Maternity care: *not* a duplication of resources

Sir,

Sarah Robinson is right to lament the medical take-over of the midwife's role (July *Journal,* p.346). However she is wrong in equating more general practitioner involvement in the full care of women with a duplication of skills.

Enlightened general practitioner obstetricians wish to return a more active role to midwives, and we have the power to do so. The sooner those of us who recognize the importance of this (consumers, midwives, doctors) work together as allies, rather than perpetuate age-old battles, the better.

PAUL SCHATZBERGER
The Birley Moor Health Centre
East Glade Crescent
Sheffield S12 4QN

Standards in training and non-training practices

Sir,

Dr Baker's comparison of standards in training and non-training practices (July *Journal,* p.330) was usefully thought-provoking.

I was interested in his inclusion of appointment systems. Although I note that he was careful not to say that their maximal use characterizes the best practices, the implication is apparent: 'Training practices employed more staff, were more likely to operate a full appointment system, and undertook preventive health screening more often. They were generally better equipped, performed more educational activities and were more likely to agree to participate in local audit schemes ...'

In the same issue of the *Journal,* Sir George Godber in his William Pickles Lecture (p.320), rightly urges us to be ready to change and to evolve according to local requirements with particular sensitivity to our practice population: 'a continuous process of change and development produces an acceptable result. Someone's revelation of the ideal structure imposed from the centre does not.'

Thus, not long ago we abandoned our full appointment system for a small part of the week (as described in The *RCGP Members Reference Book* 1982, p.236) and find from our patients that the service we now provide which includes a completely unbooked session on market days, is considered a better one.

Those who in the 'typical training practice' (Dr Baker's phrase, not mine) make comparisons of standards, would do well to remember the enormous variety of types of practice, many of which have become finely tuned over the years to the specific needs of their communities. Comparers can only too easily become arbiters.

R.H. WESTCOTT
East Street Surgery
South Malton
N. Devon EX36 3BU

Sampling of chorionic villi

Sir,

In an otherwise excellent editorial on sampling of the chorionic villi (July *Journal,* p.316), Peter Stott totally missed the point with respect to the introduction of this new technique and Down's syndrome.

The real issue in Down's syndrome detection is that the vast majority of these babies are now born to younger mothers and that this decreasing maternal age is a world-wide phenomenon. As this point was heavily borne out in a paper published in this *Journal,*[1] I would have expected the writer to have at least mentioned the point. Furthermore, a recent study, alas published elsewhere[2] has suggested that risk of Down's syndrome is related more to maternal morbidity and drug prescribing than to maternal age as such.

In our protocols of detection we now have a 'Maginot line' where the outdated 'over 35' rule requires to be reinforced by a more precise definition of risk. It is in this respect that chorionic villi sampling and ultrasound hold out the hope of a more targeted detection programme. With that in mind Dr Stott does not even mention the most important factor involved which is the cost of the technique relative to amniocentesis.

J.C. MURDOCH
Department of General Practice
Medical School
University of Otago
Dunedin
New Zealand

References

1. Murdoch JC. A survey of Down's syndrome under the care of the general practitioner in Scotland. *J R Coll Gen Pract* 1982; **32:** 410-418.
2. Murdoch JC, Ogston SA. Characteristics of parents of Down's children and control children with respect to factors present before conception. *J Ment Defic Res* 1984; **28:** 177-187.

Frequent attenders in general practice

Sir,

I found the paper by Dr Westhead on frequent attenders (July *Journal,* p.337) to be comprehensive, interesting and informative. I am sure that it goes some way to answering the question many of us wearily ask from time to time: 'Why, whenever there is an outbreak of diarrhoea or an influenza epidemic, do the same damn patients seem to get it every time?'

Dr Westhead makes the important point that this group of frequent attenders is worth looking at because of its effect on the workload of the practice, and I agree with him. But let us not forget the effect of other interreacting factors, such as the attitudes and behaviour of the doctor. What we do and how we do it has a profound effect on the way our patients behave, on their consultation rate, and therefore on our workload.

Maybe we should ask some questions of ourselves when confronted by the notes of frequent attenders. With the group suffering from long-term physical problems we could ask how frequently we need to monitor a well-controlled hypertensive. Could we delegate this to a practice nurse, and if we did would the standard of care be affected? Which patients are we helping by merely nodding and smiling and telling them to carry on taking the tablets for their arthritic limbs? Is this being supportive, or is it repetitive benign neglect while our brain is on automatic pilot? What proportion of these surgery attendances are doctor-initiated as opposed to being patient-initiated? If we have asked the patient back to see us again, are we quite clear why? Do our crowded waiting-rooms reflect our popularity or our ineffectiveness?

