

LETTERS

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Job-loss and family morbidity

Sir,
Beale and Nethercott (November *Journal*, pp. 510-514) should be congratulated for taking the opportunity of using a natural experiment to investigate the effects of job-loss on health. From the results of their study they conclude that job-loss has a negative effect on health, based on an increase in consultation rates, episodes of illness and hospital referrals in the families of recently redundant factory workers. However, we remain unconvinced that these conclusions can be drawn from their study for the following reasons:

1. Their method of choosing the study group may have biased the survey in favour of their conclusion by excluding fitter and younger employees and their families. Of the original work force of 800, only 129 were selected for investigation, although all became redundant during the study period. Unfortunately, the authors do not give information regarding the 84% of workers who were excluded from the study, but it seems likely that their selection criteria (by excluding migrants) produced an unrepresentative sample of redundant workers for investigation.

2. The method of selecting the control group is not made clear. Were the control and subject groups comparable? From information given of births and deaths within the study period, it appears that the study group may be older than the control group. Furthermore, there was a significant difference in the number of episodes of illness of female Harris employees and their control counterparts at the beginning of the study.

3. In order for a meaningful comparison to be made between the study group and control group, it is important to know the age and sex distribution of the two groups. Unfortunately, the authors have not provided this information. Data from the

General Household Survey has demonstrated the association between consulting rates and age and sex. For example, in the age group 16-44 years, the consulting rate of women is more than double that of men but in the 45-64 years age group the consulting rate of men has increased twofold to negate the sex differential.¹ These age/sex trends may be sufficient to explain the changes demonstrated in the subject and control groups of Beale and Nethercott.

4. A difficulty in longitudinal studies based on medical records is that the observer may be influenced by his awareness of the subject being in the control or experimental group, resulting in observer bias. In the paper by Beale and Nethercott there is insufficient information to reassure the reader that this possible bias has been minimized. The significant decrease in episodes of reported illness by the control employees in the latter stages of the study period may be due to observer bias causing differential recording rates between the groups.

Although the authors have shown an increase in consulting rates and episodes of illness over time in a group of families in which one member was made redundant, the conclusions they draw are not valid as they have not controlled for the changes in consulting patterns that occur with age and sex, and have not demonstrated that the study and control groups are comparable. This study highlights the difficulties of demonstrating a causal relationship when so many confounding variables are present and illustrates why the adverse effects of unemployment on health remain uncertain.

P. LITTLEJOHNS
E.S. WILLIAMS

Department of Community Medicine
Merton and Sutton Health Authority
6 Homeland Drive
Sutton
Surrey SM2 5LY

Reference

1. Wells NEJ, Chew RBS. *Compendium of health statistics*. 5th edition. London: Office of Health Economics, 1984.

Sir,

We are sorry that Drs Littlejohns and Williams remain unconvinced that our conclusions were valid.

1. Their first point is answered by a more careful reading of the text, in particular the Introduction to the paper. In fact 302 workers were made redundant at the time of final closure. About a quarter lived in other neighbouring towns and a fifth of the remainder were not registered with our practice. Of the residue, 133 workers fulfilled the criteria given in the Method — criteria adopted to select a population for its stability. The latter characteristic is essential for a longitudinal study linking health record and employment status over many years. In any event we do not feel that our study population (mean length of service at the factory 14.7 years) is unrepresentative of the thousands of workers currently losing their jobs every week, many of whom will have spent many years in stable employment in previously buoyant industries.

2. The procedure for selecting the controls is given in the Method section.

3. Restrictions on space prevented the publication of more population characteristics of the study and control cohorts. Their mean ages were in fact (as at 1 July 1982): Harris employees 42.6 years; control employees 41.5; Harris male employees 44.0; Harris female employees 40.7; control male employees 40.2; and control female employees 46.0. The significant difference in reported episodes of illness between the Harris female employees and their control counterparts was in fact the only significant difference in all the possible comparisons in years 1-4. This difference may indeed represent the influence of age since the control women are somewhat older. However, the

difference is not found when these two groups are compared in years 5–8, which would cast doubt on age being the underlying reason only (unless we postulate that the Harris women are ageing faster!).

4. This point is also answered in the text of our article (see Observations). The study was initiated a year after the factory closed and the data extracted from our practice records during the period July 1983 until September 1984 and by just one of the four doctors in the practice, thus the possibility of observer bias can apply only to one of the eight study years and then only for a quarter of the patients (those consulting N.R.B.). In other words 31/32 of the data is free of any such bias.

