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

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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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