The organisation of this meeting inevitably involved many people, but a special responsibility devolved on Dr Inglis Lamont, the local Faculty secretary, and Drs Dorward, Knox, Lawson, and Reid, who held office at this time.

Despite the difficulties, despite the doubts, there was something special this year at Dundee.

DUPLICATING PRIMARY CARE

> *" The time has come for health service prescription forms available to general practitioners . . . to be available to the family planning clinic doctor. This would enable the clinic doctor to treat the common cold and boil when it is obvious and save having to send someone away from a clinic to visit their general practitioner, wasting his time and the patient's for something that can be put right on the spot by a registered medical practitioner."*
>
> Smith, M. (1975)

THE Chief Medical Officer of the Family Planning Association, Dr Michael Smith, has recently recommended that family planning clinics should be empowered to issue National Health Service prescription forms so that clinic doctors could treat general medical conditions through the National Health Service.

At first sight this seems a simple suggestion which might save the patient's time and that of the general practitioner. It might also lead to treatment being started earlier than would otherwise be the case and would almost certainly extend the interest in the work of clinic doctors.

Nevertheless this proposal needs to be seen in perspective—a perspective which includes similar suggestions from doctors working in other clinics, such as local authority welfare, and children's clinics.

The key consideration is the little understood danger of the fragmentation of medical care and the disadvantages of Dr Smith's proposal need to be restated.

A main advantage of the British system of medical care is that each patient should have one doctor who is able to see the whole picture and pattern of illness. The more episodes of illness that are treated outside the generalist system, whether in casualty, outpatients, or special clinics, the more the generalist loses the total view—the more the patient will be lost among different doctors. Primary physicians recognise patterns and pattern recognition depends on adequate input over the whole range of conditions from which patients suffer.

There is increasing concern in all branches of the medical profession about the co-ordination of treatment. Drug interactions, drug sensitivities, and side-effects are looming ever larger in the minds of all prescribing doctors. It is of extreme importance to the patient that one doctor, and as far as possible only one doctor, should be concerned with the co-ordination of all treatment. If separate hospitals and different clinics prescribe directly, it is only a matter of time before undesirable interactions occur, because no one doctor sees all the treatment and knows all the priorities.

Furthermore the greater the number of doctors involved with a single patient's care the greater the potential difficulties of communication between the doctors—often to the patient's detriment.

At present messages from the Family Planning Association are often given to the

patient to deliver and there may be a considerable delay if the patient waits until she next sees her general practitioner. Some of these reports never arrive at all. There would have to be a vastly improved communications system between doctors working in the Family Planning Association clinics and the patient's general practitioner if this scheme were to be adopted. This would involve the Family Planning Association (and hence indirectly the Department of Health and Social Security) in considerable secretarial expense. We doubt if even then communications would be satisfactory.

The involvement of numerous clinic doctors, child health and family planning, could also lead to difficulties, especially if complications arise from the original illness itself or when side-effects arise from the treatment prescribed. What does the patient do if she develops a rash after the clinic doctor's treatment? Who then does the patient see?

Nor can we accept that treating a boil and arranging for urine to be tested is " wasting the doctor's time." A history of recurrent boils can indicate several underlying medical conditions including diabetes, anaemia, and malignant disease. Who is to carry out the appropriate examinations and investigations if patient care is divided between doctors?

It has long been one of the interesting illusions of specialists in many branches of medicine that they are perfectly capable of acting as generalists, without either the training for this job or practical experience in it. The Royal College of General Practitioners has repeatedly said that general practice is a specialty in its own right and this view has recently been endorsed by the Merrison Committee (1975). It can be dangerous for patients if doctors dabble in primary care.

The Family Planning Association has much to be proud of and its record of service to patients is considerable. It is surely clear, however, that its future now lies in providing a specialist service, particularly in psychosexual counselling and difficult contraceptive problems and not in duplicating primary medical care.

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THERAPEUTIC NON-EQUIVALENCE OF DIGOXIN TABLETS IN THE UNITED KINGDOM: CORRELATION WITH TABLET DISSOLUTION RATE

Seven types of digoxin 0.25 mg tablet in common use in the United Kingdom were administered to a total of 38 patients. Significant differences were found in the mean plasma digoxin levels and in the control of atrial fibrillation achieved with these brands. There was a close correlation between the dissolution rate of the tablets and the plasma digoxin levels. Measurement of in-vitro dissolution rate appears to be a valid method of ensuring that different tablets of digoxin are of equal efficacy. However, in some patients absorption of the drug is markedly sensitive to changes in dissolution rate and new pharmacopoeal standards should not be defined until very rapidly-dissolving formulations have been studied.

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