LETTERS

The College and Nuclear War

Sir,
The Council of the RCGP was right to advise the President not to attend the Cambridge Conference on the medical aspects of nuclear war. There was a distinct possibility that the Conference was being organized for ulterior political motives and that a resolution promoting, for instance, unilateral disarmament might have been passed. The College in the person of its President would then have appeared to be taking a particular political line which may well have been very unacceptable to a significant number of Members. It was for this reason alone that the Council gave its advice.

Now that the Conference has taken place the College is in a position to formulate its own policy with regard to the prevention of nuclear war and it would seem appropriate now that such a debate should take place.

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General Practice Obstetrics

Sir,
There can be no doubt that shared care and no general practitioner care are on the increase at the expense of total general practitioner obstetric care. In our practice (Nicol, 1981) total care remained at a steady level of 80 per cent of all pregnancies until 1973. By 1980 it was 46 per cent.

It is obvious that a fall as steep as this, if allowed to continue, will lead to zero total general practitioner care (an exercise in extrapolation which anybody can have a go at with a piece of graph paper and a pencil), let us say by 1995.

What I find difficult to accept is the implication in the report published in the *Journal* (February, p 116) that seven out of eight pregnancies and confinements require either total or partial consultant care.

There are a host of reasons for referral, but one which is insufficiently aired is that lack of practice in obstetrics leads to lack of confidence, and ultimately to fear. The young doctors of today who come into general practice with their DRCOG and six months' hospital training in obstetrics are going to find it very difficult to maintain their skills, especially when only one in eight of the United Kingdom's total confinements are coming their way. I therefore welcome this report and hope that it will help to rejuvenate general practitioner obstetrics.

The section on continuing education in the report and on the maintenance of skills is very important. I would like to ask one further question. When will scanning facilities be available to all general practitioners performing antenatal care? If I wish now to confirm a diagnosis of multiple pregnancy or ascertain the maturity of the fetus I can x-ray the patient with no difficulty at all. But if I wish the patient to be scanned, which is far safer for her, I have to refer her to a consultant. Why are scanning facilities not available to general practitioners except through a consultant?

Perhaps the nonavailability of scanners to general practice could be taken up by the Royal College as one of their next discussion points on the subject of obstetrics?

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Reference

Nicol, H. G. (1981). Culling quietly. *British Medical Journal,* **283,** 1091-1092.

Cervical Cytology and Computerizing FPC Registers

Sir,
It would be a pity to miss the opportunity provided by the computerization of Family Practitioner Committee registers to include an efficient initial call re-call system for cervical cytology screening in general practice.

The FPC list of patients is very comprehensive and accurate and I think that it would be more efficient and reliable to initiate the names of patients to be called for initial smears and recall for follow up smears at the FPC level rather than at individual practice level. There is also a strong case to be made for integrating the data on abnormal smears at present kept in cervical cytology laboratories (in manual retrieval systems, I suspect) into the FPC computer.

There can be little doubt that an intensive screening programme is associated with a fall in the death rate some years later, although the report of the Canadian task force (the Walton report) concluded that it was not possible to prove or disprove the part screening had played in the observed decline in incidence of carcinoma of the cervix, but that the relationship between screening and the decline was striking. Despite the small numbers, where intensive screening was introduced in the Tayside and Grampian areas in 1960, there has been a decline in mortality rates. Despite doubling in death rate in the under 35 age group between 1966 and 1976 elsewhere in the country, in the Tayside and Grampian areas there have been no deaths in this age group since 1972.

I doubt that financial considerations play any significant part in the decision taken by general practitioners to take a cervical smear or not. Half the smears taken already are not eligible for any payment and the money from cervical cytology at present represents less than 0.1 per cent of typical practice income. Financial arrangements are, however, important in principle if not in practice. As the general medical services for which a general practitioner is contracted to provide specifically do not include screening procedures or health education, payment for a screening programme would have to be funded separately.

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Repeat Prescription Registers

Sir,
Professor Drury kindly refers to our article on the repeat register (Pickworth and Melrose, 1972) in his review of literature relating to repeat prescribing (January *Journal,* pp. 42-45) (although the card displayed in Figure 3 is not from our system), and he describes it as a major disadvantage of the register that the doctor will not have the latest information when consulting.

In addition to the register in the reception area, our system involves the use of a drug card in the notes. This displays the names of drugs prescribed, and records the date when the patient was last reviewed, as well as that beyond which prescriptions will not be issued without further consultation. The register card, normally kept at reception, is placed in the hands of the doctor whenever he or she signs a repeat prescription, and it bears the dates of all previous 'repeats'.

It is these dates which are not ordinarily before the doctor at consultation, and, although he sees them regularly whenever he signs a 'repeat', and may even remember the last one, we agree that this may be regarded as a disadvantage in the system, especially if other partners are seeing a patient. A remedy would be to extract the register card and place it with the notes when any appointment is arranged. On the other hand, the repeat register cards are kept at reception so as to be instantly available, and access to their information can be provided for the doctor very quickly.

