equation of good medical care. Were he to do so it might make our College a little more acceptable to the many doctors working in our large cities where we are poorly represented.

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Sir,

I am sure many readers will sympathize, as I do, with some of the views expressed in your leading article (July *Journal*); but perhaps your comments should themselves have been more rational rather than emotional.

You skirt round two problems. Firstly, there is not enough evidence about the therapeutic effect of seeing a familiar face. A fourth year student project study conducted in two Southampton group practices where the partners operated their own on-call rotas showed that patient satisfaction was well correlated with the doctor's approach to the consultation but not with whether the doctor was already known to the patient.[1] Until we can show that doing out-of-hours calls in person confers worthwhile benefits on patients, doctors can be forgiven for concluding that a competent deputizing service may do as well.

Secondly, our British form of general practice, now updated to include group practices and practice rotas for out-of-hours calls, may not be the best system for city populations today. The primary care team was recommended in the Acheson report as a desirable development[2] but it has little relevance to out-of-hours work at present. In the absence of experiments involving alternative settings, staffing, facilities, opening hours and methods of payment, the best solution is a matter of opinion only. Suitable studies are hard to set up but perhaps it would be better to regard deputizing services as an experiment in progress rather than as an example of neglect of the emotional content of night calls. Sympathetic evaluation of out-of-hours services should be encouraged and may include, as you suggest, estimates of the costs to doctors in emotional terms as well as the benefits to patients.

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Guidelines for hypertension management

Sir,

The Lothian Hypertension Group are to be congratulated on their excellent set of guidelines for the management of hypertension (July *Journal,* p.405).

Having operated a somewhat similar system in Bollington for a number of years in which patients are divided into three 'boxes' dependent on whether their blood pressure warranted drug treatment, close surveillance or neither,[1] may I offer a few comments?

Patients classified initially on the basis of a 'borderline pressure' (95–104 mmHg in the Lothian protocol) on a single occasion will as often as not revert to 'normal' pressure on retake. When this happens there should be some instruction for returning them to five-yearly review as otherwise the clinic will be full of patients being reviewed every six months for very normal blood pressures. We adopt the rule that three successive blood pressures within the normal range is the signal for a change of category.

The group do not suggest routine serum cholesterols except in hypertensive patients below the age of 40 years. Raised cholesterol is however a powerful predictor of coronary disease and, even if the value of dietery treatment is not fully proved, at the very least it will help to define a group of patients in whom really energetic efforts are needed to stop that other dangerous risk factor, smoking.

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Private health insurance

Sir,

Dr Lotte Newman asks for realistic suggestions to improve co-operation between general practitioners and the Private Patients Plan (PPP) (July *Journal* p.413) and I have one.

I know I am not alone in failing to understand why PPP (and the other private health insurance companies) are unable to conform to the usual ethical conventions when they request medical evidence in respect of potential subscribers. At present, a clerk writes to the patient asking the doctor to furnish written evidence to the company. This is an imposition for the patient and insulting to general practitioners. All life insurance companies manage to write from Chief Medical Officer to general practitioner that the patient has consented to disclosure of information, and offering to pay the normal professional fee.

If the private health insurance organizations would change their practice and comply with this convention, I am sure there would be a much better spirit of co-operation to the benefit of patients, insurance companies and general practitioners.

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Paediatric surveillance

Sir,

We are sorry that the experience of Dr Moulds and Dr Martin of well-child care (July *Journal,* p.412) is so much less rewarding than our own (March *Journal,* pp.152-154). Did they really, during four years, find no undescended testes or new cases of deafness?

In a health district like ours, committed to universal preschool child surveillance, the issue for a practice is whether to have any part, not whether the service is offered at all. We agree that *appropriately trained* health visitors can do much developmental work, as ours do, but some aspects are surely best performed by doctors. Our sessions together total three-and-one-half hours weekly, and seem to produce useful returns. We also find our meetings with other members of the team helpful in developing a co-ordinated approach to the shared care of patients of all ages.

The immunization figures we reported for 1983, were inexplicably disappointing. In July 1984, rates for completed courses among children born in 1982 were 78 per cent for pertussis, 82 per cent for measles and 95 per cent for diphtheria, tetanus and poliomyelitis (health district means 73 per cent, 71 per cent and 89 per cent respectively).

Your correspondents ask about eventual outcomes, which are difficult to determine for any intervention. For a very partial answer, we have examined records of children referred in the year 1982–3 for ear and hearing problems. Audiologists confirmed a significant hearing loss in 10 out of 15 children referred with suspected deafness, while results were unknown in two. ENT surgeons saw 14 children, seven following audiology. They confirmed defects in nine children and arranged surgery in six cases. Two are still under review, two are unknown and only three were considered normal. We find that ear problems, unlike squints, are often unrecognized by parents. The short-term benefits to hearing from surgery seem to us to enable useful catching-up in speech and language development, although we remain uncertain about ideal management.[1]

Child surveillance, like antenatal care, is only partly a screening process and also offers useful support to mothers.[2] Clearly this important aspect merits further systematic inquiry.

Of course we need research into both basic developmental processes and longer-term outcomes. Much of this work is going on. Our intention was to illustrate how ordinary practices can use intermediate outcome measures[3] to see if they are providing 'good enough' care for their child patients.

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Primary health care team

Sir,

The proper functioning of a primary health care team can be greatly facilitated by regular team meetings. The value of these meetings may be restricted, however, if they meet the needs of only some team members and not others. In my position as a clinical psychologist regularly attending such meetings in three different practices I have been able to collect data that illustrates the various functions that these meetings serve.

Casual observation suggests that the history of the meeting influences its function. For instance, where the general practitioners established the meeting they tend to be brief, frequent and concerned primarily with the discussion of individual cases. When social services were the prime movers the meetings lasted longer, were less frequent and considerable time was devoted to the discussion of local problems and liaison difficulties, although not exclusively so. In both examples the team members reported that the meetings were useful.