were either caused by, or exacerbated by, the lack of any one of us being responsible for a given patient and the absence of any continuing personal care.

How lacking in continuity were we? At one third of our consultations we found that the patient had seen another partner at their last attendance. However, my partners were not impressed by this information. What small disadvantages there might have been were the price to be paid, they said, for the cardinal principle that the patient must continue to have a choice of doctor. They were adamant. No change was possible; intensive research into organizational and legal aspects confirmed this, and one partner couldn't look after a personal list if the others didn't. Sadly for us all, I left.

Partnerships, sensibly, do not want to take in someone in their late forties, so my future was either in an academic post or in single-handed practice. I chose the latter which is, of course, the ultimate in continuing personal care.

Only a minority in group practice are committed to real continuing personal care and there is some evidence that it is decreasing (Aylett, 1976); so that the big question remains to be answered, the question which all evangelists face, why does not *everyone* see the light? It is an emotionally sensitive subject; such changes are threatening to many of us, and I cannot be as optimistic as was the lecturer in looking to the future. In both my report on the extent of personal care in Wiltshire (Aylett, 1976) and my paper discussing the pros and cons of separate and combined lists (Aylett, 1977a), my remarks about emotional prejudice were edited out but eventually published in *Pulse* (1977b).

Dr Adrian Rogers of Exeter (who has also changed his practice to one giving more personal care) once said that he doubted if the majority of us would make changes in our working patterns unless they were to bring financial advantages. May all of us who believe in more personal care hope that he is proved wrong.

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STUDENT INTEREST GROUPS

Sir,
The article by Drs M. R. Salkind and J. S. Norell (March *Journal*, p. 158) prompts me to write about a student group that met last year in Cambridge.

A voluntary activity during the second and third preclinical years in Cambridge is participation in an 'interest group' in social aspects of medicine. These groups are led by a behavioural scientist and a general practitioner.

A number of students who had been members of the interest groups and who were pursuing their clinical course in Cambridge decided that they would like to continue this kind of activity. They further decided that they would like to include within the group students of other disciplines related to medicine. A preliminary meeting was held and from it two groups were formed. The one of which I became a member (leader) was composed of four medical students, two physiotherapy students, one speech therapy student, a recently qualified occupational therapist, a voluntary social worker, a nurse, and myself. We met each week for nine months, with Christmas and Easter breaks. The second group met on a few occasions only.

The initial sessions were dominated by unrelenting criticism of hospital doctors, particularly consultants. In the absence of a consultant member of the group this criticism was in some ways unproductive. However, it did lead quite quickly to a group identity. We tried to base our discussion on patients that we (including myself) had encountered. The feelings of the individual members were expressed freely, and on occasion at considerable depth. The presence of other than medical students was invaluable, as they were responsible for day-to-day treatment of patients in hospital, as opposed to the medical students, who were supernumerary. I can recall for instance one of the physiotherapy students describing her feelings about treatment of a patient with severe (and fatal) lung problems. Several similar cases were discussed.

Later in the year, the group branched out into other activities, such as inviting a university counsellor (psychiatric social worker) to a meeting; on another occasion a patient with paraplegia came to talk about his problems.

We had two extra-curricula events. The group met in London for a meal and a theatre visit to the play "Whose Life is it Anyway?". We had an end-of-year punt party which ended at 02.00 hours. No-one could leave that particular meeting early without getting very wet.

The history of this multidisciplinary group has led me to believe that the earlier students of different disciplines meet to discuss their experiences the more chance there is of a lasting mutual understanding. An essential feature of this group was that it formed itself and was voluntary. How far it could become a more widespread activity is uncertain. However, it certainly seems worth further experiment.

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COMPUTERS IN GENERAL PRACTICE

Sir,
The idea of having a patient's full records flashed on the screen at a touch of a button, with rapid reference to all the possible side-effects of the drugs taken does sound attractive, but before the information can be retrieved it must first be typed into the memory at great labour and expense. In a group practice with 20,000 patients, some of whose folders are two inches thick, the task of transferring it all into the memory of a computer defies description. Considered as a national problem its impossibility must be quite obvious. Even in hospitals the changeover to computers has often been disastrous and had to be abandoned. There are many applications for computers in medicine: they are small and they are specialized.

The comprehensive application of computers to a nationwide electronic data network in which patients case records circulate is a beautiful dream in which we have all indulged ourselves from time to time; however, when the hard facts about the difficulty and cost of making it work are considered its total impossibility becomes obvious.

Love those medical record envelopes—we've got them with us for centuries!

