teaching, but the main purpose of the council is to get far more people in Britain knowledgeable about what to do when someone collapses apparently dead.

Faculty Boards and their officers may like to note the address (Department of Anaesthetics, Royal Postgraduate Medical School, Hammersmith Hospital, Ducane Road, London W12 0HS) if they want any help in teaching their members how to teach the public.

What is *Relaxation for Living?*

This registered charity was set up to promote the teaching of physical relaxation to combat the stress and strain, anxiety and tension of modern life and to reduce fatigue. There are day and evening classes at weekly intervals. The numbers are kept down to about eight in a class. For pupils unable to reach a teacher, a correspondence course is available. Seminars are designed specially for businesses and colleges. The organization is expanding as it trains more teachers, and regular open study days are held for teachers, professional and social workers on a wide range of subjects connected with physical relaxation. There is a quarterly newsletter.

One of the vice presidents is Dr K. M. Hay, FRCGP, of 2 Greswold Park Road, Acocks Green, Birmingham B27 6QD.

LETTERS

Computers

Sir,

I have been reading with interest about the growing involvement of general practitioners in Britain in the use of computers and microcomputers. In the United States, computer systems have been widely used for some years in multispecialty and large group practices, mostly for billing and accounting services. The systems have included demographic, insurance, diagnostic, and item of service information, as well as laboratory data. Increasingly, as the hardware becomes cheaper, these systems are run as an in-house operation and more physicians are participating in programming planning.

The stage has now been reached in terms of interest, technology, and financial acceptability, for small groups of doctors to run in-house computer systems, and many family physicians have developed microcomputer systems which do the following: automatied billing; automated reminders for immunization, pap smears and routine health checks; diagnostic/age/sex profiles, laboratory test ordering profiles; automated labelling and addressing; and patient education materials (word processing). These systems (hardware and software) now cost between $600 to $10,000.

In the US there is the additional potential of using telephone lines (through a modem) to access national data systems, particularly medical information systems.

Microcomputers are also excellent tools for education and, possibly, continuing education. Computer assisted instruction, simulations and patient management problems are being developed in primary care training programmes.

Several problems are putting a damper on the astounding growth of these systems. Firstly, physicians often have difficulty in accepting this technology, and computer 'literacy' is an important aspect of the acceptance of these machines by the profession. Fortunately, many doctors here are being helped and taught by their teenage (and younger) children, who seem to have no qualms about the future.

Secondly, innovation and upgrading of hardware (particularly increased computer memory) are occurring so rapidly that it is almost a full-time job to keep up with them.

Thirdly, there has been an explosion in medical microcomputer software, with which it is again difficult to keep up. Furthermore, these software programs cannot be evaluated without being purchased.

One of the more useful attributes of this microcomputer trend is that, like long-playing records, the software is for the most part usable on both sides of the Atlantic. There also appear to be committees of family doctors in both North America and Britain who represent their organizations' interest in computers.

Would it not be helpful to develop some interchange between the two groups, to share knowledge, applications, and even software programs?

I would be pleased to hear from any *Journal* readers about the above ideas.

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Parasuicide

Sir,

I was most interested to read Dr Turner's conclusions (May *Journal*, pp. 273-281) about the characteristic features of female parasuicide repeaters, as their clinical profiles appear to overlap significantly with female problem drinkers in my own practice. Dr Turner reported that 12 out of 15 male parasuicide repeaters had a drinking problem; I suggest that there may be a similar high incidence of drinking problems amongst female repeaters.

I have identified and classified 15 known female problem drinkers in my practice (Fairley, 1981). Analysis of these cases revealed that the trigger for a drinking bout (which was often realized by the family doctor only in retrospect) was threatened, or recent, separation from her spouse or current co-habitee—who may well have a drinking problem too. Most of these patients also demonstrated significant psychiatric morbidity (personality disorder, depression, anxiety and repeated parasuicide). Thirteen of these women presented complaining of anxiety and/or depression.

Some had discussed their current domestic problems during the consultation. The general practitioner sometimes prescribed a psychotropic drug and was often unaware of any alcohol-related problems at this stage, although he may have already noted evidence of a frequently erratic lifestyle. But the extent of the woman's drinking problem was usually uncovered by an impending (and sometimes spectacular) episode of non-accidental acute self-poisoning, using drugs and alcohol, which led to emergency admission to a hospital ward for management.

Of the 10 parasuicide cases in my practice, all but one were aged under 40 at the time of the first episode.

Despite the subsequent involvement of psychiatrists, social workers and other welfare agencies, as well as the family doctor, these 10 patients took further drug overdoses, perhaps with other associated parasuicide features, e.g. superficial lacerations.

In my observation, when a woman with difficulties such as these becomes divorced, or separated, and forms a new relationship with another man, he

usually has a drinking problem too; and sadly, irrespective of the patient's age and social class when her drinking problem is first identified, her bouts of uncontrolled drinking and behavioural problems will probably persist for up to five years—and sometimes for more than a decade.

