the Disabled Living Foundation. This foundation works from their headquarters in 346, Kensington High Street, London, W.14 and provides advisory service both to the disabled and also to their advisors and friends with regard to special amenities, etc.

However, in the past they have always found it difficult to make contact with general practitioners and feel that either the work of the foundation is not generally known to them or that they may not fully appreciate its significance.

The organisation recently held a most interesting conference on the *Importance of Clothing in the Lives of the Disabled*, at which I represented the College.

Should any of your readers wish to have further details, if they write to Lady Hamilton at headquarters or to me at the address given below, I will try and put them in touch with the appropriate representative.

L. T. NEWMAN

The Abbey Medical Centre,
87–89 Abbey Road,
St Johns Wood,
London, NW8 0AG.

SIR JOHN PARKINSON

Sir,

Dr Nightingale's reference in his admirable article on migraine (May *Journal*), to fasting as one of the trigger mechanisms in migraine called to mind the experience of Sir John Parkinson, Sir James Mackenzie's distinguished successor as cardiologist to the London Hospital, who has just died at the ripe old age of 91.

Sir John was a victim of the disease, and I recall his telling me how he could postpone, but never prevent, an attack by taking food. Being a conscientious Lancastrian, he hated cancelling patients' appointments. If, therefore, he realised in the morning that an attack was impending, instead of merely having a sandwich for lunch and a cup of tea at tea-time, he would have a full three-course lunch and a full tea. In this way he found he could usually postpone the attack until evening.

By the time the last patient had been seen he was nigh prostrate, and fell into bed in a darkened bedroom, knowing full well that the increased intensity of the headache would be the price he would have to pay for keeping faith with his patients.

If he had to go to the London Hospital the next day, it was easy for his chief assistant to tell at a glance what a miserable night he must have had. But nothing was going to compel him to neglect what he considered to be his duty.

WILLIAM A. R. THOMSON

Rutland Court,
Queens Drive,
London, W.3.

REFERENCE

Nightingale, J. (1976). *Journal of the Royal College of General Practitioners*, **26**, 318–326.

SEEING THE SAME DOCTOR

Sir,

One of the dangers of the community health team and group practice is that the patient feels that no one doctor knows his or her problems in depth, that no one person takes responsibilty, and that no one person takes a particular interest.

These problems can be avoided by having separate lists; patients will not then 'box and cox" from one doctor to another, questioning their probably varying views, which may well precipitate great uncertainty and possibly, therefore, unhealth in the patient.

I am very much in favour of group practices where there is a mutual exchange of information, and for teamwork where various health care personnel can all communicate on one level with each other, but I do think it is in the doctor's and the patient's interest that patients see their own doctor except when he is not available. Admittedly, doctors cannot be all things to all patients and if a patient feels unhappy with his doctor, or a doctor feels unhappy with his patient, then a new relationship should be established with another doctor on whose list that patient should go, whether he be in the same practice or another practice. I would be most interested to hear your readers' views.

V. L. R. TOUQUET

40 Court Street,
Faversham,
Kent, ME13 7AJ.

REFERENCE

Aylett, M. S. (1976). *Journal of the Royal College of General Practitioners*, **26**, 47–52.

RESPONSE RATES TO QUESTIONNAIRES

Sir,

Dr L. A. Pike's questionnaire (March *Journal*) emphasises the problem of the poor response obtained when mounting any form of survey in general practice.

Recently our practice needed to evaluate the opinion of patients about entry into a projected health centre. It was decided that the simplest and cheapest method was by hand-out, although it was anticipated that this might produce a lower response rate. Five-hundred duplicated forms, which represented about eight per cent of the practice list, were placed on the reception counter, and the receptionists encouraged the patients to return the completed forms to a sealed box also on the counter.

The questionnaire explained the projected health centre and invited the patient to say whether or not he was in favour of the move. Space was left for comments, and the patient was given the

option to give his name and address. (Fifty seven per cent of the forms were returned, there being a 3 to 2 majority in favour of the health centre.

