have one particular source of double think: if we isolate *Trichomonas vaginalis* we congratulate ourselves instead of increasing our search for gonorrhoea, since gonorrhoea and trichomonas are known to be associated.

We need Drs Wright and Palmer to repeat their experiment using the gonococcus. How long will it live in transport? Is 'Transgrow' a better medium than Stuarts? If we can get an answer to these questions we need a survey in general practice to find the incidence, so that we can make decisions on investigation and management of all patients. Meanwhile, should we at least be aware of the problem and attempt to diagnose gonorrhoea?

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## CORONARY DISEASE, HYPERTENSION, STROKE, AND DIABETES

Sir,

A subgroup of the College Working Party on Prevention has been set up to study prevention and anticipatory care of coronary disease, hypertension, stroke, and diabetes, and we are at present trying to draw up a working document that will review present evidence on what can be done, what general practitioners are doing now, what in fairly practical terms they might do in the future, and the new resources that would be required for this.

Although we know that much innovatory work is going on here and there all over Britain, little of it has been published, and there has not been much public discussion of the real problems encountered and opportunities revealed.

It would be extremely helpful if any doctors who have run or attempted to run their own hypertension or diabetes clinics, or who have organized or attempted to organize various forms of screening activity, patient education, smoking control, or any other forms of active outreach to the public at risk, could write to me outlining the main lessons they think they have learned from this. I cannot undertake to do more than acknowledge these, but our working group at present feels very ignorant of what our colleagues are doing.

It is all too clear what we are *not* doing, but if anyone wants to write about any outstanding experiences of this negative kind, that might be useful too.

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## ACCESSIBILITY OF PRIMARY CARE

Sir,

A number of local general practitioners have commented on the article by Dr P. L. Knox on 'The accessibility of primary care to urban patients: a geographical analysis' (March *Journal*, p. 160). We wish to bring the following points to your attention:

1. There are no health centres as indicated in Figure 2. These are long established 'local authority' clinics, where certain general practitioners hold branch surgeries.
2. In 1950 general practitioners' surgeries were mainly in their own homes, whereas by 1973 many doctors rented premises in a locality which suited their practice.
3. The time taken to travel one mile in Aberdeen must vary considerably between the central area and some of the peripheral council estates.
4. Kincorth is the area of Aberdeen with the most compact practice. The surgery facilities provide a high standard of team care. If patients from Kincorth choose to go to another practice, that is their choice.
5. The paper by Richardson and Dingwall-Fordyce (1968) which is quoted, counters the argument that a few practitioners have "an excessive load of long-distance visiting". Indeed the criticism that might be made of general practices in Aberdeen is the lack of zoning. The same study was used to gauge "the effectiveness of alternative locations for new resources" when the decision was made on the building of Denburn and Foresterhill health centres.
6. There seems to be a lack of knowledge of the pattern of general practice in Aberdeen, and it seems odd that Dr Knox apparently did not discuss his method or conclusions with any of the authors of previously published papers on practice geography in Aberdeen.
7. Dr Knox appears to have given insufficient consideration to the fact that general practitioners cannot realistically be expected to build premises in anticipation of their having a use in new housing schemes. These could never be economical unless initial practice allowances were available, and Dr Knox will realize that this would not be the case in Aberdeen where the average list size is so favourable to the patient.

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#### Reference

Richardson, J. M. & Dingwall-Fordyce, J. (1968). Patient geography in general practice. *Lancet*, **2**, 1290-1293.

Sir,

It may have taken an 'outsider' like Dr P. Knox to show in his article (March *Journal*, p. 160) that we may not be readily accessible to the patients who need us most.

Many patients are prepared to travel long distances to attend their general practitioners but these tend to be the ones who are coping with life satisfactorily: the more deprived members of society must have readily available surgeries.

The problem is most acute in the peripheral housing estates where there may be many problem families who, along with problems such as vandalism to surgery buildings, make these areas less attractive to general practitioners.

Branch surgeries in the peripheral areas are not satisfactory, as general practitioners remain emotionally committed to their central premises, and zoning is not popular with doctors or some patients. However, scattered surgeries create many problems for attached staff working in patients' homes and prevent integration of the practice with the local community.

Doctors must be attracted to these areas by high quality premises and adequate attached staff. 'Drafting' will only perpetuate a second class service.

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## HOME VISITING

Sir,

Congratulations to Dr Bailey and his colleagues on their article "Home