occupationally related diseases, it is all too easy to miss the clues and forget to ask the vital question: "What is your occupation?", and fail to interpret the significance of the reply.

I suggest our College is ideally placed to fill this gap in continuing education through the GP training schemes, and I hope this letter will stimulate the consideration of an occupational health content in general practitioner trainee schemes.

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An Occupational Health Service for the NHS

Sir,

I was particularly interested in the observation by Drs Allibone, Oakes and Shannon (December *Journal,* pp. 728-734) that hospital doctors were in favour of routine medicals and an occupational health service. I naturally support the setting up of an occupational health service in the NHS, but until occupational health physicians are given the status they require to advise both seniors and juniors amongst the medical staff, it is unlikely that the best qualified candidates will be attracted to NHS posts.

Routine medical examinations are a controversial point. I am sure that we continue to believe that they are of much value. I have spent much time during the past two years weaning executives away from their yearly 'service'. I make an exception for the monitoring of blood pressure and urine. Hypertension and diabetes are detectable early, respond well to treatment and such medication appears to reduce the wastage in late middle age which occurs if these conditions are not treated. Such intervention can be shown to be advantageous to the organizations employing the patients. I am far from convinced that routine medical examinations or batteries of laboratory tests have any real contribution to make in promoting health or detecting pathology, except in certain well-recognized conditions.

I am, however, a firm believer in selecting those groups of workers who are likely to be subjected to known or suspected hazards and screening them at appropriate intervals. This is of value as has been shown in pneumoconiosis, oil-induced skin lesions, heavy metal toxicity and noise-induced hearing loss. Doctors are subjected to a variety of hazards both infectious, chemical and psychological, but it is incumbent upon us to select those most likely to be at risk and monitor them carefully.

The most valuable contribution that can be made to doctors' health would be the setting up of a competent and professional occupational health service available throughout the NHS to all employees regardless of grade. The expertise is available and the desire is there, but it appears that our political leaders have yet to be convinced of the value of such a facility.

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Towards a Computerized Primary Care Index

Sir,

I was encouraged to learn in your editorial "Computerizing FPC Registers" (February *Journal,* p. 67) that the DHSS have endorsed the computerization of registration work undertaken by FPCs.

The majority of the fifteen Scottish Health Boards have committed themselves to a computerized Primary Care Index (PCI), using common software developed by Tayside Health Board, as have Salford Area Health Authority and DHSS (Northern Ireland). Morale has risen considerably in those primary care administration departments where conversion from manual to computerized records has been completed. In the interests of integration, compatibility, standardization and economy, one national UK system would have been ideal, but unfortunately, this is already a lost cause.

What of the implications for the general practitioner? Age/sex/address registers should be available, on request, at appropriate intervals, from the primary care/FPC administration. It is likely, however, that requests for other facilities will be accorded low priority and will thus be subject to unacceptable delays.

The most significant benefit will accrue to those general practitioners who invest in a practice computer, but there will have to be many changes in attitude and financing before networks evolve between practice, administration, hospital, laboratory and third-party computers.

At the moment, any practice procuring a computer has the daunting and lengthy task of keying in by hand all basic patient details. Delays can be avoided by the computerized primary care/FPC administration, who will be able to issue relevant patient data, initially by floppy discs mailed through the post, but eventually by direct computer intercommunications.

The notion of a working age/sex/address register on the first day of computer installation will act as a considerable incentive to many general practitioners who are discouraged by the prospect of the current obligatory upheaval. It is these same general practitioners who must be recruited before large-scale computerization of primary care becomes a reality.

In the meantime, existing zealots would do well to promulgate the merits of a computerized primary care index for general practice, at local and national level.

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RCGP Oral Contraception Study

Sir,

In June 1968, together with many other doctors, I agreed to take part in this study. From the women in my practice, I recruited 28 takers of the pill and 28 matched controls.

Of the 28 takers, only one is still taking the pill. Of the controls, two became takers and three further controls were recruited. Of these 31 controls, 20 have left the practice, leaving one taker and 10 controls.

Of the original 28 takers, 14 have left the practice and 13 have stopped taking the pill for the following reasons: two have had hysterectomies; three husbands have had vasectomies; four women have reached the menopause; four women decided against taking the pill.

Altogether this leaves only two takers and 10 controls. This is supposedly a study of oral contraception. We continue to feed in data, and reports still appear, but I now question the validity of our information.

Are the figures from my practice representative of others, or are they freakishly different?

If they are representative, is it not time we stopped this study?

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