We were surprised at the low response rate to the questionnaire, and although this was almost identical to that of Dr Pike, the total cost was £2·40, involving the minimum amount of work.

F. G. C. MEYNEN
Montague House,
60, Church Street,
Leatherhead,
Surrey, KT22 8DW.

REFERENCE

Pike, L. A. (1976). *Journal of the Royal College of General Practitioners*, **26**, 204–205.

BOOK REVIEWS

The Doctor-Patient Relationship (1976). BROWNE, K. AND FREELING, P. Pp. 101. Edinburgh: Churchill-Livingstone. Price: £2.25.

During my second year in general practice I discovered in the *Practitioner* a series revealing various exciting and relevant facets of the doctor-patient relationship. Curiously though, I was left feeling a bit more stupid and no more competent. Although brief case histories often showed our splendidly perceptive authors picking out vital clues to elucidate their patients' " whole problems", I wanted to ask " Yes, but now what? " (A new chapter, *Treating the Cause*, is helpful here).

The intention was to illuminate and correct " wrong training", yet I sensed a barrier between ordinary folk like myself and those equipped, after years of special training, with insight and expertise. Re-reading those articles as a book, I realise now how greatly they influenced me. Certainly they stimulated me to join, with some trepidation, a discussion group similar to those from which Browne and Freeling hatched.

Each chapter is a little gem, lucidly analysing and illustrating our relationships from yet another point of view—a moving plea for us to acquire insight and become more disciplined, more objective, less impulsive, less intrusive in some ways, more in others—more carefully sympathetic, more interpretive of everything we see and hear.

The advantages, we are told, are great. The doctor's self-esteem and status increases; he need no longer see himself as a poor relation in the medical hierarchy but as the discerning doctor working in a uniquely difficult, but exciting, atmosphere of uncertainty, using his tools to help his " whole patient," or at least his patient's " whole problem", perhaps even preventing " organic illness."

It is rightly suggested, in the second edition, that these attitudes have now enhanced the status of general practice as a " discipline " (nasty pretentious word), may certainly have precipitated an epidemic of academic chairs, and may have changed society to expect " whole patient care ". Yet, paradoxically, I suspect that at no time have we enjoyed a *lower* status from the rank and file of our patients especially in urban areas. Could there be a link? Can we really deliver the goods?

Beware, lest in reaching upwards we lose contact with our roots and strengths, with the main bulk of practitioners and patients, lest our language and vision outstrip too far those with whom we must live and work, lest we become so objective we lose our spontaneity and honesty, lest we set goals and standards we cannot, perhaps should not, attain.

Snags? We are told without tact and warmth that insight can be untherapeutic. Our powers may assert a " negative placebo " or " discredo " effect. But there are other snags, some of which are mentioned, which occur when ordinary people, unlike saints, dabble in psychology—snags not only for the patient, but for the doctor as a person. Guggenbuhl-Craig (1971) is mentioned, but his powerful and meaningful message is not. Perhaps a third edition . . . ?

Meanwhile, even when taken with a pinch of salt, here is one of the most worthwhile and entertaining books anyone might wish to read.

P. RECORDON

REFERENCE

Guggenbuhl-Craig, A. A. (1971). *Power in the Helping Professions*. New York: Spring Publications.

Aspects of Sexual Medicine (1976). Pp. 90. London: British Medical Association. Price: £2.

It is not every day that the general practitioner is faced with giving advice on sexual problems, but changes in public attitudes have led to patients expecting that their doctors should be able to give such help.

Although we should all have read the original articles published in the *British Medical Journal* in 1975, many of us missed some. This collection of a series of 11 papers provides a useful handbook for the general practitioner.

Contemporary management of sexual disorders has changed in parallel with society's acceptance of the range of normal sexual behaviour. While every doctor must decide for himself where he personally stands, it is equally important that the advice he offers to his patients should show a reasonable tolerance of sexual attitudes and practices which may differ from his own. It is often said that normality in sexual behaviour is that which