There then followed a section devoted to the executive council. This indicated the range of printed data supplied by the council with which the doctor was expected to become familiar. The data obviously could not be included but it was suggested that acquiring this information and developing a filing system was time well spent during the trainee year. However, the majority of forms supplied by the executive council were displayed. Many of these are self-explanatory, but additional notes as to their nature and use were supplied where necessary. Particular attention was drawn to medical certificates, prescriptions, maternity forms, registration of new patients, temporary residents and patients' notes. Finally, space was given to data relating to local social services.

Both my trainer and the area general practitioner tutor have felt the project worthwhile and made useful comments. It seems reasonable to bring the idea to the notice of as many trainers and potential trainers as possible. Is there a place for a trainee general practitioner working manual?

ALAN R. DUKE
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Infectious Mononucleosis

Sir,

I was very interested in Dr K. J. Bolden's study of the effects of corticosteroids in the treatment of infectious mononucleosis (February *Journal*).

I note that "all patients had concurrently a 12 day course of phenoxymethyl penicillin—250 mg q.d.s." Dr Bolden does not state if any of his patients developed an allergic rash in the course of this treatment and if so, was this antibiotic stopped?

I recently had a case in a young woman who was originally misdiagnosed as having a β-haemolytic streptococcal throat infection and who was given a course of ampicillin. On the ninth day she developed a severe rash, and this is apparently a likely complication in 50 per cent of cases given ampicillin.

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REFERENCE

Bolden, K. J. (1972). *Journal of the Royal College of General Practitioners*, **22**, 87–95.

General Practitioners and Social Workers

Sir,

As a social worker who both teaches and works with doctors in training in a family medicine programme, I wish to take issue with some statements in the *Journal*. The report entitled *General practitioners and social services departments*, helps to clarify the problems existing between the medical and social work professions. The act of discussing problems of communication aids in the process of communication; hence, the article was most helpful.

I was particularly stirred by some remarks attributed to Dr Paul Freeling, general practitioner from Middlesex, which are refuted below:

(1) Patients *can* relate to more than one healer at a time, if they are taught and gently guided into bringing their problems to a team. Recently one cancer patient in our family health centre was introduced by her doctor to the social worker. A three way discussion about her physical, social and severe emotional problems ensued. Subsequently, she reached out for help alternatively either to the doctor or social worker, or as they were available. This kind of situation is common in our family health centre. We demonstrate to patients that any member of the team is interested and willing to be of help, while some members will have special skills to offer, such as, marital counselling by the social worker, health education by the nurse, and medical management by the physician. Patients learn to utilise all team members as a result of a casual, instructive approach.

(2) We have found great utility in formulating psychosocial-physiological diagnoses and treatment plans by use of inter-disciplinary team conferences. Families' total problems are elicited and discussed in an open, informal manner by physician, social worker, nurse and senior physician. Consensus is reached as to what plans should be undertaken, and which team member shall accomplish which task.

(3) Patients are helped immeasurably by having all resources "behind the same door", contrary to Dr Freeling's belief. Easy accessibility is one of the hallmarks of comprehensive family health care. When the patient's needs are kept foremost, and not the professional's need for self-esteem and status, close co-operation and good patient care are the result of such propinquity.

(4) In listing the resources of social workers, Dr Freeling may have been only facetious or simply uninformed in excluding case-work and counselling skills, knowledge of individual and family dynamics, knowledge of community resources of all kinds, to name only a few.

(5) In our experience, screening for emotional illness in patients and families although not always successful and certainly difficult to measure objectively, does work when patients and families are helped to look at potential trouble areas, and to accept counselling before a crisis has occurred; such as in pre-marital counselling, child management and discipline difficulties, and in many other common family developmental stages.

We advocate many of the issues raised: (a) common areas of training for all health professionals, and opportunities to study and work together so that knowledge of the skills and

areas of expertise of different team members are known to all; equality of team members with leadership of the team rotating or individual team decision; integration of social workers into general and family practices.

It is unlikely that all problems between different professions can be obliterated. Open forums and practical demonstrations appear to be at least partial answers.

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REFERENCE

Journal of the Royal College of General Practitioners (1971). **21**, 101–4.

Women doctors

Sir,

I would strongly support Dr Sapper's letter (February *Journal*). Judging from the advertisement on the inside of the cover (same issue) for the Newcastle training scheme which states " every effort will be made to devise flexible training schemes for women", opportunities are slowly becoming available for women to train as general practitioners.

The College would seem to be in an excellent position to give consideration to the specific needs of women for training and for suitable posts afterwards. Too many highly skilled women are being forced to give up work and become frustrated when they are unable to continue in a job which they find extremely satisfying. In this way many excellent general practitioners are being lost. Can the College give a lead to the rest of the profession?

AHILYA NOONE

39 Wykeham Hill,
Wembley, Middlesex.

Contraceptive advice

Sir,

As the major United Kingdom manufacturers of non-systemic contraceptives, we read with interest the article on advising patients on the risks of oral contraception, (February *Journal*). May we comment on the statistics as presented, from the Peel and Pott's table, with specific reference to the condom.

The chart showed a failure rate of 10·0 for the condom, which in turn converted to 106,000 pregnancies per million users. A point of detail is that this figure should apparently be 100,000.

Meanwhile, the mortality rate due to pregnancy is quoted at 28. Practitioners will be aware of the progress which has been achieved in reducing maternal mortality, and the latest figure from the Registrar General (Return for England and Wales, week ending 21 May 1971), gives a figure of 18 per 100,000, including therapeutic abortions.

Furthermore, the average failure rate for the condom of 10 is based partly on rather ancient American trials—in one instance dating back nearly 30 years—on products not on sale in the United Kingdom, and under unknown trial conditions. The only published United Kingdom trial of condoms to current United Kingdom standards was reported in *The Practitioner* (1969) —after the table was compiled, and provided a failure rate (Pearl formula) of 3·1 per 100 women years.

May we therefore suggest that the chart should read as follows:

Contraceptive method (one million users)	*Failure rate*
Oral contraceptive	1·0
Condom	3·1

Women of all ages Annual deaths through			
Pregnancies	*Pregnancy*	*Method*	*Total*
10,000	2	20	22
31,000	6	—	6

It is of course accepted that, as the oestrogen content of the oral contraceptive is reduced, the risk of method fatality may reduce, although conversely there has been some suggestion that the failure rate may increase.

However, the purpose of this letter is not to indulge in an attack on other methods of contraception, but to point out that the condom, which remains by far the most widely used contraceptive, is also a remarkably safe method.

E. C. CORDEROY

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Chingford, London, E4 8QA.

REFERENCE

Black, S. & Watts, K. (1972). *Journal of the Royal College of General Practitioners*, **22**, 96-99.

The Handedness of Kerrs

Sir,

Following your editorial (December *Journal*) I carried out a survey of all patients in this practice of 11,000 who were named Kerr or Carr. We have 30: not one was left handed.

D. HUTCHISON

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Musselburgh,
Scotland.