

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

cent satisfactorily recorded a range of data about all their consultations on a representative sample of 15 working days over 12 months. Apart from a slight bias towards younger general practitioners, there was little to distinguish those who did from those who did not participate. This demonstrates that under certain conditions a large and representative group of doctors will collect data about their activities. It also raises questions about the factors that influence variations in the level of participation and the factors that might work in favour of encouraging wider participation.

The response of general practitioners to an invitation to participate in a specific exercise based on practice activity analysis (PAA) tells us little about their attitudes to audit in general. PAA can be a valuable introduction to audit but should not be confused with audit *per se*. Properly seen, audit is a cycle of activity designed not only to identify problems in practice, but also to resolve them. PAA is one way, but not the only way, nor necessarily the most cost-effective way, of initiating this cycle. Other methods are necessary to complete it.

It would be unscientific to draw any conclusions on current professional opinion about audit on the basis of the over-simplified and superficial figures the authors present on the extent of doctors' agreement or disagreement with nine opinion statements. Such figures inevitably give a distorted view of the complex set of ideas, feelings and private opinions that general practitioners hold on this important issue.

If the development of peer review activities is to be one of the College's priorities for the 80s, then a properly designed qualitative study of general practitioners' attitudes to a range of review activities is clearly required. Without such a study, the promotion of peer review activities in general practice will continue to be a costly, and perhaps counter-productive process of trial and error.

JO WOOD

Department of General Practice
University of Manchester
Rusholme Health Centre
Walmer Street
Manchester M14 5NP.

Subscription Reduction after Retirement

Sir,
From time to time as Treasurer of the College I receive requests from retired Fellows, Members or Associates for a reduction in their annual subscription.

May I remind those who have retired from general practice that the normal annual subscription is reduced by 75 per cent. Alternatively, such a person may elect to become a Life Fellow, Member or Associate on a once-and-for-all payment of one and a half times the normal annual subscription appropriate to that person. I need hardly remind those concerned that these arrangements can only be brought into effect if the registration officer at the College is informed that the person has retired. It applies only of course to those who have retired from all forms of medical practice and not to those who have changed from general practice into another field of medicine.

D. G. GARVIE
Honorary Treasurer

Out-of-hospital Cardiac Arrest

Sir,

In your recent editorial (May *Journal*, p. 259) Dr Jones emphasizes the reluctance of health authorities to invest in mobile coronary care schemes due to the lack of 'firm evidence' of their value. He states 'there are no data to show that community mortality is affected'.

At the Spring meeting of the British Cardiac Society in April we presented data from the first year of a study designed to assess the effect of a mobile coronary care unit (MCCU) on community mortality. We compared the community mortality from myocardial infarction in two areas in Northern Ireland which had similar hospital coronary care, but in one a medically staffed MCCU was constantly available.

Total community mortality was significantly lower in the area with mobile coronary care and this difference was most dramatic in the younger age groups. Among those under 65 years of age, 52 per cent died in the area with a conventional coronary care system while only 27 per cent died when a MCCU was available. This represents a saving of 25 lives among every 100 people who develop a myocardial infarction under the age of 65 years. Full details of the study will be published shortly.

Dr Jones also mentions that very few general practitioners have access to defibrillators. Sixteen months ago all general practitioners in the catchment area of the Waveney Hospital, Ballymena (approximate population 150,000) were provided with portable defibrillators. Since then six people have been successfully resuscitated from cardiac arrest by their general practitioners before the arrival of the

MCCU. Five of these patients had acute myocardial infarction and the sixth had a cardiomyopathy. All were discharged from hospital and all are still alive, two to fourteen months after their arrest.

Our experience has shown that a policy of active pre-hospital coronary care by general practitioners and MCCUs will substantially reduce unnecessary loss of life from myocardial infarction in the community. We agree with Dr Jones that further development of pre-hospital coronary care schemes is long overdue.

C. WILSON
C. J. RUSSELL
Consultant physicians

B. G. MCCLOSKEY
ZELDA MATHEWSON
Research fellows

A. E. EVANS
Consultant in community medicine

Waveney Hospital
Ballymena
County Antrim
Northern Ireland.

Teams for the Year 2000

Sir,

In his editorial (February *Journal*, p. 67) Dr Brooks has thrown down a challenge to us all; the primary care team must begin to work together 'each member clearly understanding his or her own function and those of the other members of team so that they . . . provide an effective primary care service'.

How can we make a start? A year ago our practice team (three general practitioners, a trainee, three health visitors, three district nurses and health visiting and nursing students) began to meet regularly to discuss areas of mutual concern. During the year we have tackled a number of topics in a variety of ways:

- We have had joint meetings with other community nursing staff—for example the stoma care therapist, a sister from the newly opened local hospice and the local dietitian—to discuss how we can work together better and make full use of their services. One of the nurses was prompted to start a slimming group with initial help and advice from the dietitian, and the dietitian has become involved in our practice diabetic clinics.
- We have invited a number of para-health care workers to talk to us about their work and how we can be