MONITORING GENERAL PRACTITIONERS

Sir,

I would like to support the Patients' Association's plea that there should be some sort of monitoring of the service supplied by general practitioners. If the teaching profession can submit themselves to regular inspections without loss of status, isn't it time for the medical profession to come to terms with its omnipotent fantasies and evolve a system of monitoring based on that evolved by the teaching profession?

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REFERENCE

Journal of the Royal College of General Practitioners (1976). **26,** 403.

PATIENTS' ASSOCIATION

Sir,

I noticed with interest the short report on complaints reaching the Patients' Association.

I feel that it would be well if this organisation were to educate its members in the proper use of the health service. General practitioners have become reluctant to make home visits because a large number of such visits are requested for non-medical reasons. This tendency has become more marked in the last seven years or so. Twenty years ago this was a rare occurrence. So far as the commercial deputising services are concerned, these owe their existence to the increasing abuse of the service by such people as form the Patients' Association.

I suggest that a proper use of the service by our clients would produce a remarkable improvement in the standard of care we would be able to give to them. The Patients' Association could learn from the parable concerning the mote in one man's eye and the beam in another's.

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REFERENCE

Journal of the Royal College of General Practitioners (1976). **26,** 403.

TREATMENT OF COLD SORES

Sir,

For prophylaxis and treatment of cold sores in general practice Drs Grout and Barber (June *Journal*) claim that idoxuridine justifies consideration.

However, there is another less toxic and cheaper form of treatment, namely the topical application of ethyl ether (Sabin, 1975). Ethyl ether penetrates the epidermis and destroys herpes simplex virus by acting on its lipid-containing membrane. In the reports cited by Sabin the ether was applied with a cotton swab or moistened pledget until the skin blanched and local anaesthesia was produced, the process being repeated several times during the next 24 hours or when itching and pain reappeared. Sabin states that "topical ether therapy makes sense and deserves a proper, carefully designed and controlled clinical trial". Such a trial seems ideal for general practice.

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REFERENCES

Grout, P. & Barber, V. E. (1976). *Journal of the Royal College of General Practitioners*, **26,** 428–434.

Sabin, A. B. (1975). *New England Journal of Medicine*, **293,** 986–988.

NEED FOR SUPERVISION IN THE ELDERLY RECEIVING LONG-TERM PRESCRIBED MEDICATION

Sir,

As one of the general practitioners involved in the above study summarised in the July *Journal*, I would like to comment.

The critical element in the author's argument hinged primarily on the "three (patients who) might be suffering from drug toxicity". The partners, in the presence of one of the authors, conducted a clinical audit of these actual cases six months before the paper appeared in print.

The first of these was the patient whose blood profile "showed changes consistent with phenylbutazone poisoning". It transpired that this patient was not receiving repeat prescriptions from the practice at all, but was most probably receiving them from another practitioner privately. This raised many interesting subsidiary issues including ethical problems, but provided no basis for the conclusions which the authors indirectly have drawn from this case.

Two patients "were thought by nurses to be showing signs of digitalis toxicity". One of these patients (incidentally the father-in-law of one of the partners who sees him almost daily) had been known for many years to have had an athletic basal pulse of 57/minute. His pulse was now reduced to around 42/minute but this was attributed mainly to the therapeutic effect of β-blockers which he was also receiving and not to digoxin.

The second patient, some of the details of whose case have only come to light recently, was an elderly man with congestive cardiac failure well controlled on 0·0625 mg. of digoxin as 'Lanoxin' daily. His pulse rate of 52/minute had also been a feature for many years. One of the investigators decided that this was one of the cases of digoxin toxicity and the dose was reduced to alternate days. Within a few days, the patient was finding difficulty in climbing stairs and in walking any distance. When he also developed ankle swelling, the patient's daughter, an ex-nursing sister, realised what was going wrong and put him back on his original dose of 'lanoxin' with rapid improvement.

We give these clinical details for we find it surprising that the authors forbore to mention that on critical clinical review, there was no evidence of adverse effects attributable to the practitioner's prescribing. However, if they had, perhaps there would have been no basis for a paper.

The authors did not mention that the partners had introduced a manual monitoring and surveillance system which allows *selective* recall at the practitioner's discretion every six or twelve months of patients receiving repeat prescriptions. The automated system on which the authors' data were based incidentally does not include all consultations with patients and excludes casual but important contacts with patients when they return for repeat prescriptions.

I believe that the flexibility in the manual system is compatible with effective care and have found no reason to change it since reading this paper. The present repeat prescription monitoring system in use in the practice was the direct result of a previous reported audit of repeat prescribing by the partners carried out in 1970.

I believe that all forms of audit, self-assessment and critical reappraisal of clinical and operational performance where they are relevant must be an essential part of modern general practice. I also believe that service general practitioners need the help of their academic colleagues in developing this rationally. I am not convinced that the over-zealous and misguided approach demonstrated in this paper will achieve these ends.

The points made in this letter, along with many other similar criticisms were published in the *British Medical Journal* two weeks after the publication of the original paper. The fact that a summary without qualification can appear in the *College Journal* and a reference can be included in the College library list as a reference in the section on the aged in the *New Reading for General Practitioners* No. 2 January–March, 1976, also without qualification, raises an important point of principle. It would not be apparent to anyone simply reading the original paper or the summary in the *College Journal* that the conclusions drawn by the authors (which could have considerable significance for general practice) are based on inaccurate data nor that the true findings lead logically to contrary conclusions.

Is there a recognised procedure to correct this potentially dangerous misrepresentation?

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REFERENCE

Journal of the Royal College of General Practitioners (1976). **26,** 506.

GENERALISTS

Sir,

I was alarmed to note that in your July editorial you refer to general practitioners as 'generalists'. New words are of value only when they express a meaning better than the word they replace. Generalist does not.

It is sad that the jargon so much in vogue nowadays brings the College into disrepute, causing either resentment or laughter. I recently attended a meeting (? module) where there was so much repetitive jargon that a colleague of mine amused himself by creating a vocabulary for what your editorial describes as "the new generation of generalists." Few words were of the slightest value.

I wish to state firmly that I am a general practitioner and am proud to be a member of the Royal College of General Practitioners. I appeal to you to use the title adopted by your own college until such a time as it becomes the Royal College of Generalists.

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REFERENCE

Journal of the Royal College of General Practitioners (1976). Editorial, **26,** 471.

JARGON

Sir,

I believe that many of your readers would support Dr E. Adey (June *Journal*) who suggests that the length of almost every article in the *Journal* could usefully be cut.

The results of the careful research which has preceded these articles could be more effectively communicated if you, sir, as Editor, revised and shortened the obscure verbiage which spoils some of the papers. Examples of these literary lapses occur in almost every monthly issue, even from your most eminent contributors.

The following paragraph is from the pen of the President of the College, on page 13 of a *Report on the Assessment of Vocational*