LETTERS TO THE EDITOR

MEDICAL ETHICS

Sir,

I was interested to read the article by Drs Jones and Richards (March *Journal,* p. 137) and I wish to draw your attention to a matter in which issues of confidentiality and the protection of the individual are directly involved in relationship to computers.

I refer to the Notification of Birth (National Standard Computer System). This form, which is being adopted for national use but which has not yet been adopted by all areas, has the child's name, address, sex, time and date of birth, and also contains the mother's name, address, date of birth, and a statement of her previous live births, still births, abortions, and miscarriages. It thus contains potentially sensitive information without consent having been obtained from the patient and without the customary "confidential" notice on the form. Furthermore it does not identify the known groups at risk of genetic disease (for example Tay-Sach's disease—Ashkenazi Jews).

It appears that this form with its potentially delicate information might be suitable for coding, as is the Attitudes to Pregnancy Survey which the College is conducting. I hope to draw the attention of my colleagues to the potential erosion of individual liberty in which we may all unwittingly be involved.

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DISPENSARIES

Sir,

I am working on the history of outpatients and dispensaries and wondered if any of your readers would be able to help me as far as dispensaries outside London are concerned.

Apart from the short-lived Royal College of Physicians' dispensary (1696-1725), the dispensary movement really started with the Aldersgate dispensary in 1770, reached its peak in the late nineteenth and early twentieth century, lost a lot of impetus with the introduction of National Health Insurance in 1911, and finally died with the introduction of the NHS.

Apart from the Poor Law dispensaries, they were of two kinds. First there were the free dispensaries, supported by voluntary contributions like the voluntary hospitals (all the early ones were of this kind), and secondly there were the provident dispensaries, sometimes known as self-supporting dispensaries. The provident dispensaries, the first of which was founded in 1823, were institutions at which the poor above the pauper class made a regular weekly contribution and were able to receive medical care at the dispensary or at home if they were too ill to venture out of the house. The medical officers at these dispensaries were apothecaries in the period up to about 1850 and were then general practitioners, but in many dispensaries, particularly in London, honorary physicians and surgeons also attended at the dispensaries on one or two days a week.

Information about dispensaries in London is fairly easy to obtain, but there has been, as far as I can ascertain, relatively little published on dispensaries elsewhere, especially in the smaller towns. Rentoul (1887) lists 88 provident dispensaries in England, 30 of them in London, and Burdett (1893) in a table of the hospitals and dispensaries in the 34 largest towns in Great Britain and Ireland lists 45 free and provident dispensaries outside London, and 57 in London. Other sources of the same period give similar figures, but it seems almost certain that all these estimates are too low, probably by a large amount.

The dispensary movement served a large part of the population for more than 150 years and played an important role in the development of clinical care in this country. They were a source of income for some general practitioners, sometimes on a reasonable scale, though more often not, I suspect, and they were sometimes a source of strife within the profession, even although they probably worked smoothly most of the time. As such they form a fascinating and hitherto neglected part of the history of medicine, and particularly of general practice.

I should therefore be grateful for any information on provincial dispensaries —when they were founded, when they were closed down, how many patients attended each year or were registered at provident dispensaries, who staffed them as medical officers and how much they were paid, whether consultants held honorary appointments, and any other facts. On a number of occasions dispensaries that were originally free subsequently became provident, and occasionally a free and a provident system were run simultaneously in the same building (interestingly, this was said to be a recipe for disaster: I can imagine why) and I would be interested to hear of such examples. If there are records available, such as annual reports, I would hope to be able to travel to see them sooner or later, or, if they could be sent to me, I would happily refund postage, treat them with the greatest reverence, and undertake to return them safe and sound.

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EPIDIDYMO-ORCHITIS

Sir,

I was concerned by the letter from Dr Graham (March *Journal,* p. 185). Dr Barnes and colleagues (1974) classified epididymo-orchitis as gonorrhoeal, non-specific, or tuberculous, overlooking the fact that the majority of such cases are secondary to urinary infection (Blandy, 1976); but this classification does serve to dramatize the fact that such patients should always be regarded in the first instance as potentially having venereal disease.

Epididymitis complicates two per cent of cases of non-specific urethritis (King, 1972), and in a series of cases in which gonorrhoea was considered possible ten per cent proved to be gonococcal in origin (Furness, 1974).

Pelouze (1944) quoting Benzda's earlier study in German soldiers, described 53·4 per cent of cases of unilateral epididymitis, and 41·7 per cent of bilateral cases, resulting in sterility.

