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.

R. F. HUNT

The Health Centre
Bay View Road
Northam
Devon EX39 1AZ.

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.

D. J. PAYNTON

9 Bath Road
Bitterne
Southampton.

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 MRCGP 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.

DAVID R. WALLACE

Croftlea
Shiskine
Isle of Arran KA27 8EW.

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.

A. M. ROBSON

Craven Lane
Southam
Leamington Spa.

'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-

lectual failure, or of previously faddy or eccentric behaviour and those of advanced age are worthy of surveillance.

The implications of 'at risk' are therefore that without this concept preventive medicine can never achieve selectivity and precision. It is not to be confused with 'risk factors' which are abstract, or taking risks which is behavioural. It is not confined to children, for a person is at risk at every age for different reasons, but particularly when a fetus or beyond the age of 75 years.

M. KEITH THOMPSON
24 Fryston Avenue
Croydon CR0 7HL.

Oasis or Beachhead?

Sir,
I could not have put more politely the sentiments expressed by Dr Alastair Donald (March *Journal,* p. 183). He made some very enlightened statements and I wish to give him my support. I was particularly interested to read that lack of time per consultation is one of the chief complaints of doctors; it is certainly true for patients.

To put it bluntly, generally speaking the organization of general practice in this country is a mess, both for the doctor and the patient, with care being reduced to the equivalent of children being given Smarties by paternal doctors.

As for the general public, the tide is changing. The children are reaching adolescence, and some have already reached maturity; soon they will ditch medical help as organized today—some already have.

The College reminds me of timid, insecure teenagers who take praise and feel good for doing the so-called 'right things' but are not brave enough to act and speak as themselves. They usually end up going to a respectable university and living thoroughly ordinary and boring lives.

As for the present general practitioners, many of them will already be scarred for life; mentally, physically or by marital or family disharmony. I only hope that enough good doctors survive to develop a mature adult to adult service. At present we are losing good doctors as soon as they are produced. They get sucked into the mess.

From a doctor awaiting the new age.

R. D. COLMAN
Cowl House
Bransdale
Fadmoor
York YO6 6JW.

WORKING PARTY REPORTS

Evidence to the Government Inquiry into Human Fertilization and Embryology

This report of a working party of Council was considered by College Council at its meeting on 12 March 1983.

Introduction

1. General practitioners working as family doctors have a personal and continuing role at all stages in the management of subfertile couples, and have a duty to protect the autonomy of the patient and the family.
2. Family doctors are in a privileged position and are able to give an objective and informed opinion, balancing the enthusiasm of specialists in research of this nature, the needs of the subfertile couple and the interests of the community.
3. The subject evokes an emotional response initially. This is because it deals with the creation of human life, it is open to abuse and the importance of 'love' in human creation seems sometimes to be overshadowed by technical and scientific achievements.
4. Although there are conflicting views about the onset of human life, the process can be considered to commence at fertilization, since this is the point at which a genetically complete embryo is formed. From that moment, therefore, the embryo should be treated with respect and experimentation on human embryos should be subject to the same ethical considerations as on children and adults.
5. Experimentation on embryos has been going on for some time. Advances in medical science were made through unethical experiments such as those performed on human subjects during the last World War. However beneficial the information gained, the continuation of such unethical experiments cannot be justified.

Experimentation on human embryos

Experimentation on human embryos is unethical, because:

i) It is not in the interest of the subject under study.
ii) The mental, physical and legal state of the subject is such that informed consent cannot be obtained.
iii) The genetic parents are not able to give objective and informed consent because of their inevitable emotional vulnerability.
iv) It could be abused to the detriment of humanity.
v) Failure to maintain ethical standards in relation to human embryos represents a threat to the application of ethical standards in medicine and science generally.

Unethical procedures

In the light of the above views, the procedures listed below are considered to be unethical:

i) Cloning.
ii) Freezing of human embryos.
iii) Choosing the sex of human offspring by IVF techniques where this involves cloning and freezing techniques.
iv) Experimental use of human embryos.
v) Continuing development of the human embryo and fetus in vitro (ectogenesis).
vi) Continuing genetic manipulation of human embryos.
vii) The use of cloned IVF tissues and organs for transplantation.
viii) Teratogenicity studies on human embryos.

In Vitro Fertilization (IVF) and Embryo Transfer (ET)

IVF and ET for a subfertile couple is ethically acceptable. Couples should be counselled throughout the period of investigation and treatment and afterwards, whatever the final outcome. Family doctors are particularly well placed to provide such counselling because of their long-term involvement with the family.

As part of the treatment for subfertility, the induction of superovulation and the freezing of sperm and ova are ethically acceptable.

There will be some natural wastage of fertilized ova as part of the IVF

The members of the working party were Drs R. C. Froggatt, J. A. Lee, Maureen Reynolds, Clare Ronalds, W. McN. Styles and J. B. White.