George Swift Lecture

Sir,

In his excellent George Swift lecture (February *Journal,* p.63) Julian Tudor Hart reviewed the widely acknowledged fact that in spite of an overall improvement in the standard of primary medical care practised in this country today, there still exists a wide range of quality exhibited, so that the gap between the extremes of good and bad medicine is as wide as ever. With respect I take issue with his 'globus inversus' thesis on how this situation could be rectified, not because it is radically unconventional, but because in my view it will not achieve its aim.

Fundamentally, every general practitioner should have a thorough appreciation of a wide spectrum of medical issues in order to afford his patients sound clinical expertise. This can only be acquired by having formal training in preclinical and clinical disciplines, although tuition in highly specialized fields is not desirable. Sharing the basic education with others destined to follow careers as hospital consultants has much in its favour. It serves as an area of common ground in academic and social circles, and from this a mutual respect of ability and personality evolves. Indeed one major advantage afforded to Oxbridge undergraduates is the free mixing of students from a host of faculties. A second consideration for sharing basic training is that it permits individuals to reflect on their future potential, and many have changed their clinical objectives during these years. The separation of undergraduates in training for hospital careers from those entering general practice would lead to dichotomy, with those in specialized medicine having a low opinion of those in general practice.

Having acquired this education, young doctors can then enter general practice training and learn the specialized skills necessary to become a primary care practitioner. In this way the objectives of the College, which must be forever paramount, can he achieved: 'Cum Scientia Caritas'.

This still begs the question, 'Why is there not a uniformity of skill practised in primary care?' It is my belief that the reason is to be found in the recruitment of medical undergraduates. It is all very well to assume that the higher GCE 'A' level attainment required for selection affords a better candidate for medical training, but this in itself is not sufficient. An interview of possible candidates is still desirable and highly relevant. Those who practice a poor quality standard of general practice largely do so because they are poorly motivated and not because of academic ineptitude. There is more chance of these facets being identified by personal assessment than by the analysis of 'A' level results on an UCCA computer.

By comparison, our veterinary colleagues, who incidentally have to have higher 'A' level grades for entry into their faculty, are also submitted to a selection interview and it must be acknowledged that their standard of practice is uniformly high throughout the country.

There is no quarrel with George Swift's view that 'reformed practice will redesign medical education'. However, issue must be taken as to how the alterations can be most beneficial. As the research units in teaching hospitals expand their scientific medical approach to the practice of medicine, so it will become more necessary for all doctors in training whatever their ambitions to experience some of the more generalized practices of medical disciplines, as is exemplified by district general hospitals and general practice. There is an undoubted rebirth of general practice and this must take the form of general practitioners becoming more involved with undergraduate teaching. An alliance between primary care academic units in teaching hospitals and general practices could well have a beneficial effect on the practices involved. This presupposes the willingness of doctors to become so involved and I feel those committed to the aims of the College could achieve this ideal. Sir Henry Wade in his Ramon Guiteras lecture of 1932 said, 'The wards are the greatest of all research laboratories. We have in our wards a treasure house of clinical wealth and opportunity.'

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Opportunistic surveillance of children

Sir,

In their recent article on opportunistic child surveillance (February *Journal,* p.77), Houston and Davis propose that detecting abnormalities in children and counselling mothers can be effectively carried out during everyday encounters in the surgery and at home.

They draw attention to the large numbers of children seen by doctors and health visitors in the first years of life, but also to the wide variation in contact rate (between three and 46 in the 12-month period).

Our own study[1] showed comparable figures. In a six-month study period in an inner London practice there were 1146 contacts with 100 infants, all of whom were seen at least on two occasions and several of whom made contact on over 20 occasions. Roughly half of these contacts occurred in the child health clinic run jointly by the general practitioners and health visitors. Despite this high clinic attendance with its emphasis on prevention, it was of interest that there was no indication that this had a sparing effect on the use of doctors and health visitors' time in other settings. Though most children were seen both in the clinic and outside, it was nevertheless felt that the child health clinic did perform a number of important functions which were not always met elsewhere. This emerged from a questionnaire given to mothers and from an analysis of the problems presented.

First, the clinic provided easy access to professional help for problems which the mothers themselves felt diffident about airing in other settings. Secondly, it provided a convenient meeting place for some mothers who felt isolated and in need of sharing their anxieties about the welfare and development of their children (not just with professionals but with other mothers). Many obtained support from each other either informally or in groups run by the health visitors.

Thirdly, it was notable that many parents used the opportunity of discussing their child's welfare to talk more freely about their own health and that of other family members in relation to the child. Much hitherto undisclosed anxiety and stress was thus detected.

