administration. Inoculations and screening checks are necessary and helpful but the personal approach of the family doctor, with proper records, training and the confidence to help the patient to increase his resistance to disease, must be achieved.

Clapham, via Lancaster. J. A. FARRER.

Medicine today

Sir,

I hope you will forgive a covering letter to the circular concerning the Royal College of General Practitioners *Journal.*

I am most concerned at the general trends in medicine which appear to be away from the concept of the service of one individual to another. The idea that 'doctoring' can be based on statistics, mass observation and hair-brained political philosophy, all negate the time-honoured principles of medical service. On top of this the high pressure 'ethical' (*sic*) pharmaceutical advertising procedures on totally untried therapeutic systems on an over-stressed profession.

These concepts are the enemies of our profession and the press makes matters worse (Blaiberg and all that). Surely the *Journal* should have an antidote effect on the medical world—it should make a stand for wisdom, common sense, humanity and political freedom. It should avoid jargon, pseudo-science and clap-trap, political or medical. In fact it should aim to be a stabilizing influence in this troubled revolutionary world.

Sleaford. T. SMALLHORN.

Cambridge Spring Meeting

Sir,

Many application forms to attend this meeting have been received. Unhappily not a few are without the names and addresses of the senders.

May I please urge any applicant who has *not* received an acknowledgement to write to me immediately, detailing the session or hotel bookings which he had requested?

A. S. PLAYFAIR,
Honorary secretary,
East Anglia Faculty.

20 Long Road,
Cambridge. CB2 2PS.

Question and answer

Sir,

The following exchange of letters took place between a general practitioner and the Professor of Haematology at Cambridge University.

Dear Professor Hayhoe,

I wonder if you can help me in a dilemma. Like many other general practitioners I find myself increasingly involved in the supply of contraceptive pills to my patients. My only scruple about this is the thromboembolic risk. Every now and again a coroner attributes a woman's death to the taking of ' the pill '. Could this, I ask myself, happen to one of my patients?

It seems to me that there are three major risks of the occurrence of fatal pulmonary embolism—postoperative, obstetric and 'the pill'. In the first of these the circumstances are grossly abnormal (pre-operative disease of some sort, anaesthesia, surgical intervention, postoperative inactivity). In the second, I am unable to imagine such a fatality occurring in any normal physiological childbirth in an entirely healthy woman. In the third, does the coroner's verdict reveal all the facts? Can a normally healthy woman lose her life simply through the agency of the contraceptive pill?

Are there, perhaps, two possibilities here? May not the circumstances in all three types of cases be similar, namely, the presence of abnormality in the woman? This is obviously the case in the surgical fatality. I think it probably is the case in the obstetric fatality. I feel this must be the case also in 'the pill' fatality. Were this factually established I should have my answer. The contraceptive pill ought not to be given without very careful thought to a woman about whose state of health there is doubt. Data gathered from known fatalities might provide clues to the sort of predisposing pathology which would suggest complete contraindication to the use of the contraceptive pill.

But there is a second possibility, the one in which I am especially seeking your guidance. Having regard to the complicated chain of physiological factors involved in the process of blood-clotting, is it possible that one or more of the links in this chain may be weak or missing or behaving abnormally in all the three classes of fatal thromboembolism I have mentioned? If this were so, and were it possible to detect the presence of such an abnormality in the clotting mechanism before starting to take 'the pill', or its development whilst taking it, this would remove the fear that must be in the minds of so many of us who find ourselves with this responsibility. By suitable blood tests it might then be possible to discover the woman in whom the use of the contraceptive pill would be a bad risk.

This would be the answer to the general practi-

tioner's dilemma.

If all this has already been considered I must ask your forgiveness for this trespass upon your time.

Yours sincerely,

G. L. McCULLOCH, F.R.C.G.P.

Dear Dr McCulloch,

I was interested to read your thoughtful letter concerning the thromboembolic risk associated with oral contraception. You may well be right in believing that the small minority of people who actually have thrombotic trouble do so because of an underlying weakness in thrombogenic and thrombolytic mechanisms, but if so the weakness is not yet detectable by any of the methods of investigations widely employed to date to assess thrombotic risk. As far as oral contraception is concerned there is recent evidence from an M. R. C. survey that the risk is about 8 to 10 times greater in those taking the pill than in otherwise comparable women in the same age groups. Nevertheless, mortality from pulmonary embolus and cerebral thrombosis is still only of the order of 1–3 per 100,000 users and you can imagine the very wide screening programme which would have to be undertaken to select those most at risk even if a laboratory abnormality had been recognized. I think most laboratories would baulk at the prospect of doing 99,997 negative tests to pick up three abnormal ones.

One possible answer to the scruples you may have is that all the extensive surveys carried out in different countries appear to agree that the risk of thrombosis is greater in pregnancy than it is while on oral contraceptives.

Yours sincerely,

F. G. J. HAYHOE, M.D.

From this correspondence I derived considerable relief to my conscience and fears, especially when I was able to calculate that it would require something like 600 practices the size of mine with an equivalent incidence of oral contraception to produce a single case of fatal risk.

March. G. L. McCULLOCH.

Practice recording and computer terminal information system

Sir,

The article on the *Practice recording and computer terminal information system*, was very interesting, but raised several issues.

The requirements of the ideal general-practitioner records' system, surely leaves a sixth item unmentioned, namely that the cost (capital and running) of the system should be reasonable.

The fourth requirement "It should yield recoverable information for epidemiological and research purposes", is really a requirement of an ideal research set-up, as opposed to an ideal general-practitioner record system. It appears to me that the advantages of a computer, as used by Dr Clark, Mr Dickson and Dr Rickards, are marginal other than for research purposes, and in many instances, the requirements could be met equally well by other much less costly means. For example, the heading of the patient's name and address onto the prescription could easily be achieved by using an addressograph system, or the cheaper Carter-Parratt Visi Recorder. The same technique can also be applied to repeat prescription cards. I feel that computers will play a large part in medical practice in the future but there is a danger that too much talk about them at this stage, may cloud other more essential changes, relevant at the present moment. For example, I note that Dr Clarke and Dr Rickards still retain the anachronistic evening surgery. Also the table giving a sample daily listing of patients suggests that they are over visiting, for example, an 18-year-old girl with tonsillitis who required no treatment. Further it could well be argued that it is a further waste of medical time for a doctor to write note details in long hand when dictation is three times faster.

Glasgow. K. A. HARDEN.

Hypertension—a study in general practice

Sir,

I wish to thank Dr Philip Hopkins for his observations on my recent article. I am delighted to find that he is so interested in this fascinating condition.

I would not disagree that personality and environment have their effect on the level of a person's blood pressure, but I feel that the aetiology is much more complicated than that. My own feeling is that the aetiology is based on many factors, which is at the present moment still open to controversy and argument. Perhaps I might have the opportunity of enlarging on this at a later date.

I agree with Dr Hopkins that it is probably wrong to describe hypertension as a disease. It is only a measurable physical sign of an underlying disorder, as indeed is the rash of measles or the swollen and painful joints of acute rheumatic fever.

Falkirk. R. G. SINCLAIR.