

Journal). If general-practice obstetrics is to survive then it must be in a form similar to that which they describe. There is one minor point, however, with which I would like to disagree. They state that patients booked for general-practitioner care should after delivery be nursed in a group of beds set apart from the consultant beds. I would suspect that it is better for these beds to be fully integrated. Certainly such a system works extremely well in the general-practitioner beds in the Queen Mother's Hospital Glasgow, which are fully integrated with the consultant beds.

K. A. HARDEN

85 Milngavie Road,
Bearsden,
Glasgow, G61 2DW.

REFERENCE

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SOCIAL CLASS AND MORBIDITY/ MORTALITY

Sir,

I read with great interest (April *Journal*) that the Manchester Research Unit of the Royal College of General Practitioners responsible for the Oral Contraception Study is setting up a joint study with the Royal College of Obstetricians and Gynaecologists on the consequences of induced abortion. Such a study would be of great importance.

However, one aspect of the report *Oral Contraceptives and Health* which has been of great concern to me, is the under-representation of working-class women (which is not mentioned in the report). Social classes 4 and 5 form 17.4 per cent of Takers and 19.7 per cent of Controls. The 1970 census showed that social classes 4 and 5 form 27 per cent of women aged 15-44. Social class 3 women were equally represented in Takers and Controls (42.6 per cent) but are in fact 53.32 per cent of the female population in the reproductive years.

Since the Registrar General's 1961 occupational mortality tables show that women in social classes 4 and 5 already have a much higher mortality rate than middle-class women apart from the possible serious side-effects of the Pill—and the difference is particularly noticeable in certain groups, e.g. miners' wives—I cannot help wondering whether they are at greater additional risk as takers of oral contraceptives.

I have tried, but failed, to trace any studies of social class differences in mortality and morbidity among women on the Pill.

The social class composition of the sample is, presumably, because working-class patients are under-represented in the lists of those doctors who took part in the oral contraception study.

One can well imagine how such a bias might affect conclusions about the consequences of abortion.

JEAN ROBINSON
Chairman

The Patients' Association

335 Gray's Inn Road,
London, WC1X 8PX

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PARTICIPATION BY PATIENTS IN PRIMARY CARE

Sir,

When, in July 1973, the Aberdare Health Centre was opened it was considered that the patients (10,000) should be encouraged to become involved in running their general-practitioner services.

It was decided that this could best be done by calling a general meeting open to all patients from which a patients' committee would be elected and also to have lectures on the theme *Look after your Health*. At the first general meeting a committee of eight patients was formed. At the second general meeting this was increased to 13. The chairman is a retired teacher, the secretary a young industrial worker. One of the members is also a member of the local Community Health Council.

The Patients' Committee now meets (with the practice health team, doctors and nurses) every five or six weeks—in future the liaison social worker, will also attend. Initially the Committee discussed immediate difficulties, the doctors' weekend rota arrangements, the surgery appointments system, parking facilities, redecoration, the provision of picture rails, the health education programme.

Now, however, we have worked out how to provide a new limited screening for the over 60s to whom letters, signed by the senior doctor and the secretary of the patients' committee, are being sent soon after their 60th birthdays.

At a recent meeting the main matters discussed were, the waiting time for barium meal x-rays, the open university, training of doctors, the James White Abortion (Amendment) Bill, the health education programme for the next session, and euthanasia.

There has been a public lecture on *The Open University and Doctors*, but not yet on abortion or euthanasia.

The Community Health Council is now helping the Patients' Committee in pressing for improvements in the special x-rays service and the local abortion services.

One of the doctors reported at a recent Committee meeting that he had had difficulty in getting a violent mentally ill patient into hospital at a holiday weekend. It was decided, after discussion, to ask a psychiatrist to give an open lecture on *The Care of the Mentally Ill at home and in Hospital*, so that difficulties of this nature can be discussed in an amicable way.

I think, that patients should be encouraged to attend the Patients' Committee meetings to give their opinions, advice or complaints. There should also be more frequent general meetings for the same purpose.

What is envisaged is co-operation between the health centre staff and the patients, rather than confrontation, the aim being to involve as many patients as possible and to use the unique and varied experience of as many of the 10,000 patients as possible to assist the practice team of 15 to provide a better service.

Our local Patients' Committee is an example of grass roots democracy in the NHS which is, more and more, being controlled at all levels, by appointed, not elected, bodies.

Our relations with the Community Health Council are excellent; the Community Health Council Secretary has already spoken to one open meeting of the patients.

Is there any good reason why this cannot also happen at every other health centre?

At a Valleys' Community Project Conference held at Aberfan on 8 February 1975 on *Health in the Valleys* at which I reported on the discussions at the primary care group, the following recommendations were made:-

(1) There should be more community participation in the primary care service.

(a) Community Health Councils could ask local doctors for appointments to visit their surgeries or health centres—in this way barriers between doctors and the Community Health Councils can be broken down.

(b) It was considered that the appropriate Community Health Council could "associate" with the patients' committee.

(c) There should be increasing democratic local control of the health services.

(2) There should be central exchequer control of health service finances, but with a larger and wider distribution of funds particularly to areas of greatest need.

(3) It should be an essential part of primary care that general health education should be provided for the community particularly at health centres.

A final remark in this discussion from the Secretary of the Patients' Committee was:

"If doctors are prepared to discuss the provision of health services with their patients this could benefit both doctors and patients and could provide a better service for the community."

Pritchard (1975) has a community participation group at Bennfield Health Centre. I am sure that many forms of patient participation will develop. Soon I hope the College will arrange a meeting of the doctors involved so that we can discuss our experiences.

A. WILSON

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INVESTIGATIONS IN THE PRACTICE

Sir,

At a recent meeting of the Wessex Faculty on the Isle of Wight the question of the future pattern of general practice and the function of the MRCGP examination came under discussion. If one salient point emerged it was the fundamental importance of clinical excellence. One aspect of this is what might be termed "office procedures," i.e. procedures which can be performed for the patient in the surgery. As a contribution to this discussion I would like to enumerate those procedures which I regard as desirable for the modern general practitioner to have at his command and that his ability in them should be demonstrable in the MRCGP examination.

(1) The use of the ophthalmoscope for diagnostic purposes.

(2) The use of the electrocardiogram.

(3) The use of the sigmoidoscope for diagnostic purposes.

(4) The ability to perform Eustachian catheterisation.

(5) The ability to perform indirect laryngoscopy, for diagnostic purposes.

(6) The ability to perform minor surgery under local anaesthetic.

(7) The ability to fit IUDs and to arrange the fitting of the contraceptive diaphragm.

(8) The knowledge of the indications and techniques for the intraarticular injections of cortisone and also its injection into soft tissues.

(9) The injection or rubber band treatment of haemorrhoids.

(10) The injection treatment for varicose veins.

These desiderata will no doubt evoke protests from the 'behaviourists' in our ranks. They are however, with the exceptions of numbers (4) and (5) techniques which have been in regular use in this practice for the last ten years or more without any detriment to the other aspects of general practice and it is my view that in the 1980s no one should become a principal in general practice without having mastered them.

Furthermore, they ought now to be available amongst the different members of a group practice.

P. D. HOOPER

The Dower House,
 27 Pyle Street,
 Newport, Isle of Wight.

LETTERS TO AND FROM HOSPITALS

Sir,

I read with interest the article in the July *Journal* by C. J. Durkin and A. Edwards on referral letters from general practitioners.

I agree that such letters are important, although on occasions I have had it reported back to me that my careful letter has been brushed aside by a busy doctor, who only wants to hear what the patient has to say.

I would now welcome a follow-up research project on letters from the hospital to the general