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SPRING GENERAL MEETING

Sir,
The North of England Faculty and the Cumbria Sub-Faculty are extremely

sorry that some fellows, members, and associates of the College had difficulty in booking places at the Spring General Meeting.

It had been hoped that the January issue of the *Journal* would carry an insertion giving details of booking, but unfortunately it was not distributed as planned.

Once this became known, the College Officers had to choose between authorizing an individual distribution to the whole membership, which would have cost about £1,000, or waiting for the February issue and using that for the Spring Meeting insertion. The *Journal* publishing schedules were re-arranged to bring the February issue out several days earlier than scheduled. Unfortunately, members in Scotland, Wales and parts of the Midlands and Southern England did not receive insertions with this issue either.

The College Officers and staff therefore arranged for members in the areas concerned to be sent insertions individually and this was done.

The organizing committee of the Spring Meeting decided to extend the deadline for closing bookings by a week, and in addition held back a number of places to allow for applications from those areas which had twice been deprived of receiving application forms.

From the time of the first notice appearing, applications arrived thick and fast and the meeting was very heavily oversubscribed.

I can assure all members of the College that the Organizing Committee, consisting largely of members of the Cumbria Sub-Faculty, did everything in their power to nullify the obstacles which prejudiced the smooth running of the Spring Meeting and which were totally beyond their control. Many more applications for the meeting were received than places were available and the committee is extremely sorry that so many applications could not be accepted.

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BOOK REVIEWS

THE PRACTICING PHYSICIAN'S APPROACH TO HEADACHE 2ND EDITION

Seymour Diamond and Donald J. Dalessio

Williams and Wilkins Company Maryland, USA (1978)

154 pages. Price £11.50

C'est magnifique, mais ce n'est pas la guerre!

Headache is known to be one of the commonest symptoms from which patients suffer. Morrell and Wale (1976) have shown that headache is the commonest symptom experienced by women, and the vast majority of patients with headache do not even seek medical advice. When they do, however, general practitioners need a logical and systematic approach to the problem, since the chief difficulty is that while most headaches are probably due to tension or anxiety, others may be due to any number of other causes.

The practising physician's approach in this book turns out to be the practising neurologist's, which is perhaps not surprising as both Professor Diamond and Dr Dalessio are working in neurological clinics. In such a setting, their detailed and logical approach, concentrating as it does on the identification of serious organic causes of headaches, is valuable and useful. The writing is clear, the presentation attractive, and each section closes with a self-assessment section.

However, the book cannot be recommended for family physicians because the balance of the text is inappropriate, and tension states, which form the biggest single cause of headache in general practice, are virtually ignored. The give-away comes on page 94: "It is our contention that the typical, occasional, episodic 'tension headache', related to contraction of head and neck muscles, is relieved with over-the-counter medications, is associated with fatigue and temporary stress situations in life, and is rarely seen in a physician's office."

Some physician! Some office!

D. J. PEREIRA GRAY

Reference

Morrell, D. C. & Wale, C. J. (1976). Symptoms perceived and recorded by patients. *Journal of the Royal College of General Practitioners,* **26**, 398-403.

FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS. 11th EDITION

F. Dudley-Hart (Ed.)

John Wright Bristol (1979)

1,003 pages. Price £29.50

The stated aim of this book is "to help the clinician to be sure that he has considered all the disorders that might lie behind his patients' particular symptoms or physical signs." At first sight this is an attractive, if ambitious, proposition: I do not think that it has been achieved and I question the appropriateness of this aim, especially for family doctors whose skills encompass the use of probability in diagnosis and whose patient-centred approach to the practice of medicine runs, if not counter to, tangentially to analysis by signs and symptoms.

I do not wish to underrate the importance of accurate diagnosis but if such lists are to be helpful and to avoid creating a false sense of security they must be accurate and reasonably complete. I was disappointed to find that the four possible causes of drop attacks listed included no mention of Stokes-Adams attacks: an important omission. (They are described elsewhere, under the heading "Fainting-cardiac syncope" but this is of little use if the presenting symptom under consideration is a drop attack.) Likewise, "Limbs—lower—pain in" makes no reference to Osgood-Schlatters disease although brief mention can be found by using the index again somewhere amidst 16 pages headed "Joints—affections of". This section starts by listing 169 types of arthropathy classified into 14 groups. Surely the place for such detail is a textbook of rheumatology. There is a danger that important diagnoses will be lost amidst the rarities. In contrast, depression, which so often underlies symptoms, merits just one page.

Finally, while signs and symptoms may not change, I am still naive enough