

are rated, that is charged a temporary or permanent extra because of some impairment. The general practitioner should tell his patients why this is likely and can obtain this information by writing to the chief medical officer of the life office at head office. Difficulties also can arise when a hospital says that a proposer is cured of a particular form of cancer after say five years, and the life office only considers cures after 10 years.

The Assurance Medical Society

There are various areas of common interest between the medical and insurance worlds. The Assurance Medical Society provides a meeting place where topics, usually medical, are presented and discussed from an underwriting point of view. The Society does not distribute work and doctors who are interested in increasing the content of life assurance medicine in the practices should write to the chief

medical officers of the offices that they have been doing business with and request that they be included in their list of examiners.

The Society has three evening meetings a year on the first Wednesday of February, May and November at the House of the Medical Society of London, 11 Chandos Street, London W1. Recently it has introduced an all-day meeting held once a year in a different part of the country. This year we are meeting in Edinburgh at the Royal College of Physicians on Friday 14 October.

Further details about the meeting and the Society can be obtained from Dr C. R. W. Gill, Blossoms Inn, 23 Lawrence Lane, London EC2V 8DA. (Tel: 01 606-6159).

Reference

MacDonald I D (1981). *Practitioner*, 225, 659-664.

LETTERS

Healthier Children—Thinking Prevention

Sir,

We are pleased that Professor Bain and his colleagues should have given detailed attention to our report¹ (*January Journal*, p. 55) and we welcome constructive debate about child care in general practice.

We appreciate that they would like further research on the value of screening in general practice. We considered this argument carefully, and unambiguously concluded that the greatest good could be done to the greatest number of children by starting our programme immediately. The programme which we identified especially in paragraph 7.26 is already well validated. Can Professor Bain or his colleagues challenge any one of the 20 suggested interventions?

It is not true that screening is presented as an activity that ceases at the age of five years. Our working party emphasized the importance of care throughout childhood, and indeed paragraphs 8.29 and 8.30 specifically recommended a new check-up for children in early adolescence. We agree that health visitors should continue to play a very large role and acknowledged this in paragraphs 5.2, 5.3 and 5.5.

Of course we accept that there are many systems for examining children, including both the Denver and Woodside methods. We were deliberately selective as our report was already longer than its four predecessors.

The responsibilities that we outlined will involve general practitioners as independent contractors in additional

postage, paper, staff and duplicating costs and we believe that it is only fair that doctors who do this work should be reimbursed for it. We unanimously felt that this was an appropriate extension of the payments for public service which already exist for preventive medicine in general practice such as immunization, contraception and clinical cytology. Professor Bain and his colleagues may disagree, but we believe that most of the profession will see this as fair and appropriate. Suggestions from the United States about the fee for service approach are not relevant because those fees are paid by patients and not by the Government as in the UK.

Professor Bain and his colleagues may not fully appreciate the implications of our chapter on training. In fact it warmly endorses training, recommends its widespread introduction but does not believe that this should be used as an excuse for delaying the implementation of the service. The arguments against their proposals for general practitioner paediatricians are reproduced in Appendix 18. Our chapter on training certainly does not duck the challenge of the Court report.

We agree that most handicapped children will require the benefit of consultant care and we welcome shared care arrangements for them. We also agree that most consultant paediatricians do have a great interest in the physical, psychological and social factors of child care but they do not normally have as much knowledge of the health care of the other members of the family or of the home.

The Livingstone Primary Care Scheme is an interesting experiment. It

has not however been reproduced in other parts of the UK and the essential message of our report was to propose a system that could be introduced in England, Scotland, Wales and Northern Ireland immediately.

We have been encouraged by the growing number of general practitioners who are now getting on and doing this work. We still think that this is one of the highest priorities for the future development of clinical work in general practice.

DENIS PEREIRA GRAY

Joint Convenor, Working Party on Child Care.

Reference

1. Royal College of General Practitioners. *Healthier Children—Thinking Prevention. Report from General Practice 22.* London: RCGP, 1982.

Attitudes to Audit

Sir,

According to the authors of the recent article (*May Journal*, p. 263) the results of an exercise among general practitioners in the Doncaster area point to a bleak outlook for audit in general practice. To the authors' evident disappointment, only 28 per cent of those approached took part.

However, the prospects for audit in general practice may not be as gloomy as they suggest for a variety of reasons. A similar exercise conducted in five districts in Greater Manchester produced a better response. Of the 522 doctors invited to take part in a study of their practice patterns, 44 per cent agreed in principle to do so and 40 per