chooses to ignore many of the ideas put forward by the Scottish Home and Health Department, and has seen fit to adopt a defensive posture when there is genuine recognition among planners that reorganisation of the Health Service is required.

Within the document *Towards an Integrated Child Health Service* there is no statement implying that the general practitioner's important function as doctor of first and continuing contact be eroded, and we can only suggest that the above report be re-read carefully and the full and rewarding prospects for child health in an integrated health service will become more evident.

D. J. G. BAIN  
W. J. BASSETT  
F. I. STEWART

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Livingston,  
West Lothian,  
Scotland.

REFERENCES


Scottish Home and Health Department (1973).  
*Towards an integrated child health service.*  
Edinburgh: H.M.S.O.

Sir,  

Where were Scotland's family doctors when the Scottish Home and Health Department were collecting evidence for *Towards an Integrated Child Health Service*? Were they aware of the preparation of an influential document spelling out the annihilation of family doctoring—for a household without its children is hardly a "family". I suspect that like me, they were so busy getting on with the job, that they knew little about Scotland's equivalent of England's Court Committee.

Having just heard of the Court Committee, I have been moved to write to it (Room D 1514, Alexander Fleming House, Elephant and Castle, London, SE1).

I should be most interested to know what the Royal College of General Practitioners is doing, apart from writing editorials, to influence Professor Court's committee.

D. H. WHITE

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DEPUTISING SERVICES

Sir,  

I must take issue with your editorial on *General Medical Services* in the January Journal.

In this leader you state "there is no doubt that a partner or a member of a small rota group provides the most desirable cover for off-duty time".

If you consider the five-man rota as the most popular small rota, you are left with a situation where a principal will work a full normal week during the day-time hours of ten sessions, and of the order of 40 hours, and in addition to this you will have on average 20 hours on call, during which he will have two attendances.

These 20 hours creates a tension state, even in those who are not aware of it, which creates and contributes to fatigue. Fatigue, in turn, creates a situation where faulty decision-making may arise.

It does not seem to me ideal that every principal should spend 20 hours on standby to see two patients, and be fatigued on the following day, putting maybe sixty to ninety patients at risk.

DERMOT LYNCH

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Hanworth,  
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REFERENCE


RULE OF RECEPTIONISTS

Sir,  

I was interested in page 192 of the March Journal, as I had been given an Upjohn Award to study this problem. At the outset I had started with two of the assumptions made in the article, namely that the receptionist's role was to support the patient rather than the doctor—and in this way her activities differ from those of a doctor's secretary. Secondly, I had felt that the quality of the transaction between receptionist and patient at the outset influenced, for good or evil, the final consultation with the doctor.

My investigations along this line were quite inconclusive. Admittedly to go round with a tape recorder in the year of Watergate was likely to be an unrewarding experience, but my conclusions, for what they were worth, tended to show that there was no relationship between the quality of the patient/receptionist transaction and the subsequent consultation with the doctor. In fact there was almost an inverse relationship in many cases that I recorded, as if the patient had a certain quantum of aggression to get rid of and discharged it either at the receptionist or at the doctor. In short I was unable to support my original contention by the observations I made during my Upjohn journeys.

There is still a great deal to be learned about the dynamics of the work of a receptionist.

JAMES FISHER

85 Castle Lane,  
Bournemouth, BH9 3LQ.

REFERENCE

*Journal of the Royal College of General Practitioners* (1975), 25, 192.

SIR JAMES MACKENZIE

Sir,  

I am one of the three Trustees of a bequest made in her will by the late Dorothy Mackenzie, daughter of Sir James Mackenzie. Our work as Trustees is practically over and we are at the final stages of winding up.
One of the projects sponsored by the Trustees was the writing of a biography of Mackenzie. This work was undertaken by Professor Alex Mair. You, of course, know the biography and also the fact that royalties from it have been bequeathed to our College. In assembling the material for this biography Professor Mair collected several books and original correspondence. Since the task has been completed, and with the approval of the Trustees, Professor Mair has bequeathed this material to the Library of the University of Edinburgh.

It may be that some future research workers and students might wish to know of the existence of this material and the possibility of their gaining access to it by contacting the University Librarian. I am following up and supporting Professor Mair’s suggestion that you might agree to inform readers of this possible source of “Mackenziana”.

RICHARD SCOTT

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39 COWGATE,
EDINBURGH, EH1 1JR

REFERENCES

COMMUNITY HOSPITALS
Sir,
We refer to your editorial (December Journal) on the Department of Health and Social Security paper on Community Hospitals. Your conclusion was that, in future, we may look back at this publication as an important milestone in the development of medical care.

The Lichfield doctors, however, have collectively studied this paper in detail and have reached the opposite conclusion. The undersigned would not wish, however, to be branded as insular. Clearly, there exists the “have” and the “have not”. The former, such as we who have an active general-practitioner hospital with a high turnover of acute general medicine (much of it being among the younger age groups) and cold surgery, with consultant cover, are fortunate. We also have active x-ray, casualty, and physiotherapy departments. Those who do not have these excellent facilities no doubt would welcome the Department of Health and Social Security proposals, whereas we fear many of our facilities will be taken away.

Our experience is that a wide range of acute general medical patients, many of whom require in-patient investigation, can be adequately cared for in general-practitioner hospitals with mutual benefit to patients, relatives, and to doctors. This applies also to many minor and medium grade surgical cases whose operations are normally performed by consultants but who post-operatively are cared for by general practitioners and in many cases are anaesthetised by them. Normal obstetrics can be practised safely by properly qualified practitioners in a community-hospital setting. This, of course, is provided that the antenatal selection is sufficiently discriminating and rigorous.

We are in agreement with the stated general philosophy concerning the benefit of community hospitals to local communities. However, we disagree strongly with the unbalanced emphasis on geriatric care. This would apply particularly to the cases of dementia described in the Department of Health and Social Security publication. We shall resist energetically any erosion of our casualty, surgical, obstetric, and radiological freedom.

In our considered opinion good medicine depends upon care and concern for patients. This is not possible without effective communication between the patient, the family doctor, and the consultant. We feel that care that can properly and safely be given with good communications between the three levels should be revered.

J. R. DUNCAN BROWN
M. A. BROWN
B. R. COLLIER
P. DANDO
A. R. ELSAM
L. T. HARRINGTON
B. JONES
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VICTORIA HOSPITAL,
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LICHFIELD,
STAFFS.

REFERENCES

DIPLOMA IN SEXUAL MEDICINE
Sir,
Much of the work of the general practitioner today is involved with relationship problems which are often presented as sexual difficulties.

This is a field of postgraduate education which has been largely ignored and is growing in importance. Handling such cases should stem from a broad base of knowledge and understanding. May I therefore make a plea that the College consider the implementation of a diploma in sexual medicine? This could include such topics as:

1) How relationship problems commonly present to the doctor,