identify families in which affected males have been born so that the carrier females may be offered counselling and amniocentesis at the appropriate stage.

I would be interested to hear from practitioners who have affected families in their care.

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References

Brown, W. T., Friedman, E., Jenkins, E. C. *et al.* (1982). Association of fragile X syndrome with autism. *Lancet,* **1,** 100.

Gardner, A. P., Howell, R. T. & McDermott, A. (1982). Fragile X chromosome: consistent demonstration of fragile site in fibroblast cultures. *Lancet,* **1,** 101.

Jenkins, E. C., Brown, W. T., Duncan, C. J. *et al.* (1981). Feasibility of fragile X chromosome prenatal diagnosis demonstrated. *Lancet,* **2,** 1292.

Lejeune, J. (1982). Is the fragile X syndrome amenable to treatment? *Lancet,* **1,** 273-274.

Lejeune, J. (1981) *Métabolism des monocarbones et le syndrome de l'X fragile. Bulletin de l'Académie Nationale de Médecine,* **165,** (session of Dec. 1 1981).

Lubs, H. A. (1969). A marker X chromosome. *American Journal of Human Genetics.* **21,** 231-244.

Royal College of General Practitioners. (1981). *Health and Prevention in Primary Care. Report from General Practice 18.* London *Journal of the Royal College of General Practitioners.*

Shapiro, L. R., Wilmot, P. L., Brenholz, P. *et al.* (1982). Prenatal diagnosis of fragile X chromosome. *Lancet,* **1,** 99-100.

Sutherland, G. R. & Jacky, P. B. (1982). Prenatal diagnosis of fragile X chromosome. *Lancet,* **1,** 100.

Turner, G., Daniel, A. & Frost, M. (1980). X-linked mental retardation, macro-orchidism and the Xq 27 fragile site. *Journal of Pediatrics,* **96,** 837-841.

Smoking and Health

Sir,

Since I retired from the DHSS I have involved myself in the counselling activities of the National Society of Non-Smokers and have joined its committee. During the first twelve months of operation of the Society's walk-in Advisory Centre at Latimer House, we have been approached, either personally, by telephone or by letter, by over 10,000 people wishing to give up smoking. Many did not look upon their family doctor as a likely source of assistance; others, although often motivated to stop smoking by medical advice, received little help in doing so. I doubt that the proportion of general practitioners in London who feel that they should have a major involvement in efforts to curb smoking approaches the 74 per cent found in Oxfordshire (March *Journal,* pp. 179-183), although their number may have been increased by the recent distribution of 'GUS' kits prepared by the Health Education Council.

To quote the College's Working Party on Prevention, "Smoking may require the taking of a careful history, like any other complex and important disorder whose course one wished to change." (RCGP, 1981). Our clients vary widely in the amount of support they need. The General Household Survey in 1980 found 28 per cent of men and 14 per cent of women to be "ex-regular smokers" (OPCS, 1981); many must have stopped without outside help. For some a 30-minute interview and one of the HEC's excellent booklets have sufficed but others have relapsed even after a structured course such as the "5-Day Plan" first developed in the UK by the British Temperance Society. Our experience convinces us of the need not only for weekly smoking advisory clinics of the kind so far run by a minority of Health Authorities but also for walk-in centres, manned by volunteer ex-smokers and open during normal working hours, such as we are pioneering here.

More research is needed into methods of helping people to give up smoking and on how to match the method to the person. The Society is planning a 12-month follow-up of its clients in co-operation with a research team from a London teaching hospital; dare I hope that a College Faculty will turn its attention to a similar investigation?

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References

Office of Population Censuses and Surveys (1981). *Cigarette smoking 1972 to 1980. OPCS Monitor GHS 81/2.* London: OPCS.

Royal College of General Practitioners (1981). *Prevention of Arterial Disease in General Practice. Report from General Practice 19.* London: RCGP.

Sir,

Further to Dr Cooperstock and Dr Thom's article on health, smoking and doctors' advice (March *Journal,* pp. 174-183), I feel that the authors have missed out a very common cause for not giving up smoking. This is that patients are very concerned about putting on weight. This is particularly so with female patients. On asking them, many women have at one stage given up smoking only to find that they put on pounds. I think the only way to combat this is that dietary advice must always be given when counselling female patients to give up the evils of tobacco.

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Hypertensive Drugs and the Quality of Life

Sir,

The article by Dr Jachuck and his collegues in the February *Journal* (p. 103), in which they report the more unfavourable assessment by relatives of the quality of life of a patient on hypertensive drugs than that given by either the patient or the physician, will be of concern to all those interested in screening for hypertension and the management of hypertensive patients.

It would be very interesting to know whether this observation is specific for patients being treated with hypertensive drugs or whether patients with a number of conditions give a less favourable impression to their families than they do to their physician.

