

cal conditions in a referred population'. Whilst it is always unhealthy and sometimes unfair to quote a man without quoting the context of his statements, I fear that this statement is an indicator of some of the failings of general practitioners and their concepts and particularly their teachers' concepts, as well as failings in the hospital service. Whilst one has to agree that the hospital will fail to manage all aspects of an individual's problems and the *menage* in which they occur, why is it a necessary corollary that the general practitioner will not, cannot and may not find and rectify a pathophysiological condition?

The general practitioner of today is a highly trained, clinically sensitive individual with, in most cases, direct access to specialized and sophisticated investigative procedures. At his fingertips he has the resource of consultant colleagues, who are paid to work in an advisory capacity in the domiciliary context, and I think it is an abrogation of the general practitioner's duty, if not an appalling waste of his education, not to admit that he is a clinician as well as a pastoral manager.

Dr Brookes makes the point that the hospital takeover in general practice has robbed us of much of our obstetric practice and this is true, an insidious act on the part of the Royal College of Obstetricians. We are being robbed of our paediatric practice but the General Medical Services Committee is conscious of it and trying to do something about it. We are not being robbed of our psychiatric practice in my view. Community psychiatric nurses have made domiciliary psychiatry much easier to practice. Attendance of the patient at hospital is vastly reduced and compliance in the management of psychiatric and behavioural problems is much greater.

Stoma care may appear to have been taken over by the hospital because general practitioners may not be interested, and therefore somebody has to do it. They are robbing us of diabetes and its management and that is our fault. The diabeticians have founded a domiciliary nursing service which supervises the dietary and therapeutic care of the diabetic and which reports to the consultant physician. That also is our fault. If we insisted that it reported to us, the coordination among the nursing service, the general practitioner and the consultant would be much better. The patient would be bound to benefit; the clinical standards of the general practitioner would be bound to be sustained to a higher degree.

The problem seems to be of the general practitioner allowing people to

walk over him and then screaming that he is being badly treated. Therefore it is for us to approach the hospital services and for us to tell them what they will be allowed to practise, not the reverse, and this means that general practice may achieve the ascendancy it should hold in the community at large.

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We showed Dr Million's letter to Dr Brooks, who replies as follows:

I find myself agreeing with most of what Dr Million says. I would particularly wish to agree with his comments about the general practitioner's role as a clinician, as, I am sure, would David Metcalfe. Neither Professor Metcalfe's comments in his original paper nor mine in the editorial were designed to detract from the general practitioner's role in finding and rectifying pathophysiology in a *non-referred* population. It seems necessary (if somewhat tautological) to point this out.

We cannot serve our patients best by trying to tell hospitals what they may or may not do. We can only influence our patients and the hospitals by providing a better service through the primary health care team. We need to find out what we mean by joint training for the team. What is possible? What does the word 'partnership' actually mean and how can it be developed in the interest of optimum team function? General practice will only survive if the community's needs for primary care are best met there, and this will only happen through effective team work.

College Priorities

Sir,
I was interested to read in the January *Journal* that the College has over 10,000 members, but I wonder how many members are dismayed, as I am, by some of the initiatives the College is taking.

The first, which has received considerable publicity, is the setting up of the Patients' Liaison Group. Pendleton informs us that we must beware when 80 per cent of our patients express satisfaction with our services, but when these patients become members of the Liaison Group their views must command attention. Increased accessibility is requested, but this may be for a vocal minority while the less demanding or articulate may suffer. It is surely to be expected that people suffering

from chronic conditions would be less satisfied than others—they would need to be saintly not to be dissatisfied on occasions. British medicine is overburdened by committees, and the establishment of new committees should usually be resisted.

Another curse of British medicine is the excess number of examinations. I am astonished to see the College cooperating in the establishment of a Diploma in Community Child Health. The benefits of paediatric screening are surely not so well established as to justify this step.

Even when we can recognize patients with problems such as smoking, obesity or an indifference to safety, our efforts to help frequently fail. Why we should do better with alcoholic patients who do not wish to bring their problems to our attention is not made clear in the editorial 'Alcohol—looking for problems' (*January Journal*, p. 8).

The overwhelming problem in general practice today is the inadequate facilities for the care of the elderly. The voice of the College should be raised to emphasize this, and when an improvement has been made here, then perhaps will be the time for some of these other ideas.

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Alcohol—Looking for Problems

Sir,
Your editorial (*January Journal*, p.8) clearly exposed the writer's confused state on the subject of alcoholism—a state shared by many general practitioners.

Questionnaires are useful—essential—we all use them in the consultation by a different name to diagnose any disease. Angina is comparable. The diagnosis is historical and is principally achieved by a 'questionnaire'.

His shyness in using the terms 'alcoholic' and 'alcoholism' is commonplace because the words are also terms of abuse. Is he equally shy of using the word 'syphilitic' for the sufferer from syphilis? The acquisition of both diseases is probably due to bad behaviour (syphilis can be caught from lavatory seats and, I suppose, alcoholism from communion wine) but having acquired the disease the sufferer falls into the category of a sick patient needing and deserving treatment and not moral castigation.