Our system has operated in our six-doctor group practice since we suggested it in 1972, and we think it has stood the test of time very well. The most important feature which we found necessary was that when a doctor included a patient in the system, he or she alone was then responsible for signing the 'repeats' and for review consultations after a period usually not exceeding six months. The personal commitment of doctors to patients 'on repeat' in our shared-work group has meant that the drawback which Professor Drury describes as a major disadvantage has given us no trouble, and the above remedy has not been required.

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Reference

Pickworth, K. H. & Melrose, W. M. (1972). Repeat prescriptions. Safety and control. *Update*, **4**, 961-962.

Repeat Prescribing and Consultation Rates

Sir,

Professor Drury (January *Journal*, p. 42) discusses the likelihood of indirect repeat prescribing having increased during the last decade, when consultation rate remained relatively static.

There is powerful evidence from nationally representative studies to suggest that this has happened; otherwise the consultation rate would have been substantially greater than it is (Billsborough, 1981a). As well as showing that the consultation rate has remained relatively static during the 1970s, the study of OPCS data to which Professor Drury refers identifies important differences between trends in consultation rates of people of working age and over (Billsborough, 1981b). Among people of working age, the consultation rate shows little change during this period, but for older people the rate fell substantially, due to downward trends of similar magnitude in both attendance and visiting rates.

This suggests that people over 65 years of age have either experienced a considerable change in morbidity during the last decade, an unlikely event, or that services previously provided by the general practitioner during a direct consultation, either in the surgery or the patient's home, have been obtained by some other means, possibly by requesting an indirect repeat prescription.

Although there was little overall change in the use made of repeat prescriptions during the 1970s, the comparison of two reliable nationally representative surveys by Anderson (Dunnell and Cartwright, 1972: Anderson, 1980) provides good evidence that the proportion of repeat prescriptions issued indirectly did increase, by about 50 per cent, a value of similar magnitude to those cited by Professor Drury.

These observations are consistent with the observed trends in consultation rate. The over-65-year-old age group is the one which includes the greatest proportion of people on long-term repeat regimes and an increase in indirect repeat prescribing would be expected to lead to a decrease in both attendance and visiting rates to this age group.

About one-third of adults receive repeat prescriptions and one-quarter are on a long-term repeat regime. The repeat prescription is the only way of providing continuing medication to the population and without indirect repeat prescribing there would need to be a substantial increase in consultation rate. The general practitioner alone provides this essential service and the points raised by Professor Drury are well worth careful consideration.

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References

Anderson, R. M. (1980). The use of repeatedly prescribed medicines. *Journal of the Royal College of General Practitioners* **30**, 609-613.

Billsborough, J. S. (1981a). Consultation rates drop, but workload still grows. *General Practitioner*, 3 April 1981.

Billsborough, J. S. (1981b). Do patients consult the doctor less often than they used to? *Journal of the Royal College of General Practitioners*, **31**, 99-105

Dunnell, K. & Cartwright, A. (1972). *Medicine Takers, Prescribers and Hoarders*. London: RKP.

Computers in Practice

Sir,

Bias is subjective. An atheist would call an evangelist a bigot (and vice versa!). Bias is not necessarily detrimental. As a doctor, I am biased towards the promotion of health in patients who consult me.

I am happy to reply to the letters commenting on the article "Computers in general practice: the patient's voice" (November *Journal*, pp. 683-685).

The preamble to the questionnaire contained two paragraphs. The first paragraph lists the advantages of using a computer, both for the patient and for the doctor. The second lists problems that have been voiced against their use.

The questions were designed to be those that an average patient might ask him/herself if he/she heard that his/her general practitioner was using a computer.

We would all agree that patients (and that includes ourselves) do not think or act logically or rationally much of the time. There are plenty of studies demonstrating that. The 'average' patient has probably little idea of what a computer can or cannot do. But this 'average' patient hears stories in the media that computers 'make mistakes' or can 'leak' information. It is not beyond belief therefore that such patients may be reluctant to confide in their general practitioner should they hear that 'he/she has a computer'.

Why, then, are we doctors not more sensitive to our patients fears and beliefs? Why are we persistently arrogant in assuming that what is good for us administratively is necessarily good for our patients? In any case, have computers proven to be of value to our patients? The practice to which I was attached as a trainee did not have a computer but undertook screening programmes for hypertension and cervical cancer and was exceptionally secure financially. Is this a 'grave handicap', (March *Journal*, p.195) Dr Minwalla?

It is just not true to state that computers are not used for storing patients' records nor that they are never linked outside the practice. Some are, some are not. Do patients know which practices are linked to a central computer outside the practice?

So then, I await with interest a similar study undertaken in a neutral practice with an 'unbiased' questionnaire, and let us then discuss the results.

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