recent meeting in the House of Commons. It is made up of sociologists and social workers, specialists in the field of alcoholism, an economist, doctors from various disciplines and members of Parliament. The committee does not intend to pin its hopes on any one answer. It feels that education of health and social workers concerning alcoholism should go along with teaching in the schools and a briefing of the population as a whole. This activity should prepare the way for more effective legal control over the price and availability of alcohol and its advertising.

The committee believes that alcohol may overtake tobacco as the main public health problem of the 1990s. The rate of alcoholism is increasing fastest among women and young people. The medical profession has three times the cirrhosis rate of the general population. The general practitioner is exceptional if he knows one in six of the alcoholics on his list. The chairman of this committee is Professor Eric Wilkes, of the Department of Community Medicine at the University of Sheffield.

JOINT COMMITTEE ON POSTGRADUATE TRAINING FOR GENERAL PRACTICE

The Joint Committee on Postgraduate Training for General Practice and the Royal College of General Practitioners have approved the Ayrshire and Arran Vocational Training Scheme. This scheme is recognized by the Royal College of General Practitioners for the purpose of the MRCGP examination.

MUSCULAR DYSTROPHY

The Department of Medical Genetics, University of Manchester, in association with the Muscular Dystrophy Group of Great Britain, will hold a one-day course on "The Clinical and Genetic Management of Muscular Dystrophy and Related Neuromuscular Diseases in Children" on Wednesday, 22 October 1980, in the Lecture Theatre, St Mary's Hospital, Hathersage Road, Manchester.

Further information can be obtained from The Welfare Secretary, Muscular Dystrophy Group of Great Britain, Nattrass House, 35 Macaulay Road, London SW4 OQP. Tel: 01-720 8055.

DENTAL HEALTH OF ADULTS

The dental health of adults in Britain has improved according to Volume 1 of a report on adult dental health conducted in collaboration with the Department of Health, University of Birmingham Dental School, for the United Kingdom Health Departments.

One simple yet useful indicator of dental health in adults is comparing the proportion of people of all ages who have no remaining natural teeth. Among people aged 45 to 54 in 1968, 41 per cent had no natural teeth, but in 1978 this had fallen to 29 per cent.

COMMUNICABLE DISEASE SURVEILLANCE CENTRE

The Communicable Disease Surveillance Centre of the Public Health Laboratory Service was opened on 11 July 1980 by Sir Henry Yellowlees, Chief Medical Officer, Department of Health and Social Security. This is the first national unit in a specialty of community medicine with service responsibilities to support local community physicians and others in the investigation and control of communicable disease through the laboratory services of the country.

The centre has three main functions:

1. Surveillance, that is, the collection of data on communicable disease, its analysis and interpretation to provide information and its rapid dissemination to all those who require it, enabling the rapid identification and control of cases and outbreaks of disease.

2. Disease control. Advice and assistance to those locally responsible for the investigation and control of communicable disease.

3. Teaching and training in communicable disease control.

CARE CALL

The Seton Group have introduced a new piece of equipment to help those caring for an elderly, disabled, or temporarily disorientated patient. It is called 'Care Call' and consists of a weight sensor, an alarm buzzer and beacon, and a call button. This can be placed under the castor of a patient's bed and can activate an alarm system as soon as the bed has been vacated, which may indicate that the patient is at risk.

Further information can be obtained from the Seton Group, Medlock Street, Oldham, Lancs.

PHARMACEUTICAL PROPRIETORS

The notional salary for pharmaceutical proprietors for 1979 has been confirmed as £8,565 per year.

Reference

Pharmaceutical Journal (1980). Notional salary for 1979. 28 June.

LETTERS TO THE EDITOR

From Dame Elizabeth Ackroyd

MEDICAL RECORDS

Sir,

I warmly welcome Professor D. Metcalfe's article, "Why not let patients keep their own records?" (July *Journal,* p.420).

The view of the Patients Association is, wittingly or not, laid on the line in that article. However, we have met nothing but counter arguments from the medical profession. I hope that Professor Metcalfe has more success, since he cogently answers all the points made by the opposition.

ELIZABETH ACKROYD
Chairman of the Patients Association

11 Dartmouth Street
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THE CONSULTATION

Sir,

It was interesting to read Professor P. S. Byrne and Dr C. Heath's article on non-verbal behaviour (June *Journal,* p.327), and also to have read the earlier work *Doctors Talking to Patients.* I am sure we can all recognize ourselves to a greater or lesser degree in the consultations which are quoted. Have we become so battle weary that we are simply

forgetting common civility and the basic rules of conversational etiquette?

M. THIRLWALL

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PREGNANCY DIAGNOSIS AND BACTERIURIA

Sir,

The opinion has been repeatedly expressed that, in general, urinary diagnostic testing in early pregnancy is an unnecessary extravagance. We have, however, found one advantage in obtaining urine specimens early in pregnancy as we have been able to screen them for bacteriuria. All urines submitted to our laboratory are in 'Boricon' containers (the boric acid preventing growth of organisms in the urine before culture).

