FREQUENT USERS

Sir,

I read the letter from Lord Taylor on this topic with considerable interest (November *Journal,* p. 698), but I must, with regret, take issue with him.

I did in fact follow up McGregor's pioneering work, but my technique differed from McGregor's because I used a sample population in preference to the whole practice. I argued that it would be cheaper and easier to use such a sample, and that, provided any bias in its construction was known, this could be allowed for in extrapolating the results obtained. I selected a sample of 500 people from the surgery attenders and followed each for a year, recording every contact in detail. In addition, each individual completed an intelligence and personality test. The system was called an 'artificial practice' because the population was not a random sample of the practice population and because psychometric testing is not part of normal general practice. Both factors might have introduced some unrecognized bias.

I calculated from the observations that in my practice 15·7 per cent of the real practice population would be responsible for 43 per cent of the total work, a result which is similar to McGregor's findings.

At that time, I worked with Mr James Pearson of the Department of Community and Occupational Medicine in the University of Dundee, and in response to my request that he should help me find an underlying pattern in the morbidity of the 'artificial practice', he demonstrated that the episode pattern was close to a negative bionomial distribution, a result which lends support to the 'proneness' hypothesis. We were able to go further because the proneness seemed to suggest system vulnerability, i.e. respiratory proneness, skin proneness, alimentary proneness and so on. It should be noted that recurrent illness was excluded from this part of the study in order to avoid a false result. We also demonstrated that when people had multiple episode patterns, one of the episodes was likely to be a serious condition and not necessarily related to the system involved in the recurrent part of the pattern.

A special study was made of those whom Taylor would call "multiple ailment heavy burden" patients, although I coined a different descriptive name for them. As a group their intelligence performance was poor and they had high neuroticism and introversion scores. This group also contained a larger number of young women and old men than one might expect to find by chance.

The study suggested a number of possible developments but I was sidetracked into a different area of research and will not have the opportunity to return to my original interests for another two years. However, it is clear that there is a need for much more study into the factors which generate need and demand for medical attention, and Taylor's plea for further research in this area should not go unanswered.

ALBERT JACOB

Duncraig
10 William Street
Dundee DD1 2NL.

References

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Lord Taylor was asked to comment on Dr Jacob's letter. He writes:

"I am sorry I missed Dr Jacob's papers on 'Multiple ailment heavy burden' patients. I was at that time moving to Canada and learning a new job. I must congratulate him on his good work. His finding of 'system vulnerability' is most interesting. I can confirm that, amid the multiple ailments, a serious condition often appears. Unless one is constantly alert, this can easily be missed in the welter of minor complaints.

My experience is that these patients are by no means necessarily unintelligent or introverted. I would expect to find a high neuroticism score, as Dr Jacob finds. But it is the combination of physical and psychiatric weakness which is so striking. Two further points: they seem to fatigue easily; this often, though not always, sets a limit to their achievement. They are also fairly often skilled at adapting themselves to the slings and arrows of outrageous fortune, which is just as well in view of what they have to put up with."

CATCHMENT AREAS

Sir,

I was interested to see your leader and geographical article (November *Journal*). I think the majority of patients who remain with doctors after they have moved do so through fear. They are afraid to change to a doctor that they don't know and have no confidence in should they have to see him in an emergency. I do not know whether this could be called "voting with their feet".

If we allow the organization of the NHS to be based on "better the devil you know" then it is indeed a bleak future. I am sure it is in patients' interests for us to try and educate people to use their local facilities unless they have good reasons not to.

CHRISTOPHER SLADEN

The Surgery
Llangennech
Llanelli.

KEEPING COPIES

Sir,

An aid to self-preservation as a National Service Medical Officer was to keep copies of all letters—from requests for more vaccine to copies of letters acknowledging receipt of receipts. The ploy could go on until one was posted elsewhere.

This habit has persisted in general practice. Letters received about patients are filed in their records chronologically, and if a letter contains no important information the top right hand corner is clipped off so that it is discarded when its immediate usefulness is past. When any letter is written about a patient the back of the most recent unclipped letter is used by the typist to make a carbon copy for future reference.

This proves that a letter has been typed on a certain date, and it can also give certainty that all relevant information has been passed on to a consultant—for example drug sensitivities or changes in medication. Equally, copies of letters written by another general practitioner often give a much more revealing picture of the patient's background than can ever be given by a consultant on the basis of a single interview.