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Dr Jachuck replies as follows:

To the best of my knowledge, a three-dimensional assessment involving clinicians, patients and relatives to evaluate the effect of therapy on quality of life had not been reported before. However, in our article we did mention that the QLIS was used in a group of patients following neurosurgery. We have completed a similar study in patients after certain clinical interventions (to be published) and the pattern of response is different to that of the hypertensive patients.

Primary Care Around the World

Sir,

Dr C. A. Pearson's letter in the December *Journal* (p.761) interested me greatly and I want to support his plea for

doctors to go out to Nigeria to help in the general practice training centres and in providing primary medical care.

I went to Nigeria in 1956 to organize and run the General Outpatient Clinic at the new University College Hospital, Ibadan, the first teaching hospital in the country. The clinic was organized on the lines of a large—very large—general practice health centre and became known as the GP Clinic. There were six house officers, in present day terms trainees and assistants, and medical students attended at different times in their clinical course. While this set-up was useful as a start it was not, of course, adequate training for primary care in the rural areas and we had to get additional facilities away from the hospital.

In 1961-62, in conjunction with the Departments of Medicine and Social and Preventive Medicine, the expansion was planned of an existing clinic in a suitable area by the addition of a small community hospital, quarters for senior medical staff, trainee medical officers, medical students and also health visitors, nurses and midwives. I left Nigeria in 1962, so to my regret I did not see this scheme completed, but after nearly twenty years it appears to have borne fruit. It is good, too, to see that there is now a separate Faculty of General Practice which is, I think, essential for GP training. It is an exciting prospect.

As far as the individual doctor from this country is concerned, I am sure that he or she will never regret a spell of work in West Africa. The clinical experience is vast. Though facilities are often inadequate and shortages of all kinds are frustrating, there is the satisfaction of trying to cope with the large numbers needing help—and on returning the GP will appreciate the facilities of our much criticized National Health Service.

K. COBBAN

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Patients who Change Practices

Sir,

Patients who leave the practice can be divided into many groups. The group I wish to consider are those who leave for "the practice around the corner" without obvious cause. The possible causes are legion, probably multiple in many cases and may even be difficult for the patient to define.

I am prompted to write now by such a transfer of a woman patient; the motivation for it is a complete mystery to me and indeed somewhat wounding. A letter from the consultant to whom I had referred the lady recently came complete with a copy for the neighbouring doctor and was the first indication I had had of the existence of a problem between us. A review of her notes and those of her family failed to bring to mind any clues; indeed they are for the most part infrequent attenders.

It is not my intention to complain in these august columns, but rather to suggest that a form of audit applied in these circumstances might be of use to patient and doctor alike. I suggest that when a patient transfers "round the corner" both the patient and the doctor be invited, diplomatically, to comment on the events leading to the transfer, such comments to be considered by an independent third party, perhaps the Family Practitioner Committee. This would lead I believe to much useful and perhaps even critically important information being unearthed about mismanagement, negligence, malpractice, unrealistic expectations and so on.

The present situation lacks utility or virtue in any respect and should be changed. There is an opportunity here to make a worthwhile contribution to the standards of primary care, and I look forward to hearing the views of others on this topic.

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The College as Host

Sir,

I was very pleased to see the note (July *Journal,* p.447) describing the dinners held at the College by the St. Mary's and St. Charles' vocational training schemes. The College house in Princes Gate almost always receives compliments from those who visit it for the first time. The more it is used by Members and others the better—whether for medical or social occasions.

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POSTGRADUATE EDUCATION

TOWARDS THE MRCGP

A course held at the Royal College of General Practitioners, February 8—12, 1982

THE four Thames Regions were asked to provide tutors for this course, which had first been successfully held one year previously. In the event, Dr James Scobie from the South London Faculty and Dr John Dymond from the S.W. Thames Faculty volunteered to run the course together.

Introduction

This was a residential course, held at the College, for those candidates who had failed the MRCGP examination and wished to prepare for it again. All those candidates who failed the exam in 1981 and who wrote asking for details of their marks, were sent details of the course and eventually 19 attended. The organizers invoked the help of several other tutors: Dr Gregor Bartlett, Dr Andrew Belton, Dr Ben Essex, Dr Graham Hornett, Dr Alistair Moulds and Dr Douglas Price.

The aims of the course were for the participants to attempt to identify the areas in which they were weak and unprepared, and to compile a strategy for filling these gaps. It was not intended that the five days spent at the College would in itself do anything more than set the candidates on the right lines for future work. When the course began, inevitably a degree of anger was expressed by many course members against the whole concept of the College, the exam. and the examiners. The members were allowed to bring these anxieties and conflicts out into the open and to express their anger.

The Participants

It was apparent that there was a wide range of knowledge and ability among the 19 course members. Some doctors