Epididymo-orchitis of venereal origin is not common, but is amenable to specific therapy. The blind exhibition of combined steroids and antibiotics can only be condemned as a bad example of treatment before diagnosis. Such cases should always be referred in the first instance to a venereology clinic. Such clinics offer the possibility of defining the aetiology and exclude other associ-

ated sexually transmitted disease. In Beilby's (1968) series of 58 patients with gonorrhoea, seven had coincidental herpes genitalis and one per cent condylomata accuminata (Barlow *et al.*, 1976).

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PULLED ELBOW

Sir,

I was interested to read Dr Hardy's description of the common condition, pulled elbow (April *Journal,* p. 224) but would like to disagree on a few points. His "disused forearm" is most appropriate but in my experience the position he describes is not characteristic—the arm is often held flat against the side—the most important feature being unwillingness to move the arm or have it touched.

I generally find gentle non-specific manipulation to be sufficient and painless—success, as Dr Hardy points out, being marked by a slight palpable click and rapid restoration of function. The condition, if missed, is usually cured by the radiographer who refuses to accept the existing position of the elbow joint and gently manipulates the arm till she can get an x-ray.

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WHAT KIND OF COLLEGE?

Sir,

Ever since my trainee days of 21 years ago, I have been greatly concerned about the future of general practice and the maintenance of its high ideals and standards, which I like to think have been reflected in my last ten years as a general-practitioner trainer. When I was first approached by the Royal College many years ago, I readily agreed to become an Associate, since it seemed to me that the College was what general practice needed if it was ever to be thought of as a specialty in its own right and not merely a member of the second eleven in the medical team.

Whilst I had always thought it perfectly possible, and indeed admirable at times, to practise a high standard of patient care from a small, cramped, ill-lit surgery with creaky floorboards and peeling wallpaper, four years ago I decided to strive for the Utopian ideal. And so, after two long years of disappointment, planning refusals, and local opposition, I began working in new purpose-built premises in April 1976, and a year later received the nod of approval from the JCPT, which is praise indeed.

However, after much hard work, one main problem has emerged. Expensive to build, the surgery is now expensive to run, so that to maintain even modest standards of general practice takes virtually all the practice income.

I suspect with hindsight that the profession's lack of knowledge about the problems of cash flow in running what amounts to a small business firm is due to the fact that in the past our seniors have thought it undignified to disucuss practice incomes and the exact cost of maintaining high standards.

Dr Irvine (March *Journal,* p. 146) describes three basic needs for the College membership, two of which are: first, support and encouragement from the College, and secondly, a good union to look after income and contract of service.

As far as I am concerned, patient demand and expectancy, and therefore workload, in medical practice have never been higher, but the doctor's financial expectancy has never been lower. The higher his standards, the lower his financial return becomes. The harder he works to provide expensive appointment systems and extra clinics for preventive medicine, with the extra staff and overheads that these entail, the lower his income will become. In fact, I was recently told by my practice accountant that after all expenses are paid, I am working for the enormous financial remuneration of £1 per hour!

I feel strongly that if the Royal College persists in striving for a 'Shangri-la' in general practice, with constant self review and assessment, then it should in future relate its aims more fully to a general practitioner's income and what the average doctor can reasonably hope to achieve. We do not have a benevolent Government and, as the Prime Minister said, doctors have no "political muscle". However, it seems clear that political muscle is what the College may need to acquire if it is to develop and achieve its aims, or leave them on the shelf forever.

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Sir,

I was recently at a faculty board meeting where discussions centred around the future of the College (March *Journal,* p. 142). One point that was raised was the inability of the College to attract established older general practitioners. Concern was also expressed at the failure to maintain the active interest of many of the vocationally trained new entrants to general practice, even when they have taken the examination. There appears to be a communication gap between the academic Valhalla and general practitioners who are attempting to practise in the real world outside Princess Gate.

To rectify this situation does not mean that there has to be a lowering of standards, objectives, or ideals. There should be an effort to convey to the general practitioners in the community that their College is constantly discussing and attempting to resolve problems that are faced by the average general practitioner. Unfortunately many of the efforts of the College have been lost in jargon.

Having just waded through Professor Marshall Marinker's Yorkshire Oration entitled "The chameleon, the Judas goat, and the cuckoo" (April *Journal,* p. 199) I fear that the gulf between the academics and the average general practitioner is becoming even wider. His thesis is good and few general practitioners would disagree with it. He maintains that common diseases are common; students would learn more about real medicine in the community than in the rarefied atmosphere of a medical school; and patients should be treated as whole people with emotional as well as physical problems. Unfortunately the message is lost in jargon, quotations, and references to obscure but erudite publications.

On reading the first section I was reminded of an interview that once occurred in Balham. A certain Mr Bluebottle was being interviewed at his forge, where he was employed putting the little holes in the end of toothbrushes. He told the interviewer: "Last week the highest of the highest came to