Not least, keeping copies can be a valuable method of auditing a general practitioner's work, even if only a "do I pass on all the helpful information?"

variety of audit rather than the "how often right or wrong" type.

Copies of letters were made on behalf of hundreds of National Service Medical Officers; most business firms do it. A practice medical secretary employed to type letters about patients should make copies of what is typed.

G. A. C. BINNIE

7 Pedwell Way
Norham
Berwick upon Tweed
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DRUG DEPENDENCY

Sir,

Most of the people who attend Families Anon, all relatives of drug-addicts, have found that their general practitioners, although sympathetic to their problem, have little knowledge of referral agencies or treatment centres apart from the hospital-based drug dependency clinics (and these may have long waiting lists). General practitioners also appear to feel helpless in trying to support families of addicts. This, sadly, is common to many professionals, including probation officers and social workers.

Our introductory letter reads as follows:

"We would like you to know that a self-help group called Families Anon is meeting every Tuesday, from 7.00 to 8.30 pm at 84 Margaret Street, London W1.

It is the function of Families Anon to meet the needs of the relatives and friends of drug users. The group offers support and, where appropriate, advice and information to its members.

Please assist us by making our group known as widely as possible to those whom we may be able to help (and who may help us).

We can be contacted through Release on 01-289 1123. New members will also be welcome at our meetings, without prior appointment."

FAMILIES ANON

84 Margaret Street
London W1.

FOOD FOR THE COLLEGE FUND

Sir,

I can think of little which is more detrimental to good health than sitting around a restaurant table ingesting a great many calories and saturated fatty acids. A great many pharmaceutical companies invite doctors to partake in this habit.

I have recently begun to be highly selective in which invitations I accept, but rather than refuse all invitations completely, I have suggested to drug companies that they may like to make a donation on behalf of the Royal College Appeal fund. A great many practitioners refuse to accept such invitations on principle. I think it may be constructive to request that such money that the pharmaceutical companies wish to spend might be directed towards this charity rather than refuse completely. So far I have been able to channel £25 from CIBA and £2 from a medical survey group into College funds in this way.

A. P. PRESLEY

25 Park Road
Gloucester
GL1 1LJ.

INFORMATION WANTED

Sir,

The Central Information Service for General Medical Practice has been established for over three years. It provides information for all general practitioners—not just for members of the Royal College of General Practitioners.

We are frequently asked for evaluated information on equipment and are anxious to build up a file on this subject. It would be helpful therefore if doctors who have experience of, for example, ECG machines or Sonicaids, could write giving us details of performance so that other general practitioners could benefit from their experience.

JOAN MANT

Central Information Service for General Medical Practice
14 Princes Gate
London SW7 1PU.

INTERNATIONAL CLASSIFICATIONS

Sir,

The WONCA Classification Committee (consisting of 15 doctors from different countries) has developed a draft volume of inclusive and exclusive definitions of rubrics in ICHPPC-2. The Committee plans to carry out field trials of these definitions and is looking for volunteer doctors interested in coding. The trials will involve the volunteers in: (a) looking through the definitions and saying whether they think the volume would be useful; (b) using the definitions for a short time and deciding whether or not doing so is too time-consuming; and (c) deciding whether they would wish to use the definitions for coding overall or only for specific purposes. It is hoped that the trials will take place in mid-1981. Any doctors wishing to take part should contact me at the address below. The committee is also searching for printing errors in ICHPPC-2 (OUP £5), and I should like to hear about any such mistakes discovered by other users.

The Committee is also working on an international glossary of general practice terminology and, in conjunction with WHO, on a classification of reasons for contact.

The value of the reasons for contact classification and of ICHPPC-2 is that they are both internationally compatible and mutually compatible. Both also allow for the use of 'vague' diagnoses, and so avoid labelling illnesses for the sake of finding a code number.

Dates for trials of the reasons for contact classification are not yet finalized, but anyone interested in taking part should contact me. I shall keep interested doctors informed of developments.

W. M. PATTERSON
Journal Representative
Member of WONCA Classification Committee

"Finlandia"
1 Glenlockart Bank
Edinburgh 14.

COLLEGE ACCOMMODATION

Sir,

In reply to Dr D. S. Browne's letter (November *Journal,* p. 701) I should just like to say how much my family and I appreciate the hard work as well as the kindness and courtesy of the College staff, which make a stay at Princes Gate so pleasant.

I am sure there are many people, both at home and abroad, who would echo these sentiments.

JANET HENDERSON

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