is a worthy objective, but to expect us to be able to achieve it by swallowing the brave words of a government which has openly admitted that it is no longer committed to the concept of free treatment at the point of need is laughable. We must be more aware of the hidden agenda of the government, which almost certainly includes cash limiting more and more of the family practitioner services. And that would have a catastrophic effect on the quality of service to our patients.

As a local medical committee member I know that many of my colleagues share my misgivings. For our College and *Journal* to take so uncritical a line undermines the position of those who will be involved in the many negotiations which lie ahead. The College cannot afford to re-

main academically superior to political reality and I urge them to look again at this document with a more critical eye.

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Editorials reflect the views of the individual author (in this case my views) and are not an expression of official College policy. Ed.

Sir,

The Ealing Young Principals Group is concerned that your editorial (January *Journal,* p.1), in its rush to welcome the affirmation of the central position of general practitioners in primary health care, goes on to endorse the government's white paper with surprisingly few reservations, and appears to take no cognizance of many of the contradictions in the proposals themselves or the context in which they are being presented.

You justifiably point out that the removal of restrictions on the number and type of personnel employable by general practitioners through direct reimbursement could be completely undermined by imposing cost limits. However, you fail to point out that the whole emphasis on improving quality of care and encouraging prevention, is at odds with the plan to increase the proportion of remuneration made up of capitation fees, and the need for a stable population for screening will not be helped by the proposal to make it easier for patients to change their doctors.

In our enthusiasm to promote 'screening' we must not forget that this is only one part of the 'triad' of preventive care and not necessarily the most cost effective. The proposal to 'screen' our elderly patients is a useful example. Many measures could be adopted to promote primary prevention of ill health in elderly people — in particular adequate pensions to allow them to make their homes warm and secure and to eat a nutritious diet, more and better day centres and transport for the socially isolated and housebound, adequate numbers of places in part 3 homes with sufficient well-trained staff, and more home helps and meals-on-wheels. Tertiary prevention — the provision of an adequate 'reactive' service to limit the damage done by disease once it becomes manifest and to aid rehabilitation — is also a major priority and in our daily work we recognize the glaring need for more acute and chronic geriatric and psychogeriatric beds in our district, shorter outpatient and surgical waiting lists, and a reliable ambulance service for our elderly patients. This is just a start and the situation is growing worse not better.

If we cannot provide a good reactive service for the needs we can already identify, why screen the asymptomatic? There is a clear danger that this will become 'window dressing' to disfigure a service collapsing through lack of funding.

We urge the College to recognize the true intentions behind the white paper and to start reacting vigorously to the threat facing our health service. Failure to grasp this nettle now will prove disastrous in the long term.

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Small group teaching

Sir,

In general practice the formal methods of traditional hospital medical education have been replaced by more informal teaching styles. In your editorial (January *Journal,* p.1) you state that small group teaching will be an important part of continuing medical education in general practice. Small group teaching is now used widely at the trainee level and will increasingly become the hallmark of continuing medical education.

In any form of education an assessment of the aims, objectives and techniques is of paramount importance. However, one aspect of small group teaching is that peer review takes place both at the explicit and the implicit level. This can be important when dealing with qualitative aspects of general practice, such as attitudes, values and behaviour. Furthermore, in postgraduate medical education the role of small group teaching has been most important in psychiatry and general practice.

Small group teaching can probably make its greatest contribution to general practice in the handling of the consultation as it is the doctor's 'attitudes and feelings'[1] and the relationships he engenders that are the essence of the consultation. Moreover, it is in the analysis of the dynamics of the doctor–patient relationship that small group teaching is most pertinent. It may be that the ability to tolerate peer group discussion is more applicable to general practitioners in their attitude to continuing education.[1]

Not only can this type of education encompass the techniques of the consultation but it can deal with a range of other issues and topics in general practice which lend themselves to discussion in small groups.

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Reference

1. Anonymous. Some insights from seminars. *J R Coll Gen Pract* 1976; **26**: 471-472.

Hours of work and fatigue in doctors

Sir,

May I comment on the editorial 'Hours of work and fatigue in doctors' (January *Journal,* p.2). General practitioners clearly want to be seen as super human — why else should we look upon working through the night, having disturbed sleep and then doing a full day's work as a sensible and honorable activity? What would we say to our patients if they did this?

While we have a 24-hour contract we have to develop reasonable mechanisms for coping — certainly for the period 23.00 to 07.00 hours. Deputizing services fall down, not in theory — a major percentage of the world's general practice seems to cope with similar systems — but in practice. What is required at night is a caring, competent doctor who can deal with problems efficiently, who attends when requested and who recognizes the times when drug therapy is not required and that many problems can be dealt with at home. Deputizing has fallen down because of poor response rates, inappropriate management and overuse of the hospital services.

What is required at night is a general practitioner, provided by a deputizing service, by a large rota in urban areas or by a local rota in rural areas. Most importantly, the doctor who is on call at night should not work the next day. His patients will survive, as they do when he goes on holiday, attends a course or carries out hospital work. Only when we cross this hurdle will general practice have finally grown up.

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Comments on the *Journal*

Sir,

The Epsom District RCGP Group met in November 1987 to reflect on the content of the *Journal,* and the September 1987 issue in particular. Ten College members attended the meeting.