institutional bias of the meeting was so evident. There are no external distinguishing features by which the observers can recognize a computer-minded practitioner though certain characteristics did appear to be shared amongst the whole audience. Youth was one. More than one observer estimated the average age as being in the mid-thirties, balding crowns and greying temples occurring rather among the chairmen of sessions. A further feature was clear evidence of an intense, almost obsessional absorption in their subject. This is all to the good provided that in future the effort and energies of these enthusiasts can be directed towards problems of wider significance. There are known to be a number of practitioners who are working on the reduction of the amorphous flow of data from their practices and reducing it to computer compatible terms. Perhaps, when the next conference in this series is held in a few years' time, we may hear of their work among commonplace rather than esoteric problems. These former are equally deserving of the attention of good medical software.

Correspondence

Education Foundation Board

From Professor Lord Rosenheim.

Sir,

As chairman of the Education Foundation Board of the College, I have been asked by the members of the Board to submit to you a report on its activities. As most of your readers will know, the Board was founded in November 1966 with the aims of providing financial and other assistance for educational projects, whether by research or by study of existing schemes, which were unlikely to be funded from other sources. The Board is deeply aware of its responsibility to promote studies not only of professional training in general practice, but also of the continued education of established practitioners. It has taken special interest in the problems of training those responsible for the training of future general practitioners.

There have been recent changes in the composition of the Board. At its last meeting on Friday, 13 November 1970, the Board with regret accepted the resignations of Dame Annis Gillie, the Lord Platt and Mr Brian Young, but I am glad to say that an invitation to serve on the Board has been accepted by Professor A. S. Duncan, executive dean of the Medical School in Edinburgh, Dr J. O. F. Davies, Secretary of the Central Council for Postgraduate Medical Education and Training in England and Wales, Dr David Morrell and Dr Donald Irvine.

Among the projects recently supported has been the visit of the Secretary of the Board of Censors (Professor J. D. E. Knox) to study the examination methods of the Canadian College of General Practitioners. It has also supported the conference of secretaries of the education committees of the faculties held in Birmingham last July, and a survey by Dr D. H. Irvine of practices in England, Wales and Northern Ireland that had been identified as suitable to accept vocational trainees. Reports on these and other projects will be published in due course.

The Board controls certain specific trust funds such as that which provides the undergraduate essay prizes, funds the annual Pickles lecture and has recently accepted responsibility for the annual selection of Upjohn Travelling Fellows.

The amount of money available annually is limited, but the Board is anxious to receive applications for the support of projects that have a direct bearing on the education of general practitioners. It continues to look forward to the time when, with more funds at its disposal, it can embark upon more permanent and more ambitious schemes.

University College Hospital Medical School. ROSENHEIM.

Rising sickness absence

Sir,

I read Dr Semmence's article 'Rising sickness absence in Great Britain—A general practitioner's view' with great interest. Perhaps I might comment on it from my experience as a regional medical officer and a general practitioner in Scotland.

There can be little room for speculation about the sickness absence of sufferers from the large groups of organic diseases which can be diagnosed with fair certainty, such as chronic bronchitis and emphysema, rheumatoid arthritis, etc., and which cause such human misery and economic loss.

My impression is that many patients suffering from anxiety states/low threshold for stress, masquerade in our statistical columns under various organic diagnostic labels which are determined mainly by their presenting symptoms, because

objective confirmatory tests are not available. Such cases substantially affect comparison of sickness rates related to diseases, and comparison between reports by different authors.

In sickness absence which is difficult to comprehend in terms of organic or overt psychiatric disability, my impression is that there is frequently overcommitment of the individual's time and energy. Married women are particularly vulnerable in this respect; they may have domestic responsibilities constituting a full day's work and yet (often in response to great economic pressure) contract to do a second job outside their homes. This job may be part or full time; if the patient goes sick after discovering that she cannot do two full time jobs in one day, is the diagnosis 'anxiety state' or 'battle exhaustion'? If she leaves work because of an accident and finds that her Injury Benefit is as much as the wages for her part time job, and that she has time to cope comfortably at home, her convalescence may well be prolonged.

At the risk of apparent self interest may I suggest that Dr Semmence's statement in the third and fourth sentences of fifth paragraph on page 134 ("Although studies have shown unnecessary use of medical services, descriptions of unnecessary sickness absence are largely anecdotal and its extent unknown. The close correlation between social class and occupation and mortality and sickness absence statistics suggests that it may be small."), seem to me at variance with the figures he gives on page 140 under the heading 'Supervision of sickness absence' (which show that 42 per cent of 536,000 cases ceased to claim Sickness Benefit following referral to a medical referee) and may invalidate the third paragraph on page 141 where he doubts the need for the control doctor!

Of course before an estimate of the effect of the medical referee system can be made we need to know the rate at which a comparable group of 536,000 patients 'sign off' in absence of a request to attend for RMO examination.

SCOTTISH RMO.

A College exhibition display

Sir,

The Yorkshire Faculty now possesses a display suitable for exhibitions consisting of three panels. These deal with the founding and early history of the College and include a very interesting collection of photographs of well-known pioneers. The exhibit is readily transported in its purpose-built container and, though heavy enough to need two men to lift it, will fit into the back of a medium sized car. (The size with packing case is length 41¾ ins. x 30 ins height.)

The Faculty displays this exhibit on various occasions and will be pleased to arrange to loan it to other faculties when required. For this a charge to cover expenses would be made. Any who are interested are asked to correspond with: **Dr D. H. Judson, 39 Low Ash Road, Wrose, Shipley, Yorkshire.**

Harrogate. G. W. C. JOHNSON

The college journal

Sir,

Owing to the postal strike the January, February and March issues of the *Journal* came together. I must confess I find little of clinical interest in our *Journal* these days. Only one article and that came from Rotterdam (March issue) was found to be of any interest. Statistical papers seem to overload each issue.

It is felt that more emphasis should be placed on some clinical subjects from family doctors in active practice.

I wonder if other doctors feel the same as I do.

Wallasey. M. Macleod.

Fluphenazine

Sir,

At the present time there are two long-acting injectable phenothiazines (L.A.P.) available in the United Kingdom, Moditen Enanthate (fluphenazine enanthate) and Modecate (fluphenazine decanoate). Both these preparations are metabolised in the body to free fluphenazine or fluphenazine hydrochloride. The pharmacological action is, therefore, identical to *oral* fluphenazine, a drug which has been in use for some years. It is essential to appreciate that there is no evidence that the specific action of fluphenazine differs from other phenothiazines. The potential benefits of long-acting phenothiazines come from their duration of action, the mode of administration, and the associated administrative regime of management.

The side-effects of fluphenazine are shared equally by all other phenothiazines, although the sedative effects may vary. It is true that once injected the drug remains active for several weeks, but this need not increase the risks to the patient provided that care has been taken to stabilize the patient on oral medication *before* transfer to the long-acting injectable form. All the side-effects listed in Dr West's letter (December, 1970) are known to occur with oral phenothiazines. It is well recognized that only 50 per cent of outpatients take their medication regularly and it is likely that any recorded increase may simply be a reflection of the higher percentage of patients receiving regular medication or the increased frequency that patients are seen. A possible additional hazard is a peak rise in the serum level of the long-acting phenothiazines between the second and sixth day after the injection. In our experience (Johnson and Freeman) there is quite likely to be a cluster of Parkinsonian side-effects during this period. A smaller dosage given more frequently overcomes this problem.

Depressive mood swings in patients on long-acting phenothiazines may be aetiologically associated with the drug, as it may with any phenothiazine (Johnson 1969, Dally 1970), but affective changes occur frequently during the