HEARING AIDS

Sir,

Like other general practitioners I see a number of people suffering from presbyausis. If I have my definitions right the symptom is deafness, with marked high-frequency loss, which affects the ageing. Whether moderately deaf or very deaf indeed, it is my experience that people suffering in this way get little or no help from hearing aids. It may be that they only rarely get enough help to be thoroughly worthwhile and it is the management of this difficult group which provokes this letter.

It has been my experience that they get into the hands of people who have more salesmanship than science. I can think of three patients who never ever use the very expensive gadget they have bought. When one has given a patient very clear advice that he should be prepared to test a gadget and pay liberally for a test period but on no account buy it, it is indeed rather frustrating to find that he has been persuaded to buy outright.

It may well be that colleagues know of a supplier of hearing aids who is willing to lend apparatus so that patients can find out whether it is going to help them or not. I should very much like to hear of such a firm if it exists.

E. B. GROGONO

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SEEING THE SAME DOCTOR

Sir,

I agree with Dr Touquet (August *Journal*) on the disadvantages to patients of a combined list. There are disadvantages for the doctors as well. With a large combined list it is impossible for any partner to know all the patients. This must mean he is a poorer doctor for anyone who sees him. If the patients ' chop and change ' between doctors, they allow the doctor to evade his responsibilities, and a job without responsibility is a boring job.

The partnership can suffer. When a patient consults his doctor's partner, the partner is flattered. He will be reluctant to refer back the patient, thinking it a kindness to solve a medical problem for his partner. But he may see the patient as a failure and come to resent his partner. Worse, he may get delusions of excellence about his own capabilities. He may not observe his own patients changing partners and will forget to ask himself why they have done it.

The reputation of the practice is damaged. If a patient is referred to a consultant, how is the reply to be addressed? To the referring doctor? To the partnership? To the doctor with whom the patient is registered? To the doctor with whom the patient thinks he is registered? If it is not clear who the patient's doctor is, the consultant may feel the doctor is only vaguely interested in the patient. This might also apply to other people with whom the partnership communicates—the health team, employers, union, solicitors, and so on.

Balint wrote about the effects of the dilution of responsibilities between family doctor and consultant. It can also happen inside a shared list group practice. Like Dr Touquet, I favour group practice, but the shared list is not a feature which notably contributes to its great advantages.

M. FISHER

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JARGON

Sir,

In reply to Dr C. W. L. Smith's letter (August *Journal*), my letter (May *Journal*) was written more in response to Graham and Sher's paper (February *Journal*) than to Brook and Temperley's.

I was expressing what I think is a fairly widespread concern about the dangers of introducing ideas and particularly jargon from another discipline into our own, where they may act as a smoke screen for the passage of new methods, or simply cloud the issue; hence my comments about propaganda and brain-washing, and betraying the principles of our respective disciplines.

I was not convinced that the techniques of psychotherapy or the use of the sociological concepts described had themselves significantly altered the outcome for the patients. I suspect it was the enthusiasm, the continuing contact, and the compassion of the workers that largely benefited the patients—as was the case in the teams that once gave insulin coma therapy to schizophrenics.

We all have our particular enthusiasms and fantasies which may quite legitimately enable us to help our patients more effectively. In the case of the writers of an article in a medical journal, however, the onus of proof is on them, particularly if their ideas are going to be applied more universally.

In the case of Mrs A. (Brook and Temperley) we are not told whether the black woman lodger did in fact have a terrible temper. This could be important in enabling readers to judge whether the clinic worker had recognised correctly the unconscious meaning of Mrs A's preoccupation with her dangerous black lodger—that she " had within herself another, a black and violent side . . . ."

At the risk of being speculative myself, I suggest that the worker's technique may be merely an

'aid' to get closer to Mrs A and allow her to express her feelings of guilt. The success of this does not validate the psychotherapeutic interpretation of Mrs A's subconscious thought processes. After all, there are other ways of arriving at the same successful result. On the evidence available, Mrs A with her previously stable personality might have had a true depressive illness, something perhaps which her husband could not tolerate, and which made her irritable and troublesome with her children and her lodger, and caused pathological guilt. The article does not say whether or not tricyclic antidepressants were prescribed.

Graham and Sher's main summary emphasises the difficult (not "undisclosed") tensions present between the two professions. Surely any tensions are unlikely to be eased by such statements as "... the social worker would act as consultant to the general practitioner ...". This relationship seems to persist through much of their article and introduces ideas of status and hierarchy which are entirely artificial, if not condescending.

Dr Smith comments on my "aggressive dismissal", when I think he really means my rude dismissal. In a short letter encompassing many ideas, I am afraid this impression is easily, if unwittingly, conveyed. The rest of his highly speculative penultimate paragraph is obviously difficult for me to answer objectively. But it does point to the dangers of the techniques which we are discussing, in that your contributor's ways of thinking can lead to almost automatic, mechanical conclusions which at the very least require scientific verification.

C. H. MAYCOCK

55 High Street,
Crediton,
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CONVERTING MEDICAL RECORDS

Sir,

I agree with Dr Cormack that letters in the medical records should be arranged in chronological order before being thinned out (August *Journal*).

In January 1970 I decided to go through the medical records of the 4,500 patients who are looked after by my wife and me, thinning out repetitive letters, discarding pathology reports which were no longer of value, and case notes which were illegible. This exercise took me two years in my spare time. Two main advantages were that the information contained in the records was much more readily available and that the storage space for the records was reduced by about 20 per cent.

Since then I have continued to thin out the records for new patients as they come in, and a side benefit has been that one does not miss significant information about a new patient.

Using this method I find the present envelopes very convenient and I am not in favour of changing to the large A4 folders.

ANDREW MILLAR

Benson,
Oxford.

REFERENCE

Cormack, J. (1976). *Royal College of General Practitioners*, **26**, 576.

UGANDA FACULTY

Sir,

As the Founder Secretary of the Uganda Faculty, and having been as well secretary for nearly seven years, and provost for one, I hope you will allow me to comment on Dr M. J. Aylett's letter (August *Journal*).

Like Dr Aylett, I also hope that one day the Uganda Faculty will form again, although I have very serious doubts about this ever happening during the next decade. Almost all the expatriate members are now settled outside Uganda. I have been in contact with some of the members who are now settled in this country, and none has so far indicated his desire to go back. So the only possibility is that the local African doctors may in future become members of the College and form a Faculty.

We all are very grateful to Dr E. R. Gibbons for the excellent service he has rendered to the Faculty. We admire the way in which he has sent out the gifts from the remaining funds in Uganda. I am sure that, but for his efforts, these funds would have been frozen by the Amin Government.

DAMODAR B. NEGANDHI

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Rugeley, Staffs.

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PAYMENT FOR PASSING THE M.R.C.G.P. EXAMINATION

Sir,

Within the next few weeks I am entering a partnership in general practice in the south-east area of London and find that although I have managed to pass the examination to become a Member of the College, this is in no way recognised in terms of additional remuneration by the government.

If I had been vocationally trained and undertaken a year as a trainee assistant, I would be entitled to a considerable annual emolument.