

professionals working in primary care.

If we really wish to pay more than lip service to the functional integration of members of the primary care team, this is the direction in which our thoughts should be moving today.

CYRIL HART

The Health Centre
Yaxley
Peterborough PE7 3JL.

PARALDEHYDE AND STATUS EPILEPTICUS

Sir,

"Does any general practitioner really use paraldehyde these days?", asks P. J. Hoyte in his recent book review (*January Journal*, p. 59).

This is not the first time that I have seen the use of paraldehyde in general practice disparaged recently, and I for one am immensely reassured by the glass syringe and the non-expired ampoules of paraldehyde I keep in my bag—even though seldom used.

Are we really to suppose that intravenous diazepam ('Valium') can always be injected into the veins of a fitting child or an obese woman, particularly in general practice, where good illumination and a strong helper may not be available, and when the disadvantages of a short-acting drug may become all too apparent in the ambulance?

C. H. MAYCOCK

55 High Street
Crediton
Devon EX17 3JY.

SIGMOIDOSCOPY IN GENERAL PRACTICE

Sir,

Last year (*April Journal*) I was taken to task for recommending the use of a sigmoidoscope as a diagnostic instrument in general practice. I therefore thought it might be useful to review the patients who were sigmoidoscoped in this practice in 1976, and then readers can draw their own conclusions.

The practice comprises five partners of whom four use the sigmoidoscope. The total practice population is about 12,500. In 1976 41 sigmoidoscopies were performed; 23 of these were done before requesting a barium enema because the local x-ray department will not accept people for barium enema until they have been sigmoidoscoped. It is not surprising, therefore, that in 29 cases the examination was negative.

There were 12 positive findings consisting of five cases of non-specific

proctitis (which included some follow-up examinations) and two cases of patchy erythematous changes, which were possibly due to early proctitis. Haemorrhoids were confirmed as a cause of rectal bleeding in three cases, and there was a case each of a rectal polyp and a villous adenoma.

Twenty-three cases were referred for barium enema, of which 13 were found to be normal and ten were abnormal; there were seven cases of diverticular disease and one case of carcinoma of the sigmoid colon. One case showed x-ray evidence of proctitis and in another a filling defect was diagnosed and referred but later found to be normal.

About half way through the year we acquired some biopsy forceps and a biopsy was taken in ten cases. Five were reported as normal and three confirmed the presence of proctitis. One polyp and one villous adenoma were reported.

It will, of course, be argued that 41 sigmoidoscopies among four partners does not give each doctor enough practice to enable him to give a reliable opinion, but in our experience this is not the case. Once the technique of doing the examination has been mastered, the likelihood of any significant pathology being overlooked is very small.

P. D. HOOPER

The Dower House
27 Pyle Street
Newport
Isle of Wight PO30 1JR.

Reference

Evans, J. W. (1976). *Journal of the Royal College of General Practitioners*, 26, 261.

CONTRACEPTIVE RECORD CARD

Sir,

I would agree with Dr Froggatt (*February Journal*, p. 107) that the use of a planned contraceptive record card aids the collection of significant positive and negative data, and provides an *aide-mémoire* to ensure that important points of history are not omitted. I have been using a prototype card for the past 18 months which was printed for us by a drug firm (Wyeth Laboratories) and am aware of at least three derivatives of this which are available on request from this and other firms supplying contraceptive pills.

However, with space at a premium, I feel that Dr Froggatt's card could be modified to give greater prominence to the most relevant information and provide more space for comment. I doubt whether such full details of obstetric history (taking up a third of a side) are relevant; I have found that

more space needs to be devoted to contraceptive history, which can often be complicated, for example by reasons for failure to continue previous methods. No specific space is provided to note the presence or absence of history of pelvic inflammatory disease, which deserves consideration in assessing suitability for an IUCD. It also appears that details of personal and family history are combined under one heading; it would be easier if these were separated.

I hope that the College will be able to produce a standard record card for contraceptive services. The information contained in the medical record envelopes of patients who have previously been provided with an oral contraceptive often amounts to no more than a blood pressure reading. Any aid to improving this situation would surely be welcome.

SIMON A. SMAIL

27 Beaumont Street
Oxford OX1 2NR.

Sir,

In the February issue (p. 107-109) I was most interested to see an article on contraceptive records in general practice.

The author did ask for constructive criticism and I note that there is no space on the card to enter the fact that a claim has been submitted for either contraceptive services or a cervical smear. I think it should therefore be redesigned with this in mind.

I am of the opinion that good practice should benefit the doctor as well as the patient, and I feel that without good record-keeping money is likely to be lost by default.

IRVINE CREME

186 Canterbury Road
Davyhulme
Manchester M31 1GR.

DOCTOR/PATIENT RELATIONSHIP

Sir:

I presume that your correspondent, Dr D. M. Smith, in his letter in the *January Journal* (p. 58) means to be taken seriously, and he cannot therefore object to a systematic rebuttal of his arguments. They are in any case but a series of *non sequiturs*.

