LETTERS

Paediatric surveillance

Sir,

Perhaps Dr Moulds (Letter, July *Journal,* p.412) could explain what it is that makes Basildon babies so different. What is the training that he gives mothers that makes them such superb developmental paediatric specialists? For if it is true that he and his colleagues manage to examine a lot of Basildon under-fives and not find one child in which abnormality was not already recognized by parent or the paediatric specialist services, then there must be something very special about Basildon babies; more refugees from the planet Krypton perhaps?

Or could there be a more prosaic explanation? Could it be simply that Dr Moulds and his colleagues merely failed in the course of examinations they carried out to diagnose children who did have abnormality? Many studies have now shown that between 10–15 per cent of children of pre-school age suffer from deviation from normality, some requiring indepth diagnosis and management. A recent study showed that more than 70 per cent were only detected as the result of a carefully carried out routine surveillance examination.[1]

How did Dr Moulds measure the increase in parental anxiety when they started surveillance examinations and the consequent reduction when they ceased?

Finally, in the light of the above, may I draw his attention to the taking of blood pressure as part of opportunistic screening — the term now used by those who think they know 'a good thing'. Nothing so frightens a patient than to be told his blood pressure is raised however carefully one explains the 'doctor' effect. Nothing so puzzles a patient to be told, after four blood pressure records, that in fact the blood pressure is normal. I suspect that such a scenario occurs frequently. Yet should we stop recording blood pressure routinely for fear of worrying patients? Of course not, nor should we be worried about referring on a patient in whom we have suspected abnormality and which has subsequently proved to be wrong.

I think that Dr Moulds needs to look carefully at more recent studies on surveillance and the incidence of deviations from normality, before using his own experience to criticize others.

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Reference

1. Drillien C, Drummond M. *Developmental screening and the child with special needs.* Chapter 15, p.273 London: Heinemann Medical Books, 1983.

Focus on women at 35

Sir,

As part of the College's campaign for a Quality Initiative I have always understood as implicit the need for applying the College motto of 'cum scientia caritas' in that initiative. This does not mean only caring but also applying science, using such basic tools as epidemiology to help us decide why to do certain examinations and when. A good example of this has been the screening for cervical cancer by the use of Pap smears. This was first recommended to be performed annually from the age of first sexual activity but the recommendations have been altered over time as a result of epidemiological studies creating the development of more scientifically dictated guidelines bearing in mind such factors as cost-benefits. This method of screening also fulfils the accepted criteria for screening tests. However, none of the published criteria include financial benefit to be gained by the practitioner.

I refer, of course, to a letter in the August *Journal* (p.466) where a screening check-up was introduced to women aged 35 years — this age frankly admitted by the authors as being selected on the basis of making 'use of the fact that smears taken from that age attract a fee every five years'. Is this a scientific or epidemiological basis for timing a screening test, when epidemiology has shown little benefit from overall screening examinations at this age? Should quality of practice be judged in terms of earnings generated? We have surely learned from figures of operations in North America where tonsillectomies and cholecystectomies have been found to be performed at higher rates than in other parts of the world. This is not because epidemiological studies show a higher incidence of disease but rather because the doctors there seem to be motivated by a similar scientia and caritas as motivated the letter writers in the August edition — for example 'the chance of finding unsuspected pathology appears to be very low, but 59 x £5.70 = £336.30 additional income is welcome'.

As evidence that the authors of such screening examinations are not alone in their 'quality initiative' we are informed by another letter in the same issue that method of contraception recommended to patients is also advised on the basis of remuneration paid to the doctor and certainly not on the basis of reliability or safety.

I do not pretend to be a saint and cannot deny that my local colleagues and I completely ignored the public weal in a nasty three-month strike for better wages last year. I am therefore not in a position to cast stones, however my colleagues and I did not publish this unfortunate experience in a journal advocating quality control or under

a banner of 'cum scientia caritas'. These letters surely represent examples of 'sine scientia' and one is forced to ask to whom the 'caritas'?

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Lothian Hypertension Group Guidelines

Sir,

We are grateful to Dr Lowe (Letter, August *Journal,* p.497) for his interest in the Lothian Hypertension Group's Guidelines and for his question about the recommendation that serum urate levels should be measured in the initial assessment of hypertension. The Group would not claim that this is an essential estimation and would accept the point that hyperuricaemia is simply a biochemical abnormality.

However, the fact that such an abnormality could be exacerbated by the use of thiazide diuretics, which might precipitate clinical gout, can be a factor in determining the most appropriate management, and this seems to us to be sufficient justification for measuring urate levels before embarking on treatment.

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The 1984 William Pickles Lecture

Sir,

I would like to congratulate Dr Norell on his excellent 1984 William Pickles Lecture which I have read (August *Journal,* p.417), but was not privileged to hear. I am sure much was gained by those who attended — contentious issues and the slaughtering of sacred cows are best appreciated face-to-face.

However, the substance of his talk comes across very well on paper. Much as one appreciates the efforts of those who constantly strive to raise standards, general practice is an area where art will always rival science and where a theoretical examination will never be a proper test of competence to practice. Nevertheless I would not decry the examination out of hand as it can be rightly placed as complementary to vocational training.

The point of this short letter has put the Armed Forces viewpoint across as Dr Norell does draw attention to their training scheme and to general practice as it is carried out in the Forces.

Firstly, our spectrum of patients does indeed vary from that found in most civilian practices, even though in the latter there is also a variation depending on geography and interests. The forces' doctors see very few elderly patients, but they do look after a large number of younger ones, particularly young wives and children. Social problems arising out of this particular environment are a big problem, and the responsibility sometimes given to young doctors looking after young families separated from their relatives and home comforts is considerable. It is worth emphasizing that the Navy, Army or RAF each encapsulate a community with all the value that contains. Indeed some general practitioners become Regimental Medical Officers and have responsibility for the whole family within a forces environment, including the need to accompany the menfolk on military exercises, and maintaining their fitness as well as treating their disease. This is admirable practice.

What I am stressing, and I am sure Dr Norell understands, is that general practice in the forces *is* different in detail; and suffers not a bit in being so; also it is every bit as satisfying to individual medical officers as it is to civilian doctors in their practices.

I would agree we do pay strong attention to vocational training, which is I think of an almost uniformly high standard, and I suggest the good MRCGP results are not just a result of classroom teaching and a good examination technique following the attendance of a course, but reflections of wide, conscientious training and the accelerated maturity that goes with a doctor who serves in a varied and responsible forces environment.

Another point is that we encourage our doctors to do night calls. We do not use deputizing services, a source of some discontent in civilian life.

However, we are aware of our deficiencies and the fact that a military life does not always enable us to produce a moulded civilian general practitioner, but, as was pointed out in Dr Norell's excellent lecture, general practice covers a wide area. How can any doctor live up to the definition of a perfect general practitioner, and under what criteria can he be judged?

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Sir,

Reading Dr Norell's lecture (August *Journal,* p.417) was a pleasure. The lack of 'damned statistics' and the presence of elegant humour was refreshing in our often 'dry' *Journal.* This is not to say that his opinions are necessarily more valid than the nicely constructed reply of Dr Belton and Dr Lee.

Dr Norell struck the right chord in many of us who are beginning to wonder how far we need to stray from 'what every doctor knows' in pursuit of the indefinable. In con-