

patients at risk from non operation are re-admission for operation and death. A prospective study on its own, is unlikely to evaluate the first risk within a realistic number of years, in particular if the group of patients being studied remains as small as that at present apparently available to the East of Scotland workers (36 patients). Assessment of the risk of death—which is crucial to any study of this type—is clearly beyond the scope of the study as described. Close study of the references quoted in this paper will show the contribution of retrospective study to any attempt to tackle this problem.

There is, I believe, a more profitable area for future general practice study. The records of 650 patients dying of appendicitis and appendicectomy in Scotland between 1954 and 1963 showed a past history of previous possible appendicitis in 71 patients (11 per cent). In 24 of the 71, previous hospital admissions without operation had taken place and this represents the part of the problem being looked at using the present objective of the East of Scotland study. Of the remaining 47 patients dying with a past history of previous possible appendicitis, 14 had been seen at hospital but not admitted for observation, four had not sought medical advice, but 29 had been attended by their general practitioners without referral for second opinion. This suggests that general practice management may contribute as much to mortality from appendicitis as does hospital management.

May I suggest that a study of the reasons for referral and non-referral to hospital of patients with undiagnosed abdominal pain, and correlation of these with the subsequent progress of these patients would be the most useful contribution that general practice research can at present make to improving the management of doubtful appendicitis?

J. G. R. HOWIE

Department of General
Practice,
University Medical Buildings,
Foresterhill,
Aberdeen, AB9 2ZD.

REFERENCE

Journal of the Royal College of General Practitioners (1972), **22**, 33–38.

Appointing a partner

Sir,

Dr Graham's interesting article on *Appointing a partner* drew attention, as in your leading editorial (*February Journal*), to the deficit of published references to such an important issue.

In his lucid description Dr Graham emphasises the facts as they arose in his decision making, drawing attention to the legal aspects of partnership and the lack of career guidance in general practice, which the College is seeking to alter by vocational training.

In general practice we are infrequently called upon to make such appointments, and are neither

trained nor skilled in the task. This applies also to ancillary staff. Even hospital appointment boards appear lacking in the knowledge of selection interviewing. Apart from the legal aspect, general practice is unique only in the greater significance and infrequency of the task.

If we are prepared to be outward looking, much of this skill can be gained from the schools of management in the art of selection interviewing.

Most practitioners appear to go through a stressful period of soul searching in selecting partners. Is this not really a form of self-counselling on their own role in relationship to their colleagues?

G. H. HILTON.

Ribblesdale House,
Market Place,
Bury,
Lancs, BL9 0BU.

REFERENCES

Graham, B. (1972). *Journal of the Royal College of General Practitioners*, **22**, 73–78.

Journal of the Royal College of General Practitioners (1972). Editorial, **22**, 67–68.

Sir,

I found Dr Graham's article and your editorial (*February Journal*) interesting, particularly when you state that you are unable to find references for the paper. Might I suggest that if you read *Good General Practice* by Dr Stephen Taylor you will find an interesting section on the choice of a partner and its various problems around p. 100.

In our practice we find it of use to have an interview checklist for potential partners, trainees, or locums. This does not claim to be comprehensive but it ensures that we cover the most important areas during discussion and it is useful to check the *curriculum vitae* that will have been submitted by post, in order to get everyone relaxed.

Interview for prospective partner

- 1 Get him talking.
- 2 Age.
- 3 Address.
- 4 When and where qualified, and degree.
- 5 Hospital experience.
- 6 Details of the job and ourselves.
- 7 Last appointment.
- 8 General practitioner experience.
- 9 Testimonials.
- 10 Any special interests.
- 11 Married—children (ages).
- 12 Wife's work.
- 13 Hobbies and outside interests.
- 14 Health.
- 15 Religion.
- 16 We want details in writing—to see if we can read it!
- 17 Any questions?

I do not like this list to be considered as rendering the interview rigid, as any undue rigidity results in the candidate and the partners not really getting to know each other.

I think it might be of use for the College to prepare a small booklet on choosing a partner and would welcome comments on this.