Of the 9,970 urines submitted for pregnancy diagnosis during 1979, 3,874 (38.9 per cent) gave a positive pregnancy result. These positive pregnancy urines were cultured and in 283 (7.3 per cent) significant bacteriuria ($>10^5$ organisms/ml) was present. Midstream urine samples were requested from these 283 patients and 183 were received. Significant bacteriuria was present in 106 (58 per cent) of the second samples.

Therefore, although most pregnancy testing of urine can be described as an unnecessary extravagance, we can use the same specimen to facilitate early diagnosis of bacteriuria in pregnancy and perhaps prevent the subsequent development of acute pyelonephritis in some of those women.

E. D. S. MURRAY
Medical Assistant
Microbiology Laboratory
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Irvine
Ayrshire.

References

Millar, D. R. & Jarvis, G. J. (1980). Pregnancy diagnosis. *Lancet*, **1**, 875.

Ross, C. A. C. (1976). *Journal of the Royal College of General Practitioners*, **26**, 356.

HYPERTENSION

Sir,

May I draw your readers' attention to the General Practice Study of Hypertension in the Elderly of which I am the co-ordinator. This study, which is based so far on four general practices, is a long-term random control trial of the treatment of patients with hypertension in the age range 60-79. Patients sustaining systolic blood pressures $\geqslant$170 mm Hg or diastolic pressures $\geqslant$105 mm Hg over three examinations are selected on the basis of a total screening of the practice population at this age and, after certain exclusions, randomized into a control and treatment group. The treatment group are receiving atenolol (100 mg daily) backed by bendrofluazide (5 mg daily). Total mortality and cardiovascular morbidity are being recorded in both groups—and in those patients found to have 'normal' blood pressure.

The trial aims to include 600 patients in both the hypertensive groups. So far, 350 patients have been enrolled and we are looking for a few more practices who would be interested in joining. The first patients joined the study five years ago and there is a good adherence to trial protocol (85 per cent), with a mean reduction of 27 mm Hg for systolic and 13 mm Hg for diastolic pressure between the treatment and the control groups.

Anyone interested in the trial should write to me and I would be pleased to send them full details.

JOHN R. COOPE

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PERSONAL CARE

Sir,

I was interested to read two letters in the June issue of the *Journal*, one from Dr M. J. Faulkner-Lee (p.377) about 'fit-ins' and the other from my friend of student days, Dr Nigel Hester (p.378) about humility.

I will not dwell on the humility of the College as a body (although I agree with a good deal of what Nigel Hester says) but I do believe that the whole question of appointment systems and 'fit-ins' reflects the level of humility, or lack of it, among general practitioners. It seems to me that an appointment system which restricts the availability of doctors is a way of saying to the patient "I am a much more important and busier chap than you are and I really cannot have you disturbing the routine of my day by wanting to see me at short notice"; it also demonstrates a distinct lack of humility on the part of the doctor.

From the opening of our health centre in 1969, until five years ago, we worked an appointment system of this nature. However, it became apparent to us over that period, like Dr Faulkner-Lee, that this was not helpful to us, to the patients, or to the practice of good medicine. In 1975 we instituted our present system which is even more open than that which Dr Faulkner-Lee describes.

All four of us consult every morning from 08.30 hours onwards (with a communal coffee break for half an hour at 10.30) for as long as is necessary to see those patients who wish to see us on that day, and the afternoons are taken up with clinics of one sort or another. Appointments are made, not in order to restrict the availability of the doctors, but in order to reduce, as far as is practicable, the amount of time for which patients have to sit in the waiting room. Appointments may be booked in advance in the normal way and any patient who rings before 10.30 in the morning asking for an appointment will, if he wishes, be offered an appointment with the doctor of his choice on that day. Any patient ringing after 10.30 will, if he thinks his condition requires to be dealt with that day (and the decision is his, not the doctor's or the receptionist's), be offered an appointment with the duty doctor who is not necessarily the one he normally sees. About half a dozen patients attend this session, which is held at 17.00 hours each day. We encourage our patients to decide which doctor they wish to regard as being 'their doctor' and then encourage them to stick to him, and we find that this system gives patients the maximum opportunity to do this.

Since this system was started we have found that we very rarely see each other's patients except in cases of dire emergency and, of course, absence on holiday or sickness. Using this system we have a surgery consultation rate of 2.7 consultations per patient per year and this figure has decreased steadily over the last five years. In fact, despite an increasing practice population (our present list size is 11,000), our total consultations are dropping.

We find that this system works extremely well and is appreciated by the vast majority of patients, despite the fact that we hold no formal evening surgeries. I shall be very pleased to provide any more details should anyone wish them.

(I shall, of course, refrain from claiming that this demonstrates humility on our part!)

D. P. B. POUND

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