LETTERS

Healthier Children—Thinking Prevention

Sir,
I am currently researching the topic of children and alcohol and was delighted to read of the 'Healthier Children—Thinking Prevention' report, but disappointed to find that alcohol had been virtually ignored. The attitudes being developed now will influence the adult problems in the next decade. One redeeming feature of the prevention report was the introduction of the Brimblecombe Cycle, and if I may be allowed to adapt it to alcohol and children it should look like this.

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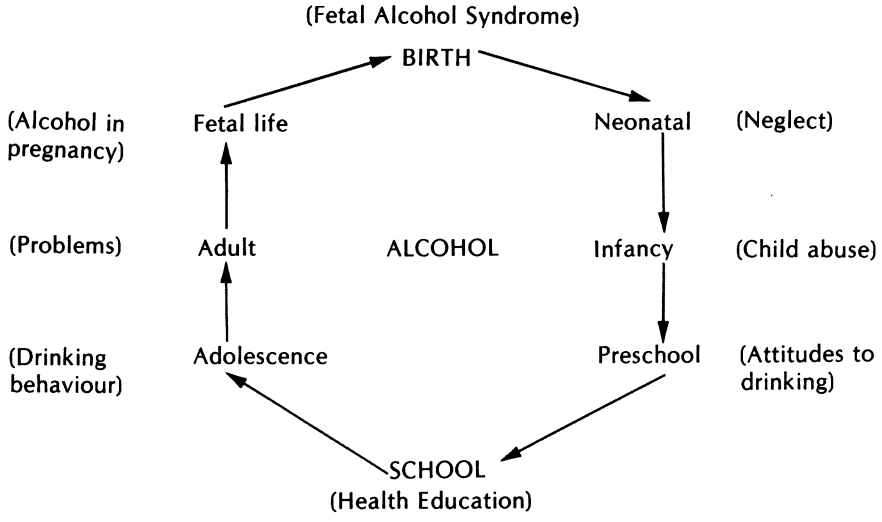

Sir,
I have been immensely impressed by the volume of work done on the above report in gathering the facts, analysing the same, and presenting them so well. I would like to congratulate the convenors and the working party for it. Nonetheless, I feel that in spite of minute details in most fields, the most important factor of prevention of disease, health education, has been very poorly dealt with and mentioned only briefly. A child is most receptive in the early years of education, and identifying to him the health-spoiling factors would save the considerable proportion of 7.9 per cent of boys and 2.6 per cent of girls under the age of ten from the hazards of smoking, and a large number of tender teens from abortion—a procedure with considerable sequelae, however efficiently procured. The WHO itemizes 'Health Education' as the main task of primary health care, which emphasizes the supreme importance of it.

I dare say that health is nature's gift to everyone, and learning a few lessons on how to preserve it is within one's own will and power. Dis-ease manifests itself only when a person does something physiologically foolish which nature is hard pressed to correct. Imparting 'physicracy' (to rhyme with literacy and numeracy) through a health oriented programme of education is the only hope of assuring that an individual is forewarned not to act foolishly.

Just as a person can preserve and advance his personal wealth aided by literacy and numeracy, similarly he should be able to preserve and improve his health through physicracy, and a doctor's role in achieving that should be as small as that of a lawyer or accountant. I assert that along with alphabet and numbers, the factors of health should be compulsorily taught from the first primary school, and proficiency in them should be as essential as that in languages and mathematics for achieving success at school certificate level.

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Medicalization and Primary Care

Sir,
Ivan Illich (August *Journal*, p. 463) is a great stimulus to self-criticism. Examining a few days' work, I found that his hypothesis that general practitioner activities are triage, policing and pastoral care is not generally true. I diagnose and treat problems and diseases that patients request help with because they cannot reasonably acquire the necessary skills themselves. Some of the work is pastoral; helping them to live more comfortably, courageously and constructively, or adaptively and adventurously. Perhaps Illich should attack 'insurancization' and its concomitant 'litiginization', especially when combined with contingent fees. These are much more potent destroyers of dignified human living.

Possibly he regrets the passing of 'religionization', where the individual needs help with the problems of daily living from an institutional religion. This was characteristic of mediaeval times. Perhaps he should recognise that people are interdependent rather than independent.

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Blood Pressure Screening by Casualty Departments

Sir,
I read with extreme interest your article "Why not blood pressure screening by casualty departments?" (July *Journal*, p. 442). I do wonder what size accident and emergency (not casualty) department the author was working in and what the staffing ratios were. It is my impression, after having done a considerable amount of general practice, that the general practitioner is far more suited to screen the practice population and can do this more efficiently than any accident and emergency department. Dr McCandless, I think, forgets the problem of communication between accident and emergency departments and the general practitioner. I would consider that some 40 per cent of the short letters we give to patients never reach the general practitioner, which renders of course the whole exercise futile if one is screening for hypertension. I would also take up his point regarding the fact that many patients have an elevated blood pressure. Many of the patients attending accident and emergency departments are of course under

considerable stress and highly anxious, and I would think that a large number of them when they have their blood pressure rechecked will present with a much lower reading.

