Sir,

Dr Watts, in his long letter (November *Journal,* p.628) has said two true things. The first is that the use of atomic weapons is abhorrent to any thinking person, and the other is that tyrannies do eventually fall. He seems to have gone on to make several false assumptions. One is that a nation which does not possess atomic weapons has a better chance of escaping bombing than one which does. Imagine a world in which both the democratic West and the communist East have laid down and destroyed their atomic weapons. This would not stop, say, an irresponsible leader from acquiring a stock of weapons. Would he be hampered by moral considerations when it came to their use? I do not think so. Tyrants are not made that way.

The other piece of fallacious reasoning is to suggest that, apart from disarmament and a consequent policy of appeasement by the West, there is no other way to stave off the holocaust. There is. One for conquering a people is to so numb their minds with fear that they are willing to accept slavery, as the only alternative to extinction. Do I detect a whiff of this in Dr Watts' letter? We must learn to recognize such propaganda for what it is, a weapon of war, and a much cheaper one than navies or missiles. People who support dictatorships must be told again and again of the evil that they are doing. We must always speak the truth, and we must find ways to make them listen. In the communist bloc, where radio broadcasts are jammed and censorship rules, it will not be easy.

Medically, we must seek to meet our counterparts behind the Iron Curtain. If they can learn from us that psychiatric patients are mentally ill and that having differing political views from those of the ruling class does not constitute a mental illness, this will be a breakthrough in itself. The more that we can do to educate and inform, the sooner the tyranny will collapse. We must demand freedom of travel for everyone both within and without the communist bloc. The freer the communications, the sooner the advent of sanity.

The opponents of the arms race, and I am sure that most of us come into that category, must direct their appeals to the East. They are preaching to the converted in the West. It is only common sense to present these arguments to the people with the largest army, navy and air forces as well as the most massive collection of atomic weapons.

You might say that it takes more than words to deter an implacable enemy, with an expanding empire, bent on conquest, but, as a very wise man said, 'it is better to have Jaw Jaw than War War, anytime'. To save ourselves from conquest and annihilation we must first identify and neutralize the enemy within.

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Prescribing

Sir,

I am disappointed by the negative response of the profession to the Department of Health and Social Security (DHSS) proposals on prescribing.

It has been clear for many years that the drugs bill was becoming an unbearable burden for the National Health Service (NHS), and despite the exhortations that we should prescribe more economically, there has been little response. Sadly, neither the British Medical Association (BMA) nor the Royal College of General Practitioners (RCGP) attempted to tackle the problem and pre-empt the current situation. Is it surprising that the Government has decided to impose controls on a profession which has failed to regulate itself? (cf. Solicitors and conveyancing.)

Given we have a strong government that will gain support from the opposition for these proposals, we must negotiate a sensible compromise. Then we will retain at least some credibility, so that if the DHSS seeks to extend generic prescribing we can be consulted at an early stage.

I would suggest that the profession agrees to the restrictions for vitamins, cough mixtures, tonics, and inhalations, since they are used almost exclusively as placebos and the generics available should be adequate. The antacid group of allowed preparations could be usefully extended to include a tablet and mixture containing dimethicone or alginate. For this purpose a low cost branded product could be specified.

The allowed generic analgesics to appear to be inadequate in excluding moderate analgesics such as codeine and dihydrocodeine, and despite objections in the British National Formulary (BNF) either of these preparations in combination with aspirin or paracetamol is popular with patients and doctors and very cheap. Curiously the laxative specified, methylcellulose, is not particularly cheap, and discussion could lead to the inclusion of other less expensive bulk-forming laxatives.

The most contentious group of restricted drugs is the anxiolytics and hypnotics. The vast majority of prescriptions in this group are totally inappropriate, and are due to repeat prescribing despite recommendations in the BNF and data sheets that these products should be used for short periods only.

Sadly as a result of their misuse large numbers of patients exhibit physical or more commonly psychological dependence on these drugs. Against this background it is difficult to find any argument against restricting the products available on the NHS, and arguments about bioavailability are laughable when most of these products should never have been made so available by doctors.

Doctors should embrace the new proposals with enthusiasm and negotiate appropriate modifications rather than hide behind the sacred cow of clinical freedom; a freedom which is used to prescribe expensive and inappropriate products of dubious value.

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Role of mini-clinics

Sir,

At the RCGP symposium on 8 and 9 November there was a discussion during the session on 'Working with other doctors' about the provision by general practitioners of community care for certain chronic illnesses such as diabetes. There are certain points which came out in the discussion which I feel should be made known to a wider audience than that present at the symposium.

Dr John Yudkin was describing the use of mini-clinics in diabetes held in general practitioners' surgeries. One of the reasons for setting up these clinics was to save money, on the assumption that community-based care is cheaper than

outpatient hospital care. It seems that the clinics were acceptable to patients, general practitioners and hospital doctors alike.

