MEDICAL NEWS

CANADA—MAINTENANCE OF CERTIFICATION

The College of Family Physicians of Canada is introducing on 1 January 1980 a programme of maintenance of certification.

The College of Family Physicians of Canada believes that assessment and confirmation of certification of standards cannot be a once only event, and that the knowledge, skills, and attitudes of the certificated family physician cannot be viewed as a static state but require constructive monitoring by the certificant and the College to ensure the maintenance of the certification standard.

There are four components forming the basis of the maintenance certification: a profile of the individual physician's practice based on a system of sampling between 150 and 300 consecutive consultations during a four-week period; a pre-test consisting of 200 multiple choice questions; a feedback from the pre-test with reference to appropriate educational reading or resources; and finally, a post-test which will provide a reassessment of the areas covered in the pre-test which would allow the certificant to evaluate whether the education had been effective.

It is anticipated that the total programme will take about a year.

Reference

Rice, D. I. (1979). Maintenance of certification. *Canadian Family Physician*, **30**, 979-980.

UNIVERSITY OF DUNDEE

The Department of General Practice, University of Dundee, has moved to new premises in the grounds of Ninewells Hospital. The address is West Gate Health Centre, Charleston Drive, Dundee DD2 4AD and the telephone number is Dundee 66313.

The Medical School Teaching Practice now operates from the same health centre and its telephone number remains Dundee 68422.

CORRECTION

In the September issue of the *Journal*, Dr T. S. Eimerl was described as a General Practitioner, Sevenoaks; he should have been described as a Retired Medical Administrator.

In his letter on page 568 of the same issue, the first sentence in the fourth paragraph should have read: "Again, what do we know about the Manual intended to aid teachers of health workers to assess their performance as teachers?"

ABORTION

The total number of terminations notified under the Abortion Act 1967 in England and Wales during 1977 was 133,004, which was a rise of 2·6 per cent. The abortion rate per 1,000 resident women aged 15 to 44 remained virtually constant—being 10·44 in 1977 and 10·46 in 1976. The number of terminations to non-resident women rose by 9·2 per cent.

SRI LANKAN FAMILY PHYSICIAN

The first issue of the *Sri Lankan Family Physician*, the official publication of the College of General Practitioners of Sri Lanka, has recently been published.

MEDICAL WOMEN'S FEDERATION

The Medical Women's Federation has prepared a leaflet on *Partnership Agreements in General Practice*, which is available from Tavistock House North, Tavistock Square, London WC1H 9HX.

GRAVES MEDICAL AUDIOVISUAL LIBRARY

The Administrator of the Graves Medical Audiovisual Library wishes to remind members of the Royal College of General Practitioners that they may take advantage of reduced rates when hiring or purchasing tape-slide programmes. Reduced rates also apply when using the Annual Hire Subscription Service, whereby tape-slide programmes may be borrowed for as long and as often as required during the year.

Further details may be obtained from GMAL, Holly House, 220 New London Road, Chelmsford, Essex CM2 9BJ. Tel: (0245) 83351.

LETTERS TO THE EDITOR

SHOULD WE LOOK FOR GONORRHOEA?

Sir,

In his response to the letters by Dr Hull and Drs Wright and Palmer (December *Journal*, pp. 714 and 719), Dr Timson (July *Journal*, p. 433) raised several interesting points.

Gonorrhoea is now being reported more frequently from venereal disease clinics in Britain than at any time in the last 45 years, having risen from 17,538 cases in 1954 to 59,028 in 1977 (DHSS, 1979). The majority of women who have gonorrhoea are unaware of the fact. Seventy to 80 per cent are asymptomatic (Morton, 1977), which raises the question as to how such patients are diagnosed.

Nielsen and colleagues (1975) showed that 70 per cent of asymptomatic patients attend as a result of contact tracing, and complications bring a further proportion of patients to medical attention. Rees and Annels (1969) reported a 10·6 per cent incidence of salpingitis in gonorrhoea, and Barr and Danielsson (1971) reported a three per cent incidence of disseminated gonococ-

cal infection in women with gonorrhoea. Such patients represent a challenge to the medical profession in that they have progressed from early, completely curable, gonorrhoea to a later stage in which permanent structural damage to the body is often unavoidable.

Routine screening has often been proposed but Felton (1971) has shown that it would require 26,450 examinations to increase the discovery of female gonorrhoea by one per cent, and Rees and Hamlett (1972) found only two cases (both symptomatic) on screening 319 antenatal patients.

If the majority of women are asymptomatic, complications represent a medical failure, and screening is unhelpful, how are we to find the cases that are occurring? The answer is in screening women with symptomatic sexually transmissible disease (STD) for associated asymptomatic gonorrhoea.

