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.

CLIVE FROGGATT
129 St George's Road
Cheltenham
Gloucester GL50 3ER.

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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.

F. K. MINWALLA
22 Shenley Green
Birmingham B29 4HH.

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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
30 Barnfield Road
Exeter EX1 1RX.

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

meets most of the criticisms of the consultant merit award system, and incidentally we feel that if consultants are involved in helping to assess general practitioners' awards, general practitioners should also be involved in assessment of consultants' merit awards.

We therefore suggest replacing the vocational training, seniority, group practice and postgraduate training allowances with this new renewable performance-sensitive payment.

S. A. HALL
C. R. HARTSHORN

23 Upper Grosvenor Road
Tunbridge Wells
Kent.

A Double Blind Randomized Control Trial of Diazepam

Sir,
We read the *Journal* regularly with great interest as the articles published are often of good quality and useful to us in our work as general practitioners.

It was therefore with great surprise and regret that we read this article by L. Condren and colleagues (October *Journal,* p.635). This work is of such poor quality that we were surprised that your *Journal* should publish it. We would like to point out some of the most obvious mistakes.

In the introductory passage the authors say that there is no conclusive proof that diazepam is better than placebo. They even suggest that diazepam is poorly documented. We have been in touch with Roche, the manufacturer of Valium (diazepam), who say that there are approximately 15,000–20,000 original articles published about diazepam. In this case, far from being poorly documented, diazepam is probably one of the best documented drugs on the market.

We are very critical of the design of the study. Only 20 out of the 150 doctors that were contacted replied, giving a drop-out of 86 per cent! Of the brave few (20) who were left only *eight* replied with filled in protocols. Furthermore, 47 per cent of the protocols from the eight doctors were incomplete. These figures are of course totally inadequate if the article is to have any pretext to scientific validity. The authors even state that one of the reasons for the large drop-out may be difficulties in getting the patient's informed consent. It seems reasonably safe to assume that the patients with the more serious symptoms would be more hesitant before taking placebo instead of diazepam than the average patient. One could assume that among these patients a relatively larger number would benefit from adequate therapy. This is of course a major objection to the whole study and its result.

The authors have not explained to our satisfaction how the scoring of the symptoms was performed. It appears that it was the treating physician who scored his own patients. In our opinion the scoring should have been performed by an impartial person, preferably a psychologist.

We quite realize and sympathize with the fact that to organize and execute scientific studies in general practice is not without its problems. To call this project a double-blind randomized control study is however an absurdity. This description is reserved for, or should be reserved for, scientifically designed studies executed with enough resources to give an acceptable result. It is of course useful and interesting to learn about the opinions of colleagues. These opinions should not however be given the halo of 'medical science' by using a pseudo-statistical cloak and publishing them in respectable journals.

INGMAR FAGERLUND
BO HEDQVIST
ULF SKOGSBERG
MARTIN SVENSSON

Vårdcentralen
S-511 02 SKENE
Sweden.

The Assessment and Teaching of Factual Knowledge

Sir,
Dr A. H. E. Williams is to be congratulated on devising an assessment programme by which trainee practitioners can evaluate their progress in comparison with a standard set by trainers (January *Journal,* p.41).

What struck me with amazement was that of the 14 areas of medicine tested, no assessment was made of knowledge in geriatric medicine. It might be argued that 'medicine' and 'human development' would encompass some aspects of this vast and growing subject. However that would not satisfy me, nor a growing number of colleagues that I meet.

The lack of a structured education in this subject, the teaching of it in hospital units devoted to rehabilitation rather than preventive medicine and the natural evolution of diseases of ageing may be responsible. But the College working party of which I was a member produced a document that is structured to allow an assessment to be made.[1] We may recall that it was not until 1980 that the MRCGP examination contained a question specifically about the elderly, and this revealed such shortcomings in the minds of candidates that it has presumably been felt best to leave that difficult area alone, although I have noted as an observer a doubling of the rate of questions asked at the oral table.

One notes, ironically, that College Council cannot yet cope with the idea of a Diploma of Geriatric Medicine, although this assessment, at least as far as hospital doctors are concerned, seems inevitable. Looking again through Dr Williams' list, it is possible that questions could have been asked concerning the elderly in every category except paediatrics and obstetrics. However, when Stuart Carne said some years ago that the quality of a practice could be found in the way it cared for children, he may already have been out of date. Today, it must lie at the other end of the age scale.

M. KEITH THOMPSON

24 Fryston Avenue
Croydon CR0 7HL

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Victualler's Thumbnail—a Condition of Subungual Osmotrauma

Sir,
In describing this condition (February *Journal,* p.118) I am sure that Stephen Head has done us all a great service. However I am rather concerned that he may be adding yet another item to the long list of great medical misnomers. In much the same way that we now know the gastro-colic reflex to have nothing to do with either the stomach or the colon (and neither is it a reflex) this condition has nothing to do with osmosis. We are all taught in 2nd MB physiology that osmosis requires the presence of a semi-permeable membrane, so that this is a simple example of rehydration by diffusion.

May I suggest, therefore, that the original title be kept as simply 'Victualler's Thumbnail' or even, perhaps, 'Head's peculiar lacticoma'!

PETER J. BANYARD

97 Greenham Wood
North Lake
Bracknell
Berks RG12 4WH.