LETTERS TO THE EDITOR

MEMBERSHIP OF THE COLLEGE

Sir,
Council has approved the report of the Board of Censors on obtaining and maintaining membership (see pages 521–524 and the reports of Council meetings in July, page 436, and this issue, page 563). This discussion document has been sent to faculty boards for consideration, but I should also like to bring it to the notice of all members, who are welcome to send me their opinion, as individuals, by 30 November.

J. C. HASLER
Honorary Secretary of Council
14 Princes Gate
London SW7 1PU.

SILICON CHIPS IN THE SURGERY

Sir,
I noted that the widespread use of silicon chip technology in primary care was not considered in the College report on computers *(Computers in Primary Care, Occasional Paper 13)*. I think it is important to discuss the developments being made by the silicon chip across its entire range, as well as that area specifically related to data bases. I also believe that most general practitioners' surgeries will have numerous silicon chip controlled devices well before the widespread introduction of medical record computers.

For example, one can look at the developments of the electronic sphygmomanometer. Early models were primitive and accurate but with a wide scatter of readings (Hunyor *et al.*, 1978), making them difficult to use to monitor blood pressure. However, subsequent advances in technology will mean that they will surpass the performance of the standard mercury sphygmomanometer by providing digital display of readings, thus avoiding observer bias, and by having the convenience of an automatic air exhaustion sequence. Certification reports will become mandatory in the USA; already the Food and Drug Administration (1980) have set a draft standard on electronic blood pressure devices of ± 3 mmHg accuracy, and this will provide a spur for technical excellence. Sadly, design is consumer-orientated, since general practitioners are usually the last to state their needs to bioengineering departments. These modern devices are convenient, quick and accurate and patients may be taught to use them to take their own blood pressure at home. Drug compliance and general understanding of their disease should be improved.

Other medical equipment incorporating silicon chips and appropriate to primary care includes pocket spirometers, pocket alcometers (screening for alcoholism in general practice), electronic sterilizers, diabetic blood sugar monitors, ultrasonic stethoscopes (antenatal care), contraceptive control using intelligent 'rhythm method temperature' monitors, electrocardiographic transmission by phone, electronic weighing scales and automatic answering machines. Here is a trend for the future; I hope the Royal College of General Practitioners will not miss it completely.

N. MASTERS
Cuckfield Hospital
Haywards Heath
Sussex.

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Hunyor, S. N., Flynn, J. M. & Cochineas, C. (1978). Comparison of performance of various sphygmomanometers with intra-arterial blood pressure readings. *British Medical Journal*, **2**, 159-162.

U101 Digital Sphygmomanometer Correlation Repeatability. Report available from Andrew Stephens Company, 41 Dickson Road, Blackpool FY1 2AP.

ORTHOPAEDICS

Sir,
In your Medical News Section of the June *Journal*, p. 374, you drew attention to Professor Duthie's report, published by the DHSS on orthopaedic outpatient waiting time.

I was surprised, therefore, that this pamphlet of 84 pages failed even to mention osteopaths and other manipulators, who see between 200 and 500 patients per day (I estimate) in Nottinghamshire alone. I was still more amazed that the pamphlet considered (on page 67) the possibility of creating a new specialty — orthopaedic medicine — while failing to acknowledge that this already exists and is beginning to flourish despite every discouragement from the medical establishment. Doctors James Cyriax and Ronald Barbor developed a system of treating the moving parts by non-operative means in the late 1930s and have been perfecting it ever since. It is (I believe) extremely effective. Dr Cyriax's book *The Slipped Disc* was reviewed with interest in the May issue of your journal (p. 315).

I wonder if other doctors find it odd that a report whose *raison d'être* was to find a way of bringing speedier help to a huge backlog of non-emergency patients did not even mention these alternative sources of relief. If ever a document supported the contention that doctors ignore facts which might undermine their authority, then this is it.

N. A. WATSON
Member of the Society of Orthopaedic Medicine
Keyworth Health Centre
Bunny Lane
Keyworth
Notts. NG12 5JU.

THE GENERAL PRACTITIONER ACCOUCHEUR

Sir,
I must congratulate Dr M. J. V. Bull on his Butterworth Gold Medal Essay (June *Journal*) for its depth, detail and enlightened approach. However, I would like to add the following points.

General practitioner involvement in obstetrics has decreased over the past few years by three factors not mentioned by Dr Bull. The first factor is the doctors' deputizing service. I noticed through the 'seventies that as young doctors qualified and went into general practice they found that they could use the deputizing service every night, which then restricted their day to 09.00 to 18.00. The only thing which kept them near a telephone at night was the fact that a midwifery case was hanging about. It was therefore a lot easier not to book any obstetric deliveries but to refer all these cases to hospital.

Although ancillary staff have become attached to primary health care teams, midwives have adhered to their own off-duty rota rather than make themselves available to the team. This means that, although a midwife can see a patient every week in antenatal clinic, there is no guarantee that she would actually be the midwife present at the delivery in the GP unit or on the district rota.