Gonorrhoea is found in 46 per cent of women with trichomoniasis (Nielsen *et al.*, 1974), 12 per cent of women with warts (Kinghorn, 1978), one per cent of all patients with syphilis (Woodcock, 1971), 11·1 per cent of women with candidosis (Eriksson and Wanger, 1975), 12 per cent of female scabetics (Nielsen *et al.*, 1976), 28 per cent of all patients with pubic lice (Fisher and Morton, 1970), and 13 per cent of patients with herpes (Beilby *et al.*, 1968).

Barlow and Phillips (1978) reported 571 female patients with gonorrhoea, of whom 200 also had trichomoniasis, 107 also had candida albicans, 31 also had chlamydia trachomatis, 19 also had warts, 12 also had herpes, six also had phthiriasis, and four also had syphilis.

The message of these studies should be clear: if a woman had a symptomatic sexually transmitted disease she must be screened for asymptomatic gonorrhoea.

Investigation of women must include urethral, cervical, and rectal sampling. If only urethral samples are tested, 23·4 per cent of cases will remain undiagnosed, if only cervical samples are tested 10·3 per cent of cases, and if only rectal samples are tested, 61·6 per cent of cases will remain undiagnosed (Barlow and Phillips, 1978). If the rectal smear is omitted, 5·6 per cent of cases will remain undiagnosed (Bhattacharya and Jephcott, 1974).

Dr Timson is correct in stating that it would be logistically impossible to refer all cases of vaginitis to a special clinic, and many women would probably refuse to attend. This problem can be readily overcome. No responsible clinic would refuse to analyse properly collected material on behalf of interested family practitioners. An air-dried smear on a microscope slide and a transport medium should be prepared from each of the three sites. The most suitable transport medium for general practice is the Vi-Pak transport swab system which can be obtained from Exogen, 1967 Dumbarton Road, Glasgow G14 0HZ.

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Bhattacharya, M. N. & Jephcott, A. E. (1974). Diagnosis of gonorrhoea in women. *British Journal of Venereal Diseases*, **50**, 109-112.

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Fisher, I. & Morton, R. S. (1970). Phthirus pubis infestation. *British Journal of Venereal Diseases*, **46**, 326-329.

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Neilsen, R. *et al.* (1975). Asymptomatic male and female gonorrhoea. *Acta Dermato-Venereologica*, **55**, 499-501.

Neilsen, A. O. *et al.* (1976). Gonorrhoea in patients with scabies. *British Journal of Venereal Diseases*, **52**, 394-395.

Rees, D. A. & Hamlett, J. D. (1972). Screening for gonorrhoea in pregnancy. *Journal of Obstetrics and Gynaecology of the British Commonwealth*, **79**, 344-347.

Rees, E. & Annels, E. H. (1969). Gonococcal salpingitis. *British Journal of Venereal Diseases*, **43**, 205-215.

Woodcock, K. R. (1971). Re-appraising the effect on incubating syphilis of treatment for gonorrhoea. *British Journal of Venereal Diseases*, **47**, 95-101.

NIGHT CALLS IN GROUP PRACTICE

Sir,

Dr Morton (May *Journal*, p. 305) asks for a comparison of night calls from an urban area with his figures from a small town in Scotland. We are a three-doctor training practice half a mile from a major accident unit in a teaching hospital. We have a small list; in 1978 it was 4,904 (average of the four quarterly counts), with 405 joining and 378 leaving (turnover eight per cent). In that year 19 per cent of the patients were over 65 years old. We do all our own night calls and try hard not to admit patients with terminal illness to hospital. Nearly all the patients have occupations classified by the Registrar General in social classes three, four and five, and 99 per cent live in houses rented from the local council. Not surprisingly there are very few holiday-makers and temporary residents.

We keep a list of all night calls in order to check that the Family Practitioner Committee are paying us for all we do (they are). Using this list, I have made a retrospective analysis of the 102 night calls the three partners and the trainees made between 23.00 and 07.00 hours from 1 January to 31 December 1978. I divided the visits into the three groups used by Lockstone (1978) and Morton, adding two categories necessitated by incompleteness of retrospection. The results are shown in Table 1.

Table 1. Analysis of 102 night calls.

	Number	Percentage
Genuine emergencies	36	*35.3*
Irresponsible calls	0	*0*
Unnecessary but reasonable	34	*33.3*
No record in the notes	2	*2.0*
Died or left the list	30	*29.4*
	102	*100*

The rate of calls per 1,000 patients was 20·8 (Morton 15·9/1,000 and Lockstone 10·7/1,000).

I found it difficult to distinguish, in retrospect, a genuine emergency from an unnecessary but reasonable call. The complete lack of calls I would now deem irresponsible reflects more than anything my belief that exceedingly few patients are so malign that they will insist on getting their own doctor out of bed for something which they are sure is trivial (that being my interpretation of 'irresponsible').

The main conclusions I draw from these figures are that there is a high rate of illness in our patients and that—like workload in general—the smaller the