Patients' Views of General Practice

Sir,
We were surprised and dismayed to see our study, *General Practice Revisited,* quoted in your editorial (January *Journal,* p.5) as supporting the view that "patients and doctors agree in defining the 'good' patient as one who is deferential and does not question the doctor's decision". We are at a loss to understand which of our findings you interpret in this way. In fact, compared with an earlier study (Cartwright, 1967) we found higher expectations among patients and a greater willingness to express criticisms of a service which the great majority value highly. In our 1977 study both patients and doctors thought that patients were more likely to question whether the doctor was right than they had been ten years before, and both groups thought that patients were more knowledgeable. We commented "in our view the change is an encouraging one: to more knowledgeable and less passive patients".

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Reference

Cartwright, A. (1967). *Patients and their Doctors.* London: Routledge and Kegan Paul.

Faculty Size

Sir,
In a recent farewell message the retiring Chairman of Council, Dr A. G. Donald, said "The strength of the College is reflected in the strength of the faculties. If the faculties are to flourish, they need drive and imagination, with support from the centre to integrate them effectively".

This is a sentiment with which we would all agree. But how can such sentiments be realized when faculties are so large? I am a member of the Trent Faculty, which is one of the largest in the country. In the two years that I have been a member I have not received a single communication from the faculty: the newsletter is circulated only in Lincolnshire.

The College makes a financial contribution to each faculty according to the size of its membership. I feel that the Trent members at the periphery are not getting a fair deal. It is time that serious consideration was given to the idea of dividing the Trent Faculty into smaller and geographically more sensible areas. Members with similar thoughts are requested to write to the secretary of the Trent Faculty or to make known their views through the pages of this *Journal.*

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'At Risk'

Sir,
Could someone please tell me what this expression really means? Ten years ago this term was frequently seen in medical journals, but it appears that its use has been more or less abandoned. Formerly it was not unusual to read that so and so many patients 'at risk' developed carcinoma of the prostate. Sometimes one was left with the impression that the incidence was calculated from the actual number per year/number of persons on the list. Sometimes it was apparent that women and children had been excluded, which is fair enough. Anyway, I feel that I may not be up to date concerning the exact implications of 'at risk'. Principally I want to have my own curiosity satisfied, but it might be worthwhile to offer the readers of the *Journal* a few lines on the matter.

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We showed Dr Frølund's letter to Dr Clifford Kay, chairman of the Research Division Executive, who replies as follows:—

I think there are, at present, two meanings of the phrase 'at risk'.

1. A register of patients, usually children, who are considered to be at greater risk than normal and who require close surveillance. Children who have had a difficult birth come into this category, and those who have developed symptoms which might be the precursor of more serious illness. Subjects with borderline hypertension would come into this class. This use of the phrase essentially embodies an approach to preventive medicine.
2. The use of the term in epidemiology and statistics. In this case the meaning is confined to those subjects who are liable to develop a particular condition. Using Dr Frølund's example, the incidence of carcinoma of the prostate might be related to the total population of a practice, an area or a country. It would be much more appropriately related, however, to men of the particular age range in which carcinoma of the prostate can occur. In both cases, however, the denominator can be considered the population 'at risk', and it is the responsibility of the author or the investigator to define precisely what he means by that 'at risk' population.

Why Not Sports Medicine in General Practice?

Sir,
I must reply to Domhnall C. MacAuley's paper (November *Journal,* p. 700). Accurate diagnosis is essential for the correct treatment and management of all injuries including sports injuries. This is why accident departments have been established throughout the UK. These departments are fully equipped and staffed day and night to deal especially with all forms of injury. It would be an error of judgement for any general practitioner to treat blindly any but the most minor injury. There is a high morbidity amongst those who have been treated in the fashion suggested by Dr MacCauley.

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Anglo-German Contrasts

Sir,
I read with some shame the student project on Anglo-German contrasts in general practice by Wieland Kiess (December *Journal,* p. 771). It illustrated very clearly the lack of knowledge on both sides but more especially our ignorance of German practice.

The Anglo-German Medical Society was formed in 1959 (and the Deutsch-Englische Arztevereinigung in Germany) with the express intention of promoting contact between members of the profession in the two countries. The annual conference in September alternates between Germany and the UK, and is very popular with those who know of it. In 1983 the meeting will be in Plymouth, and in 1984 in Celle in Northern Germany. May I invite anyone interested who has even the minimum knowledge of the language to contact me or the Honorary Secretary, Dr S. L. Geoghegan at 'Fairways', Broseley Avenue, Culcheth, Warrington.

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