NORMAN BEALE
SUSAN NETHERCOTT

The Health Centre
Calne
Wiltshire SN11 8NQ

Sir,

We are a group of doctors who are meeting as part of the MSD Scottish Leadership Course. As one of our joint tasks we agreed to review the November 1985 issue of the *Journal*.

Using a rating scale to evaluate the articles for interest, relevance, quality and readability a high degree of accord was reached for the article 'Job-loss and family morbidity' by Beale and Nethercott. It was agreed that the study was of high quality, of interest to us, and relevant to general practice. In addition it seemed from reading the editorial 'Job-loss and the use of medical services' that there is a paucity of relevant information regarding unemployment and health.

If this is really the case then it would seem that general practitioners are the ideal group to establish the facts and we would be interested to know if others think likewise? This does seem an important issue and a widespread problem, and raises the question of whether this is an area of work to which the Council of the College should be addressing itself.

CINDY BROOK
COLIN BROWN
DOUGLAS BURT
DAVID JOLLIFFE
KEN MACK
AISTAIR SHORT
IAN SMITH
MIKE TAYLOR

MSD Scottish Leadership Course
c/o The Surgery
Dickson Street
West Calder

Personal lists

Sir,

Dr Tant's editorial (November *Journal*, pp.507-508) contains many untested assertions that would be open to complete rebuttal. In addition the conclusions he draws from his own unfounded premises are suspect.

In his first paragraph he implies that if partners are committed to dealing with all the work that is generated from their own personal lists then the distribution will be equal. How is this achieved? Even if the list numbers are kept more or less level, it is likely that individual doctors will attract patients of a particular kind that may involve more or less time. For example, one partner may be more interested and skilled in obstetrics and find that he has the largest share of maternity work in the practice. It is not uncommon for the oldest partner to have the greatest proportion of elderly patients in the practice who require more medical attention and home visiting. In some practices one partner may have more experience and interest in psychiatry and he is likely to collect patients who take longer to treat than those with obviously organic conditions.

Dr Tant says that the system he supports can only work if none of the partners is away from the practice for more than one session a week in addition to his half day. At whose expense can this be achieved? Certainly there is no obligation on us to do clinical assistantships or industrial medicine, but who is to serve on the NHS committees or run the postgraduate education programmes?

Two or three years ago those attending a trainee seminar were asked to bring three records from their practices. Some came from practices with separate lists and others from those with combined lists. On looking at the last 10 consultations in the records, on average only seven consultations had been with one doctor no matter what kind of practice the patient attended.

The concept of separate lists appears to exist chiefly in the mind of the doctor but is important, for if the patient believes himself to be a patient of a particular doctor but nevertheless is obliged to see another doctor for three out of 10 consultations he will be more put out and critical than if he knew that the practice ran a combined list. Indeed, I wonder whether it is the doctor who needs to feel that he has his own patient rather than the patient who wishes to have his own doctor.

SAMUEL PRIESTMAN

Fairfield Park Health Centre
Tynning Lane
Camden Road
Bath BA1 6EA

Sir,

Dr Tant's editorial on personal lists provides a summary of many of the main advantages of this system and we feel that it has great relevance to quality of care in general practice. However, in examining one of the most fundamental principles of practice management we do think it is important to review the issue critically and to examine carefully the disadvantages of this system as well. Historically the debate was opened by Forman¹ in 1971 and Marsh and Kaim-Caudle² contributed considerably in the mid-1970s, as did Aylett³ in 1976.

This subject was reviewed in detail in 1979⁴ in the North of England Faculty lecture 'The key to personal care' and the term personal lists was introduced to emphasize the importance of the personal relationship between a patient and a doctor compared with the previous term 'separate lists'. Analyses from our practice in the same article showed changes associated with the adoption of a personal list system in 1973.

We are enthusiasts for this system and we do believe that it offers the potential for better patient care. However, we take seriously some of the difficulties, including for example the problem of patients wishing to consult a particular partner who undertakes developmental child care or women patients wishing to see a woman doctor for gynaecological conditions. Freeman⁵ reviewed this subject recently.

It is not yet scientifically certain that 'patients undoubtedly prefer having a personal doctor'. We believe that they do, but proper academic evidence on a controlled basis is not yet available. Nor is it true that 'the system breaks down if a partner is involved in other medical activities and spends several sessions away from the practice'. All three of us take more time out from the practice than one half day a week but still find the personal list system satisfactory. It does mean, however, that adjustments have to be made in such practices, for example to the list sizes.

We would be glad to hear from other practices which have changed their policy towards personal lists and to learn of the opinions of the partners and staff after this change has taken place.

DENIS PEREIRA GRAY
ANN BUXTON
RUSSELL STEELE

34 Denmark Road
Exeter EX1 1SF

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