The professionals themselves felt that in addition, the clinic provided an opportunity for them to meet and communicate about young families, share their knowledge and understand problems in a more comprehensive way.

Unfortunately, we were not able to comment upon the number of developmental abnormalities in children which were discovered in the clinic. However it was certain that disorders of hearing, speech and behaviour were more commonly recognized in the clinic setting than elsewhere.

While agreeing with the authors that there is a need to extend the consultation beyond the presenting complaints, it must surely be recognized that the setting too must be acceptable to both doctors and patients, and a busy Monday morning

surgery is not always the occasion to pick up delayed speech or maternal depression, let alone to provide the necessary advice and support.

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Reference

1. Williams PR, Argent EHM, Chalmers C. A study of an urban health centre: factors influencing contact with mothers and their babies. *Child Care Health Dev* 1981; **1**: 255-266.

Sir,

The authors of this paper (February *Journal,* p.77) suggest that opportunistic surveillance by the primary health care team might cover at-risk children better than local authority clinics, if all contacts between children and the team are used for this purpose. The data they give could support this view, and if the at-risk children can be identified in advance they would undoubtedly benefit from this extension of care, despite the logistic problems mentioned by the authors in their final paragraph.

However, abandoning clinics would affect low-risk children. Our practice has been running a formal well-baby clinic for many years, and can confirm that efficient as well as effective surveillance of both physical and developmental factors is enhanced by assessment at specified and clinically appropriate ages.

We have therefore reviewed our total current nine- to 12-month age group and listed all their ordinary surgery attendances, and those at the well-baby clinic when they were seen by a doctor. We have not counted telephone contacts or home visits. Of the total group 76 per cent were assessed by a doctor at an appropriate time at the clinic, 53 per cent completing the full programme (64 per cent of the clinic group). In contrast, by using surgery consultations only, 34 per cent would have completed the same programme, and a further 34 per cent could have undergone a part of it.

These results suggest that opportunistic surveillance for high-risk children should go hand in glove with programmed screening for the whole practice paediatric population, and that more results of analyses such as this should be awaited before Houston and Davis's preliminary paper is siezed upon to discredit paediatric surveillance clinics in primary care.

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Do we need to repeat prescribe?

Sir,

I commend Dr Scott on his excellent article on repeat prescribing (February *Journal,* p.91) and the thinking behind it.

I would like to question one concept in his 'Points at random' (no. 7) regarding epileptics, for whom he now prescribes anticonvulsive drugs for up to six months, and the following discussive paragraph on the same topic, wherein he writes, 'logically, four months supply of an anticonvulsant or an antihypertensive is neither particularly risky to life nor wasteful...'

In the 22-bedded observation ward which attaches to this hospital unit, I have under my care on average two to three overdose patients every single day, and among these, not infrequently, an epileptic patient passing through a depressive phase of life. I would suggest that the availability in the home of two containers, each holding over 500 tablets or capsules, presents a tempting facility to the patient whose mood is inclining toward overdose by intent.

Self-harm is a well documented hazard in a not insignificant number of epileptic patients and the ensuing problems are often profound. In this particular, therefore, I would put it to Dr Scott that it would be reasonable to exclude epileptics from long term prescribing.

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Social class and health status

Sir,

With regard to Dr Crombie's letter (April *Journal,* p.203), we agree with him that his paper presented a complex set of data; where we disagree is with his conclusion. We are pleased that Dr Crombie accepts our class differences in perinatal mortality, suggesting that in this country too, the primary care team might be able to have an influence.

The specific points that Dr Crombie makes are open to debate. First, we need to look at the quality as well as quantity of consultations. Secondly, the concept of a use:need ratio is surely one that needs further discussion and refinement rather than dismissal. Thirdly, the importance of inter-doctor variability was documented by Richardson in 1973 when he reported 'perhaps the strongest impression ... is the wide variation between general practitioners in the quantity of work they do ... our findings point towards the doctor himself as the major source of variability in consulting rates.'[1] Finally, we would also point out that the French system of bribery and compulsion has not 'efficiently solved' a problem, but has had no demonstrable effect on the uptake of antenatal services or perinatal mortality.[2-5]

Regarding his more general points about under-use and misuse of the health service, we agree that finding ways of improving uptake is vital. Is this, however, inconsistant with some forms of positive discrimination, for example, evening antenatal clinics for working women? Improvement of services can never produce total equality in health. No society on earth has achieved this, despite, in some cases, massive social engineering of a type which we do not support. All we would assert is that when something can be done, something should be done. Far from trying to spread communal guilt, we feel that the challenging position is that general practice may have a small but important part to play, not only in raising the overall level of health but also in reducing some of the social class differences. We agree that this can best be started by examining the data in an unprejudiced way.

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