Sir,

I have been interested to read the recent correspondence in our *Journal* regarding membership of the College.

I am a founder Associate of the College and have been in active practice for over 30 years. I remember many years ago receiving a form inviting me to become a Member at an increased annual subscription. Because of being away on holiday at the time, I think, the form was not returned by the required date and I thought nothing else of it until, soon after, I noted that some of my colleagues were adding MRCGP to their signatures with a flourish, having done no more than return the form on time, and that I now had to pass an examination if I desired to do the same.

Is this food for thought?

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Bromazepam, a new anxiolytic

Sir,

Having recently joined the College, I was disappointed to see that the second College *Journal* I received (September *Journal,* p.509), contained a promotional article, disguised as a scientific paper.

The article in question is 'Bromazepam, a new anxiolytic: a comparative study with diazepam in general practice'. I note that the paper was co-written by someone employed by the company that makes bromazepam, thus casting doubt onto the objectivity of the study.

The summary states that bromazepam is as effective as diazepam as an anxiolytic. It then goes on to say 'a global rating scale showed that in the physicians' opinion, the lower dose of bromazepam was preferred' — a highly subjective statement, and, if you read the text of the paper, one which is based on a statistically insignificant result. The summary, therefore, implies that bromazepam is a superior drug to diazepam, which is not born out by this paper.

I particularly object to this article because bromazepam is an unnecessary drug, as there are already too many benzodiazepines on the market, and most doctors are reducing their prescription of the drugs, as we have become aware of the problems of addiction to benzodiazepines.

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Social class and health status

Sir,

In their letter (September *Journal,* p.492), McPherson, Coulter and McPherson quite rightly point out that there is little to justify the assumption that recurrent episodes of illness are all initiated by the general practitioner rather than by the patient. Without this assumption, Dr Crombie's assertion that general practitioners compensate for under-use of services by social classes 3, 4 and 5 is unsupported.

But there are some additional problems with the 1971 analysis that has made interpretation difficult. The first point is that in comparing different social classes account must be taken of the reasons why they consult and the different diagnoses for which they consult. A consultation for a cold is not comparable to a consultation for lung cancer or immunization against whooping cough. The Registrar General's *Decennial supplement on occupational mortality*[1] provides a useful set of individual diagnoses and sets of diagnoses for serious conditions, such as chronic bronchitis; asthma and emphysema; ischaemic heart disease. It would be helpful if such a presentation could be included in the 1981 figures for persons consulting and episodes and consultation by social class.

Secondly, there is a difficulty in interpreting social class gradients in this study. Like Fox and Goldblatt's longitudinal study,[2] which deals with the mortality of a 1 per cent sample of the 1971 Census, people are classified into social classes 1–5, 6 (Inadequately described) and 7 (Unoccupied at the time of the Census). Fox[2] has described how half of the 'inadequately described' class 6 were temporarily out of work owing to sickness, and most of the 'unoccupied men' class 7 were permanently sick. In other words, men who are sick tend to be classified as social class 6 or 7 rather than 1–5. Furthermore, men in social class 5 are six times more likely to be allocated to the 6 and 7 groupings. The same selection effect takes place in the general practitioner study and the consultation rates for social classes 3, 4 and 5 are going to be considerably reduced because of it. Hence great care must be taken in interpreting gradients across social classes, as the slope is likely to underestimate consultations in social classes 3, 4 and 5.

These provisos do not invalidate the use of social class in analysing data from the National Morbidity Survey, but they should engender caution in interpreting results, particularly when they run counter to most published material.

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References

1. Office of Population Censuses and Surveys. *Occupational mortality 1970–72. Registrar general's decennial supplement.* Series DS1. London: HMSO, 1978.
2. Fox J, Goldblatt PO. *Longitudinal study. Sociodemographic mortality differentials 1971–75.* London: HMSO, 1982.

Night calls: an emotional issue

Sir,

I was so intrigued by Dr Stevenson's angry response (September *Journal,* p.496) to your July editorial on night calls that I went back to read the original. I must say that I agree with Dr Stevenson that it is a perplexing collec-