illness is between two and three times higher amongst people who begin to smoke before the age of 15.[3]

4. 88 per cent of cigarettes bought by children are sold by retailers (the remainder coming from vending machines).[2]
5. 65 per cent of adults favour raising the legal age for purchase of cigarettes from 16 to 18. *(Pers. comm.* Parliamentary Undersecretary of State for Health.)
6. The law was enacted 50 years ago, long before the scale of smoking-related illness was appreciated; a review now is long overdue.

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2. Smoking attitudes and behaviour. Office of Population Censuses and Surveys. London: HMSO 1983.
3. Hammond EC. Smoking in relation to death rate of 1,000,000 men and women. *National Cancer Institute Monograph* 1966; **19:** 127.

**In Scotland, the relevant Act prohibiting the sale of tobacco to persons under 16 years of age is the Children and Young Persons Act (Scotland) 1937, Section 18—editor.*

Computers in Medicine: Patients' Attitudes

Sir,

I was interested to read P. J. Cruickshank's article (February *Journal,* p.77). There has been a very similar article by Dr M. Pringle and colleagues.[1] The authors have followed up an earlier similar study by Dr A. R. Potter.[2] I find it hard to accept that such questionnaires provide any really useful information. The patients are being asked questions to which they are unable to give an informed reply.

I appreciate that the authors are attempting to assess patients' attitudes and views rather than the truth behind them. All that one can obtain in response to such questionnaires is a collection of responses made from a standpoint of total ignorance relating to the subject under discussion.

Presumably the findings from these questionnaires are intended to guide those general practitioners contemplating computerization in the field of likely responses from their patients. I am bound to express concern both at the reasonableness of asking patients questions relating to matters about which they have no real factual information, and also astonishment at the willingness on the part of patients even to attempt to respond to such enquiries. In real life some of us have found that a microcomputer can be placed in the secretary's office to store and access patient data, with adequate safeguards of confidentiality and resulting in enormous benefits in practically all aspects of a general practitioner's field of activities. I see no cause to alarm our patients and every doctor knows that most patients would, in fact, be alarmed if they were truly aware of the difficulties relating to confidentiality using the usual manual records.

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1. Pringle M, Robins S, Brown G. The patient's view. *Brit Med J* 1984; **288:** 289-291.
2. Potter AR. Computers in general practice: the patient's voice. *J R Coll Gen Pract* 1981; **31:** 683-685.

Prescribing Cervical Collars

Sir,

Contrary to popular belief, general practitioners *can* prescribe cervical collars on FP10: not ready made, but as the raw materials which are then easily made into a soft collar. These are a piece of adhesive latex foam—22.5 cm × 45 cm × 7 mm and some surgical tubular cotton stockinette—7.5 cm × 1 metre.

The collar is made thus: peel off the waxed paper backing and fold the foam in half lengthways, sticky side inwards. Encircle the neck with this double thickness length of foam and mark where the foam should then be cut to the correct length for the individual. Then cut out a semi-circle from the middle of the upper edge of the foam, for the chin. Cover the foam with the stockinette and use the loose ends of the stockinette tied to hold the collar in place.

NICHOLAS BRADLEY

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Prescribing—a Suitable Case for Treatment

Sir,

This editorial (January *Journal,* p.5) made me feel very guilty about contributing to the £60 million wasted on prescribing. The College would be right to ostracise me from the 'educated practitioners, who prescribed less, prescribed *generically* more and used cheaper equivalent drugs'. It is our duty as general practitioners to ensure that the limited NHS funds are best used to serve the whole community and not frittered away by thoughtless prescribing.

However my Collegiate and professional fervour was somewhat dampened when the full page advertisement on the opposite page suddenly caught my eye.

'Why Have You Changed My Tablets, Doctor? Write *Inderal* by name . . . ensure that the patient always receives the original ICI formulation.'

I realize that advertising revenue is important but surely, for the College and its *Journal* to retain their credibility it must vet these advertisements more carefully.

R. J. GALLOW

The Bungalow
Featherbed Lane
Felden
Hemel Hemstead.

A similar letter has been received from Dr W. H. Foster of 18 Park Brake, Highnam, Gloucester.

Payment for Practice Performance

Sir,

It seems to us that there are converging trends in general practice which could be encouraged by a payment based on performance.

First is a desire to measure and improve the quality of care; secondly, a feeling that there should be more patient feedback; thirdly, with vocational training now compulsory, the vocational training allowance will become effectively an addition to the basic practice allowance, and an easy target for government economy. Lastly it is illogical to think in terms of compulsory retirement on the one hand and make payments based solely on seniority on the other.

We propose that there should be negotiated a new payment awarded on the basis of practice performance. Performance would be assessed primarily on objective measures of practice and clinical activity. There would also be accountability to the consumer, perhaps in the form of a questionnaire sent to a sample of patients and consultant colleagues. The payment would be to the practice rather than to the individual doctor. Any award would only be for, say, five years with the opportunity for renewal before expiry.

We maintain that our proposal