In the discussion the following points came up:

1. That mini-clinics or some other form of general practitioner based care was acceptable and beneficial for sufferers of a variety of chronic illnesses.
2. That the use of such clinics in various chronic diseases would probably increase in the near future.

It seems to me that many general practitioners, including myself, will be interested in promoting these clinics in one form or another in our surgeries and certainly that the hospitals will be encouraging us to do so. An important point is that these clinics will cost money to set up and to run. A major part of this cost will be manpower, since although workload in our general surgeries may be slightly reduced, it is likely to lead to an overall rise in our workload. Indeed, one doctor pointed out that if all the partners in a practice were doing specialist mini-clinics on a certain day, there would be nobody left to do the general surgeries. The consequence of this may well be that partnerships will wish to take on extra doctors, which, with scarcity of jobs, is no bad thing.

Where is the money to come from to pay for the extra staff required? It seems that the National Health Service's determination to move clinics into community care is not matched by any willingness to provide funds to do so. The Health Minister's intentions can be deduced from his reply in the House of Commons to Labour MP David Nellist when he asked about provision of item of service payments: 'We expect general practitioners to provide a wide range of services to their patients but do not expect to provide a special item of service fee for every item.' It would seem, therefore, that no extra money (for item of service and other payments) will easily be made available for primary care.

I predict that unless this matter is monitored most carefully general practitioners will find themselves providing extra care free of charge (except to their own pockets) and I would strongly urge all doctors to be aware of this possible development. I would emphasize that we would not be asking for money to improve our standard of living, but merely to provide the best possible care to patients in a new sphere. I am, therefore, echoing Dr R.B.H. Maxwell's concern as expressed in his letter (July *Journal,* p.414).

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General practitioner obstetrics — a visitor's viewpoint

Sir,

From January to June last year I enjoyed a practice exchange with a general practitioner from Oxford, England. This exchange arose out of our meeting in 1979, firstly in New Zealand, and later in England. We had a mutual interest in general practitioner obstetrics and are both concerned that general practitioners should continue to participate in the management of their patients during both pregnancy and delivery. Having worked in England for six months, I now volunteer the following thoughts on the matter.

Articles in the medical press recently have warned that participation by general practitioners in intrapartum care is likely to disappear completely in the near future. The changes leading to this situation appear complex and often paradoxical. The emphasis in general practitioner obstetrics for many years has been to eliminate risk factors. Home deliveries have been actively discouraged as dangerous, and all-enveloping specialist units have been developed. Small general practitioner units in rural districts have been closed ostensibly on account of financial economies, and patients have been referred to the base hospital. General practitioners have been encouraged to continue to provide antenatal and postnatal care, otherwise the present system would be unworkable, since travelling too often to attend regular hospital clinics would be extremely unpopular with patients, and the clinics would be overcrowded. The result of these trends is that, whereas in New Zealand general practitioners are still responsible for more than 50 per cent of all deliveries, in the UK this figure is now below 15 per cent.

The community midwife, for many years the key figure in domiciliary obstetrics, has had her position eroded by the removal of deliveries from the home to the hospital. In response she may now discourage the general practitioner from intervening in his own cases until a problem occurs and transfer to a specialist becomes inevitable.

The first paradox is that if the general practitioner obstetrician disappears it seems likely that the community midwife will follow suit. Both need to work in a spirit of co-operation to retain their practices, but a general practitioner who never makes decisions in obstetrics and who does not use modern technology as well as more traditional obstetric skills, will soon lose interest.

A second paradox is to train a majority of general practitioners to the level of obtaining the diploma in obstetrics and then to discourage him or her from practising because of lack of patients, or opportunity to look after them. It is perfectly understandable that not all general practitioners will be interested in this aspect of family medicine, but surely in every group of four or five there should be at least two prepared to accept this particular responsibility. I believe that since at least 50 per cent of obstetric cases are 'low risk' these should be delivered in general practitioner care, to the advantage of both patient and doctor.

The third paradox is to see general practitioners withdrawing from obstetrics at a time when recent advances in this specialty have made the process of parturition far less uncertain and stressful to patients or doctors than at any time in the past. The use of ultrasound scans, prostaglandins, intravenous oxytoxics, fetal monitors and epidural analgesia have all contributed to this change, and should no longer be unfamiliar to the properly trained general practitioner. These techniques have made the management of obstetrics much safer and less traumatic for all and the days of long drawn out labours with consequent maternal, fetal and obstetrician distress have almost disappeared.

In discussing the possibility of general practitioner obstetricians disappearing, it should be stressed that ready consultation and co-operation with our specialist colleagues is essential. Early referral or consultation is not an admission of failure, but usually results in a feeling of increased confidence by patients, midwives and doctors. A final paradox will arise if general practitioner units are closed due to apathy or indirect pressures. If all patients are to be delivered in base hospitals, there will almost certainly be a significant upsurge in the demand for home deliveries. General practitioners should endeavour to avoid this happening or they will face dissatisfied patients whose demands they will be unable or unwilling to meet.

Many excellent general practitioner units are already established in the UK and working happily in conjunction with