

# LETTERS TO THE EDITOR

## MEMBERSHIP OF THE COLLEGE

Sir,  
Council has approved the report of the Board of Censors on obtaining and maintaining membership (see pages 521-524 and the reports of Council meetings in July, page 436, and this issue, page 563). This discussion document has been sent to faculty boards for consideration, but I should also like to bring it to the notice of all members, who are welcome to send me their opinion, as individuals, by 30 November.

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## SILICON CHIPS IN THE SURGERY

Sir,  
I noted that the widespread use of silicon chip technology in primary care was not considered in the College report on computers (*Computers in Primary Care, Occasional Paper 13*). I think it is important to discuss the developments being made by the silicon chip across its entire range, as well as that area specifically related to data bases. I also believe that most general practitioners' surgeries will have numerous silicon chip controlled devices well before the widespread introduction of medical record computers.

For example, one can look at the developments of the electronic sphygmomanometer. Early models were primitive and accurate but with a wide scatter of readings (Hunyor *et al.*, 1978), making them difficult to use to monitor blood pressure. However, subsequent advances in technology will mean that they will surpass the performance of the standard mercury sphygmomanometer by providing digital display of readings, thus avoiding observer bias, and by having the convenience of an automatic air exhaustion sequence. Certification reports will become mandatory in the USA; already the Food and Drug Administration (1980) have set a draft standard on electronic blood pressure devices of  $\pm 3$  mmHg accuracy, and this will provide a spur for technical excellence. Sadly, design is consumer-orientated, since general practitioners are usually the last to state their needs to

bioengineering departments. These modern devices are convenient, quick and accurate and patients may be taught to use them to take their own blood pressure at home. Drug compliance and general understanding of their disease should be improved.

Other medical equipment incorporating silicon chips and appropriate to primary care includes pocket spirometers, pocket alcometers (screening for alcoholism in general practice), electronic sterilizers, diabetic blood sugar monitors, ultrasonic stethoscopes (antenatal care), contraceptive control using intelligent 'rhythm method temperature' monitors, electrocardiographic transmission by phone, electronic weighing scales and automatic answering machines. Here is a trend for the future; I hope the Royal College of General Practitioners will not miss it completely.

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### References

- Food and Drug Administration Bureau of Medical Devices (1980). Standard for electronic or automated sphygmomanometers. Draft report. Document Control Centre, 8757 Georgia Avenue, Silver Spring, MD 20910.
- Hunyor, S. N., Flynn, J. M. & Cochineas, C. (1978). Comparison of performance of various sphygmomanometers with intra-arterial blood pressure readings. *British Medical Journal*, 2, 159-162.
- U101 Digital Sphygmomanometer Correlation Repeatability. Report available from Andrew Stephens Company, 41 Dickson Road, Blackpool FY1 2AP.

## ORTHOPAEDICS

Sir,  
In your Medical News Section of the June *Journal*, p. 374, you drew attention to Professor Duthie's report, published by the DHSS on orthopaedic outpatient waiting time.

I was surprised, therefore, that this pamphlet of 84 pages failed even to mention osteopaths and other manipulators, who see between 200 and 500 patients per day (I estimate) in Nottinghamshire alone. I was still more amazed that the pamphlet considered (on page 67) the possibility of creating a new specialty — orthopaedic medicine — while failing to acknowledge that this already exists and is beginning to flourish

despite every discouragement from the medical establishment. Doctors James Cyriax and Ronald Barbor developed a system of treating the moving parts by non-operative means in the late 1930s and have been perfecting it ever since. It is (I believe) extremely effective. Dr Cyriax's book *The Slipped Disc* was reviewed with interest in the May issue of your journal (p. 315).

I wonder if other doctors find it odd that a report whose *raison d'être* was to find a way of bringing speedier help to a huge backlog of non-emergency patients did not even mention these alternative sources of relief. If ever a document supported the contention that doctors ignore facts which might undermine their authority, then this is it.

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## THE GENERAL PRACTITIONER ACCOUCHEUR

Sir,  
I must congratulate Dr M. J. V. Bull on his Butterworth Gold Medal Essay (June *Journal*) for its depth, detail and enlightened approach. However, I would like to add the following points.

General practitioner involvement in obstetrics has decreased over the past few years by three factors not mentioned by Dr Bull. The first factor is the doctors' deputizing service. I noticed through the 'seventies that as young doctors qualified and went into general practice they found that they could use the deputizing service every night, which then restricted their day to 09.00 to 18.00. The only thing which kept them near a telephone at night was the fact that a midwifery case was hanging about. It was therefore a lot easier not to book any obstetric deliveries but to refer all these cases to hospital.

Although ancillary staff have become attached to primary health care teams, midwives have adhered to their own off-duty rota rather than make themselves available to the team. This means that, although a midwife can see a patient every week in antenatal clinic, there is no guarantee that she would actually be the midwife present at the delivery in the GP unit or on the district rota.