With the introduction of newer techniques such as epidurals, fewer patients now fit the category of normal cases as originally laid down by the GP unit's code. There have therefore been fewer cases for which the general practitioner has sole charge.

I also wondered why Dr Bull was so keen on pregnancy tests. He did not explain in his paper what there was to be gained by a pregnancy test at six weeks over a clinical assessment at eight weeks. Doctors have for years been diagnosing pregnancy and I wondered if there was anything to be gained by the high cost of routine pregnancy testing.

However, Dr Bull's essay was worth while in that we may well need more general practitioner obstetricians in the future. With the present rise in the birth rate following the decrease in the 'seventies, we are finding in many cases that Area Health Authorities have failed to re-provide the obstetric beds which were taken away five years ago. In the present economic climate we do not look like getting these beds back. After the end of the recession there may well be a further rise in the birth rate and it could well be that hospital obstetricians will then look very hard to primary health care teams to provide general practitioner accouchers.

STEPHEN J. WRIGHT
4 Cobnar Road
Sheffield S8 8QB.

SICK DOCTORS

Sir,

Recent editorials in the *Journal* (December issue) and the *BMJ* (3.1.81) rightly highlight the urgent need for consideration of the problems facing potentially sick doctors and their families in a climate of increasing patient expectations.

The isolated, self-employed general practitioner may be especially vulnerable because of his status in the community.

The College, presently preoccupied with prevention, is perhaps ideally placed to demonstrate its caring nature to its colleagues, by co-ordinating local networks of willing counsellors to whom practitioners felt to be at risk could turn for confidential guidance before their problems got out of hand. This would be in the certain knowledge that they would be received sympathetically by someone independent, but with a good working knowledge of the problems of general practice, and without being formally cast in the role of 'the sick doctor', with all its attendant connotations and implications.

It is perhaps salutary to note that such arrangements have existed successfully for some time amongst our nursing sisters who, whilst acknowledging that there is a counselling function within the nursing process itself, also recognize that counselling forms an important feature of the nurse manager's role. More recently the needs of nurses themselves in their caring roles have also been recognized, and indeed, in some areas, special posts have been created in order to try to meet these, particularly at St Thomas's and Guy's hospitals in London, and also at the Royal College of Nursing, where courses in co-counselling are being promoted.

Perhaps general practitioners could follow this lead, and help each other to put their own houses in order, for it is well known that their record of managing their own psychological problems to date has not been good. Surely there could be no finer role for the College to explore, since patients are likely to benefit considerably from having healthier and happier doctors?

R. B. H. MAXWELL
267 Soundwell Road
Kingswood
Bristol BS15 1PW.

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DIET AND ARTERIAL DISEASE

Sir,

In the Report of our Sub-Committee on the Prevention of Arterial Disease in General Practice (RCGP, 1981) we attempted to be brief. We now consider that our brevity may have caused us to be misleading with regard to our views on the role of blood fats and dietary modification (Ch. 2, p. 5 of the Report).

Abnormalities of lipid metabolism are associated with an increased risk of arterial disease and there is considerable evidence that one or more aspects of the Western diet are important in the aetiology of ischaemic heart disease. Numerous official organizations have recommended dietary change, including an increase in fibre-rich carbohydrate, a decrease in saturated fat and some increase of polyunsaturated fat. The circumstantial evidence in favour of such change is strong. The Sub-Committee did not, however, consider dietary change in great detail as it was felt that the role of general practitioners should in the first instance be in dealing with hypertensives and cigarette smokers. For this reason, our chief recommendation concerning diet is the control of obesity. This is the first dietary goal in the treatment of all hyperlipidaemias, and achieving ideal body weight will also help to achieve lower levels of blood pressure and blood glucose. Failure to offer further advice concerning diet reflects only our view that this would have gone beyond the scope of the present Report rather than disagreement with other recommendations.

J. COOPE
P. FELL
G. FOWLER
B. GRIBBIN
J. TUDOR HART
J. MANN
L. PIKE

Reference

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POLYMYALGIA RHEUMATICA

Sir,

The article by Drs J. G. Jones and B. L. Hazleman (May *Journal)* highlights the difficulty in diagnosing polymyalgia rheumatica and giant cell arteritis, but they gave no real answers to the problem. They stressed that these syndromes may present non-specifically with systemic illness, elevated alkaline phosphatase, anaemia, raised immunoglobin level or even occasionally as depression. Surely the key to correct diagnosis must be a high index of suspicion of these diseases in those patients with limb girdle pain and morning stiffness without joint swelling. Those with giant cell arteritis will have cranial artery tenderness, headaches or visual disturbances. Because the diagnosis of these conditions is difficult, it is impossible to give a true incidence of them in the population; however, Ostberg (1973) suggested, on histological evidence, that at least one in 50 of elderly subjects might be affected by some form of the temporal