

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.

I am disappointed that the writer should question the value of early detection. A seed implanted by the general practitioner in the alcoholic's mind may not germinate for months but that is no reason for not implanting it in the first place. The results of the College Study,¹ finding that general practitioners did not wish to be involved with alcoholics is as well known as it is disappointing. The alcoholic requires the ultimate in the skill of consultation. If a doctor can relate to the alcoholic, he can relate to anyone.

The laboratory test (γ glutamyl transferase) is useful as it brings home to the alcoholic in a physically tangible form the damage which he is doing, which his loss of wife, job, self-respect or even memory may not. Its function is as a therapeutic weapon not as a diagnostic tool.

An understanding of alcoholism is best obtained from recovered alcoholics and Alcoholics Anonymous provides an unsurpassed source. Their beliefs are simple (simplistic say their critics) but their knowledge and experience is profound. A visit to an open meeting can be most rewarding. Meeting some of one's patients there and realizing what one has missed is very sobering.

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Reference

1. Rathod NH. An enquiry into general practitioners' opinions about alcoholism. *Br J Addict* 1967; **62**, 103-111.

Polymyalgia Rheumatica

Sir,
With reference to the paper by Dr R. M. Turner (*March Journal*, p. 167), I would like to comment that an elevated erythrocyte sedimentation rate (ESR) is not necessarily pathognomonic of this condition in the early stages.

An 83 year old ex-carpenter, a normally fit, stoical individual, presented to me with a history of aching and weakness of his upper limbs associated with lassitude and fatigue, difficulty with sleeping and mild pyrexia. After his symptoms had continued for a few weeks I performed a full blood count and ESR with the diagnosis of polymyalgia in mind: the haemoglobin was 14 g/dl and the ESR was 21 mm in the first hour. He was treated symptomatically for a month with nonsteroidal anti-inflammatory agents and a

mild sleeping tablet, but with no obvious improvement.

I repeated the ESR which was 31 in the first hour, which I would regard as a non-significant rise in a man of his age. Despite his low ESRs and in view of the clinical presentation I put him on a therapeutic trial of prednisolone 5 mg three times a day. When I revisited him a week later, the response was evident as soon as he opened the door. He had undergone a complete remission of symptoms within 48 hours of starting his steroids and this process has continued for some months.

From the clinical presentation and the rapid therapeutic response to steroids, I assume that the diagnosis of polymyalgia rheumatica was correct. Nevertheless, the low ESRs were deceptive. Are we in general practice seeing a different type of condition, or are we seeing the condition at an earlier stage, before the ESR tends to rise?

I would be interested in any other reader's opinions.

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What Sort of Fellow?

Sir,
Before the College begins to worry about the meaning of the fellowship (*March Journal*, p. 131) should it not decide the meaning of the membership?

There are two sorts of member—those who bought their commissions and those who won them in battle with the examiners. The former had the foresight and the tenacity to make the College possible and have now supported it for many years; without them it would not exist. If all those who received the membership without examination were promoted to the fellowship that dedication would be rewarded and those outside would know what the letters MRCP meant. It is for them then to decide if they are of value.

I am an elderly retired associate who only became so when he needed the considerable resources of the library and the research support units and who remained an associate to support what he found of value in the College. Now *hors de combat*, I offer this comment from the sidelines.

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Problems of Fertility and their Management

Sir,
That infertility is a diagnosis to be applied to the presenting couple is reiterated in Dr Frogatt's stimulating paper (*March Journal* p. 171).

My initial surprise on finding, as a new general practitioner, that investigation of the subfertile husband usually was undertaken in a unit and by a consultant other than the one investigating his wife has turned to gloom. If one third of childless marriages are due to infertility factors present in both partners, then if those gynaecologists interested in fertility (for they seem to be receiving most initial referrals from general practitioners) would include the investigation of the husband in their referral, much saving of time and nervous energy might be simply achieved. Admittedly, some larger centres do this, but it can mean a great deal of travelling for an often already apprehensive pair.

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'At Risk'

Sir,
In asking what 'at risk' really means (*March Journal*, p. 189), I suspect Dr Frølund of being disingenuous. It is a pity also that his letter was not shown to others than Dr Clifford Kay who has answered tautologically in the case of children, and on probability in a statistical sense. Children who have had a difficult birth were obviously at risk *in utero*, while in the case of prostatic carcinoma there is an incidence to which all men over a certain age are at risk, but this is not the meaning of the phrase as usefully employed.

It is about the elderly that the term is still much used ten years after Dr Frølund read about it in his medical journals. It means the identification of those likely to enter into unstable conditions. The ageing process, which is always deleterious and universal, can be said to put all at risk, but there are now methods for predicting forms of medical and social breakdown well before they occur. The ability to do so depends on the quality with which thinking acts upon experience. In this sense the registration of people at risk must be arbitrary, but there is a consensus that among the elderly those living alone, recently bereaved or discharged from hospital, those with intel-