I would consider that by far the best place to screen for blood pressure, if it is necessary, would be in the general practitioner's surgery using a practice nurse working efficiently in an environment where the patients are at rest, especially if they are regular attenders. I would certainly be very opposed to screening procedures taking place in any accident and emergency department. I think we probably do enough of the community work already.

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Amniocentesis for Down's Syndrome

Sir,
Thoughtful readers of the report on Down's syndrome in Scotland (July *Journal*, p. 410) must surely have found themselves grappling with the ethical dilemmas involved.

Two ethical issues were raised. First the health care economist's view. "Offering amniocentesis to women over 35 is based on cost-benefit analysis studies". Limited funds must be used wisely, but the economic factor cannot be the over-riding one for the general practitioner dealing with an individual patient. It has recently been reported that female fetuses are being aborted abroad. The cost-effectiveness is to parents rather than health care planners but as an illustration of where the "cost-effective" argument can lead, it serves as a warning.

The second issue raised was the effect on the family of having a Down's person added to it. The implication is that the study in Scotland may reveal that the challenge to a family of rearing a Down's person, whilst making great demands on time, energy and love, may even be "to the great enrichment of society". This may turn out to be true and many of us could think of such a Down's family.

But surely the fate of a Down's fetus should be decided neither by economics, nor by the statistical risk to family survival, but on an individual basis. Each couple must be helped to consider every aspect: the risks of amniocentesis for a possibly normal fetus, their own personal resources, their wider family's ability to help and their own beliefs about the extent to which a fetus is a human life.

As in all abortion counselling the general practitioner must help an anxious and possibly torn patient to think through all the issues before making a decision. Whatever they decide, we want them to be able to look back and feel that they took the best course of action for them at that time.

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Measles Vaccine

Sir,
In this practice we have been impressed in the same way as Dr Robinson (September *Journal*, p. 578) by the current outbreak of measles, many of the cases occurring in immunized children. We are a practice of eight doctors with a list size of 19,387 patients. In June we kept a record of the number of cases occurring in immunized and non-immunized children. Their age was mainly five to six years. In that period 15 who had not been immunized and 18 who had been immunized developed measles. It is difficult to advise patients in emphatic terms to have their children immunized when the success rate of immunization seems so patchy.

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Mental Health Foundation

Sir,
I would like to make a small correction to your article about the Mental Health Foundation (July *Journal*, p. 448).

During the past few years the Mental Health Foundation has sponsored a number of research projects carried out by individual general practitioners as well as community-based projects designed to support the work of general practitioners. Our practice is located in inner London with a list size of approximately 7,000, and we have been recording consultation data for computer analysis since 1971. A grant from the Mental Health Foundation has enabled us to look in some detail at those patients who consult their general practitioner for psychological problems, and to study the outcome of referrals for psychiatric treatment.

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Sir,
I note your concern (July *Journal*, p. 448) about the lack of representation from general practice on the committees of the Mental Health Foundation. It may be a small consolation to you that I am a member of the Executive Committee of the Mental Health Foundation, Scotland. I would like to add that the Mental Health Foundation provided much needed support to me as a general practitioner in the early days of my research into Down's syndrome, so I do not think this oversight in representation should be interpreted as lack of concern.

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Annual Report

Sir,
I bisected the Annual Report through the spine at pages 192 to 193 and discarded the back half. Even so it is still too cumbersome to have in the pocket for the AGM itself—shame. The College has accepted a free gift which it will rue, because it will cost more than appears at first sight. Any organisation that cannot afford £2 per member per year for an Annual Report and Annual Statement of Accounts is hardly saying much about its own worth.

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Jackpot

Sir,
You note (September *Journal*, p. 580) that "no such memorable euphony" as WHO or UNICEF has befallen the JCPTGP. For a profession that has coined 'Itchpick' for the index properly called ICHPPC and 'Asskebab' (a nicely judged culinary touch, that) for the Armed Services General Practice Training Approval Board, this degree of pessimism is challenging.

May I suggest that ex-trainees (and others) joyfully receiving their Certificates from the JCPT refer to them as 'their Jackpot'. Surely this would succinctly indicate the value of this piece of paper, and at the same time give lasting tribute to the labours of our former Dean of Studies. Maybe 'Jackspot' would be even better?

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