With great respect, his apologia is a prime example of woolly thinking combined with a hopelessly impractical approach to common problems. Such attitudes bid fair to be some of the main

reasons why family doctors have had, and are still having, such an uphill task in their struggle to be taken seriously by their specialist confrères.

On the subject of acute otitis media, I will say only that it is important to examine the ears of febrile children because a child of two years of age or less will frequently not be able to localize his discomfort and actually complain of pain in his ear. No one can distinguish between acute otitis externa, involving only the external auditory canal, and otitis media without looking in the ear. The treatment of both conditions is not the same, but the practical approach to diagnosis is.

If we are to consider that "skilled hands" ever knowingly hand out unnecessary prescriptions, then I suggest to Dr Smith that he should leave a dispenser containing signed blank prescription forms in his waiting-room so that his patients might help themselves and write the prescription themselves. They are already doing almost that.

I might also suggest that the only aspects of the doctor-patient relationship that have been neglected by Dr Smith are those relating to the doctor's duty to examine always and prescribe only when necessary.

There are techniques which one can learn readily to enable examination of the ear in an unwilling child without undue disturbance and I suggest that Dr Smith learn them.

JAMES A. MC SHERRY

Carruthers Clinic
1150 Pontiac Drive
Sarnia
Ontario N7S 3A7
Canada.

HOW MANY PATIENTS?

Sir,
We were very interested in your editorial "How many patients?"

(January *Journal*, p. 3) and in your comments on Marsh and Kaim-Caudle's analysis of team care in general practice.

Preliminary analysis of our research data collected by a primary care team over a four-year period does not wholly support Marsh's findings.

For a practice population of about 7,000 we recorded detailed information for every face-to-face consultation made with each member of the practice team of three doctors, a trainee general practitioner and fully attached district nurse, health visitor, and social worker from 1970 to 1973. The consultation rate for the whole team was 4.1 per patient-year at risk in 1970 before the social worker joined the team, rising to 4.3 per patient-year from 1971 to 1973, whereas the consultation rate for doctors only was 3.4 per patient-year throughout the four years. Similarly, the visiting rates per patient-year for the team were 1.1 in 1970, 1.2 in 1971, and 1.3 in 1972 and 1973, while the corresponding rate for doctors only was 0.5 per patient-year in each year studied.

We suggest that two of the most important factors affecting the general practitioner's consultation rate will be his clinical interests and his perception of his role, for both these factors influence what he permits his patients to consult him about. Some evidence can be presented to support this view from a comparison of the proportion of diagnoses falling into broad diagnostic categories in Marsh's data and in our own 1972 data (Table 1).

As regards individual diagnoses, Marsh records URTI in 9.4 per cent of diagnoses, whereas the Liverpool team figure was 5.4 per cent and the Liverpool doctors recorded 6.6 per cent. Marsh recorded "anxiety" in 3.9 per cent and "depression" in 6.8 per cent of contacts, whereas the Liverpool doctors recorded 6.0 per cent of

contacts as "anxiety" and 2.4 per cent as "depression". Antenatal care accounted for 2.9 per cent of Liverpool doctors' diagnoses compared with 5.8 per cent for Marsh, but they also recorded 3.4 per cent of diagnoses for contraception, an item not recorded by Marsh.

These figures suggest that workload studies from specialized practices may not be sufficient to make judgements about the overall provision of primary medical care in the community, and that much work remains to be done on the influence doctors themselves exert on shaping the demands of their patients.

LEN RATOFF
JOAN MUNRO
VALERIE F. HILLIER

363 Park Road
Liverpool L8 9RD.

Sir:

Your editorial, "How Many Patients?" (January *Journal*, p. 3) has added to the current controversy over medical manpower (*British Medical Journal*, 1977). The much quoted figures of Fry (1972) who has reported caring for 4,000 patients in his practice, and the more recent publication of Marsh and Kaim-Caudle (1976), showing surgery consultation and home visit rates of 1.9 and 0.4 respectively, have to be interpreted with caution. These are results from *individual* practices and despite the apparent fall in consulting rates in other practices, (RCGP, 1973) a number of questions arise:

1. Patterns of morbidity and patients' consulting habits are often drawn from practices where practitioners are members of the Royal College of General Practitioners. Are these doctors and practices truly representative?
2. To what extent has the fall in demand for general-practitioner services been related to the growth in deputizing

Table 1. Rank order of diagnostic categories according to percentage of diagnoses in each category.

Marsh <i>et al.</i>			Liverpool team			Liverpool doctors only		
Rank		%	Rank		%	Rank		%
1.	Respiratory disorder	25	1.	Respiratory disorder	19	1.	Respiratory disorder	23
2.	Mental disorder	14	2.	Prophylactic procedures	12	2.	Mental disorder	13
3.	Cardiovascular disease	12	3.	Mental disorder	11	3.	Prophylactic procedure	10
4.	Central nervous system including eyes and ears	10	4.	Central nervous system including eyes and ears	7	4.	Central nervous system including eyes and ears	8
5.	Musculoskeletal Digestive disorder	8	5.	Social problems	7	5.	Cardiovascular disease	6