R. FAIRLEY

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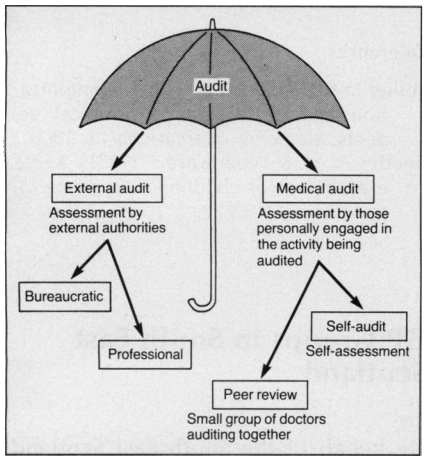
Reference

Fairley, R. (1981). Problem Drinkers. Letter. *Journal of the Royal College of General Practitioners,* **31,** 503-505.

In Defence of Audit



The umbrella of audit. (From Sheldon, M. G. (1982). Medical Audit in General Practice. Occasional Paper No.20. *Figure 1. London: RCGP.)*

Sir,

May I defend the use of the word audit? It has now been in use for over half a century and in the medical sphere it is mainly used to represent an activity which is analogous to internal audit in the business sense, where the whole organization and management of a concern is investigated by those directly involved.

It seems to me that we must distinguish between external audit, which no one seems to want, and that activity which we may define as medical audit, for which I would like to propose the following definition.

"Medical audit is a study of some part of the structure, process or outcome of medical care, carried out by those personally engaged in the activity concerned, to measure whether set objectives have been attained, and thus assess the quality of care delivered."

If we always qualify the word audit with external or medical, we will better understand what is meant. All other phrases such as critical review or peer evaluation seem to fall short, and as the word audit seems to be here to stay, why don't we make the best of it?

Medical audit is something to be proud of!

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Geriatrics

Sir,

You report (May *Journal,* p. 320) that Council has agreed to support proposals put by a joint working party of the College, the Royal College of Physicians of Edinburgh and the Faculty of Community Medicine to institute a diploma in community paediatrics. This will presumably underpin the teaching and training of doctors prepared to undertake paediatric surveillance in their own practices.

Nobody, least of all myself, would disagree with such a forward-looking proposal when it is abundantly clear that there is a great gulf between the knowledge required for the DCH (Lond.) and the paediatric nannying that forms most of the case-work in general practice.

What is daunting is the clear feeling expressed that there is no need for a diploma or other higher qualification in geriatric medicine by members of the General Purposes Committee. Reliance is placed instead on the joint working party document of the British Geriatrics Society and the College (1978), in the hope that the recommendations of that document would be implemented.

There are now good reasons to believe, and they were expressed at the Spring Meeting of the British Geriatrics Society last month at Aberystwyth, that the care of the elderly is not being taught and assessed in proportion to the present and future impact on medicine of an expanding elderly population. That Council should disagree that "an opportunity might again have been missed to let the profession and patients know what sort of standard could be expected of College members who had passed the exam" is rather laughable, and even shows a preposterous degree of self-concern at a time when its senior officers should be recognizing that society needs to learn, through our members, that we are rapidly approaching the twenty-first century, the century of ageing.

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Reference

The British Geriatrics Society and The Royal College of General Practitioners (1978). Training general practitioners in geriatric medicine. *Journal of the Royal College of General Practitioners,* **28,** 355-359.

Idiopathic Oedema and Renal Tenderness

Sir,

I should like to record an association between idiopathic oedema and renal tenderness. Idiopathic oedema (Edwards, 1982; Edwards and Bayliss, 1976) is defined as a condition causing a daily weight gain of 1.4kg (3lb) in the absence of any of the known causes of oedema. It appears to occur only in the adult female.

In the period 1 January 1982 to 13 March 1982, I saw 60 adult females suffering from inflammatory disease of the urinary tract and of these 39 had unilateral or bilateral renal tenderness. Of the patients with renal tenderness nine had idiopathic oedema. I was unable to identify any adult female with idiopathic oedema in the absence of renal tenderness to percussion. In the adult female, a number of symptoms, such as pallor, frontal headache, abdominal tension, depression, irritability and tiredness regularly accompany renal tenderness to percussion. That nine out of 39 patients of this kind also suffered from idiopathic oedema, suggests that there may be a relation between the two conditions.

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References

Edwards, O. M. (1982). Idiopathic oedema in females. *Update,* **24,** 943-952.

Edwards, O. M. & Bayliss, R. I. S. (1976). Idiopathic oedema of women. *Quarterly Journal of Medicine,* **45,** 125-144.

Pyridoxine to Suppress Lactation

Sir,

It is possible that the antilactogenic effect of pyridoxine is not widely known (Foukas, 1973). In 1967 Daniel