R. LAW

9 Wrotesley Road,
Willesden,
London, NW10

REFERENCES

- Graham, B. (1972). *Journal of the Royal College of General Practitioners*, 22, 73-78.
Journal of the Royal College of General Practitioners (1972). Editorial, 22, 67-68.

Fashions in pharmacy

Sir,

Mr Ronald Levin's letter (February *Journal*) cannot be allowed to pass without comment. He raises problems of great importance both for the medical profession, particularly general practitioners, and for the pharmaceutical industry.

He makes two points in his letter. First, pharmaceutical companies are encountering "often strong resistance" by the profession to their methods of communicating information about the new drugs which they have developed. Secondly, he suggests that this might be circumvented if postgraduate medical centres were to be used as an arena in which data about new drugs could be presented and submitted to "adequate probing by local experts".

Few would disagree with the latter suggestion, provided that the meetings which he envisages did not become a mere substitute of venue for the kind of lunch meetings at local hotels to which general practitioners are nowadays invited so frequently by the pharmaceutical companies.

I was interested by his assertion that there has been increasing resistance by the profession to what he describes as the traditional methods of communicating information about new drugs. I have no means of telling how widespread is this resistance, although I would be both surprised and pleased if it were really as great as he believes.

Mr Levin claims that "pharmaceutical manufacturers are anxious to ensure that prescribers are in full possession of all relevant information, so that they can exercise their professional judgment in deciding whether a new medication has a role in their own armamentarium". At first sight this appears eminently reasonable, and one's reaction is to applaud the industry for its concern about the need to help the profession to keep abreast of advances in therapeutics. However, the true position is very different, as I am sure Mr Levin and his colleagues in the industry will acknowledge.

Any anxiety which pharmaceutical companies feel over difficulties of communication is much less disinterested than his letter suggests. Nowhere in it does he discriminate between the educational and the promotional activities of pharmaceutical companies. I find it hard to believe that he imagines that we really regard visits by "trained medical representatives complete with the provision of comprehensive literature" as having anything other

than a promotional objective. Perhaps this is one explanation why there are signs of the traditional methods of communication between the industry and the profession becoming discredited.

At a meeting last year at the Royal Society of Medicine a senior medical adviser to a famous pharmaceutical firm was astonishingly frank about the training and activities of his firm's representatives. He freely admitted that their role was nothing more or less than that of salesmen and that they were trained to present their firm's product in as favourable a light as possible.

I know personally the medical advisers to a number of different firms. Some of them have deplored the fact that their duties include giving their representatives a biased version of their firm's products, and suggesting how the indications for the use of a given drug can be widened to include a range of conditions tenuously related to that for which the drug was specifically intended. On top of this they have to ensure that representatives are sufficiently well informed about each product that they can easily "baffle the general practitioner with a little bit of science".

I would suggest that the overriding objectives of most pharmaceutical firms are twofold—first, to persuade the general practitioner to prescribe their products in preference to drugs with a similar action made by other companies, and secondly, to persuade general practitioners to prescribe their drugs for as wide a range of conditions as possible.

I should like to make it clear that I am not taking issue with the perfectly respectable desire of any firm to make a profit from its products. Indeed, in our competitive free enterprise society to make as large a profit as possible is every firm's duty to its shareholders. My criticism of some (but by no means all) pharmaceutical firms is first that they have failed to exercise a much greater responsibility over their promotional activities and, secondly, that they do not draw any distinction between the latter and the provision of truthful, objective data about their products.

Mr Levin, while agreeing in principle with the adage quoted in your editorial (September *Journal*) "use few drugs and be familiar with all their properties", considers that if applied too rigidly, it would lead to excessively conservative treatment and, by implication, to patients being deprived of the benefits of treatment. Has he not fallen into the same dangerous position as many representatives—that of having an unbridled enthusiasm for the power of drugs and particularly the newest ones? Many of us do not share that enthusiasm. It is salutary to reflect upon how many conditions are self-limiting or are amenable to well-established forms of treatment. The sin of too conservative prescribing must be much rarer, as well as being less hazardous, than the sin of indiscriminate or excessive prescribing.

Regrettably, despite the gratifying increase in the number of lectures for general practitioners at medical centres and the like, almost all the post-