With regard to the 'psychoneurotic' group attending a practice partnership of three or more general practitioners, we should not only look at the frequency of attendance — we should also look to see if practically every entry is written by a different member of the practice where the patient has 'done the rounds' with related symptoms. Is his 'doctor promiscuity' a further sign that he cannot form and maintain relationships with anyone — let alone his doctor? How far is this behaviour encouraged by the doctor, either unconsciously by failing to recognize the real reason for attending, or consciously by passing him to another partner to sort out? Recently one new patient, when asked who her last doctor was, told me: 'I didn't have one — we were in a group practice.'

In 'doing the rounds' of the partners, the patient's notes become bulkier with each exasperated written entry and negative investigation, and in the process the patient acquires a stigma which is not merely the result of his own personality. He gradually loses all hope of being taken seriously, for as he relentlessly turns up he increases the doctor's bile which in time leads to the jaundiced eye.

Our own attitudes, the way we dispense and share care within our practices, may therefore be the biggest remediable factor in influencing our own workload. Next time we look through a fat folder and feel despairing, we should reflect on the fact that we may be looking into a mirror of our working methods.

J.R. MANTON

74 Station Road
Marple
Cheshire SK6 6NY

Sir,

I was interested to see the paper by Dr Westhead (July *Journal,* p.337) which set out to study the medical, psychological and social characteristics of frequent attenders. He noticed that the main social characteristic of frequent attenders, which was different from controls, was marital breakdown. This conclusion agreed with my own research.[1]

I felt the higher instance of marital breakdown was perhaps due to the difficulty patients have in sustaining relationships as I also noticed among my fat folders that there was a higher instance of those patients having changed their allegiance between one doctor and another.

D.M.G. GOODRIDGE

2 Hanover House
203 High Street
Tonbridge
Kent TN9 1LA

Reference

1. Goodridge DMG. An analysis of fat folders. *J R Coll Gen Pract* 1982; **32:** 239-241.

Sir,

In Dr Westhead's excellent study of frequent attenders in general practice (July *Journal,* p.337) it was interesting to note that he based his definition of frequency on four years of attendance information, unlike most studies which have been based on attendance data over 12 months. The potential problem with the latter approach is that attendance characteristics may be a temporary feature and high attenders one year may not necessarily be so in previous or later years.

Several years ago we examined the stability of attendance patterns by looking at the attendances of 698 patients registered at Howden Health Centre, Livingston, West Lothian over a three-year period. To do this we had to follow attendances for individual patients and not just examine the overall attendance patterns In the practice. Correlation analysis demonstrated stability with high and low attending patients tending to remain in these categories over the three-year study period.

Since there is very little published information on this question it would be interesting to know if Dr Westhead was able to study this aspect of attendance patterns.

CHARLES B. FREER

Primary Medical Care
Faculty of Medicine
Aldermoor Health Centre
Aldermoor Close
Southampton SO1 6ST

MICHAEL P. RYAN

Howden Health Centre
Livingston
West Lothian

Laughter and medicine

Sir,

Dr C.P. Elliott-Binns' editorial on laughter and medicine (August *Journal,* p.364) was a timely and welcome reminder of the interactions of the two, which have long fascinated me. The 'lead balloon' response by patients to attempts at iatrogenic jocularity seems often to give worthwhile insights into personality, but these are, I agree, better not attempted twice. Another interesting aspect of humour in the consulting room is the way patients often use it to conceal underlying problems which are too difficult to openly discuss. I remember particularly, one patient who successfully avoided discussion of hypogonadism due to Klinefelter's syndrome by a smoke screen of 'humour' which fooled me for quite a time.

A more specific therapeutic use of humour is in the treatment of free-floating anxiety episodes. Along with insight counselling, 'floating' and non-control techniques, I find that teaching the patient to learn to laugh at the swelling panic — often by them giving it a funny name — is a useful defusing ploy which helps many.

The description of Ventis' case of the girl at the dinner party, and her successful use of amusement to overcome an external worry, matches a similar use of humour on vaguer internal anxieties.

It is difficult to fear that at which we can also laugh.

N.E. EARLY

The New Surgery
Church Street
Ashover
Chesterfield S45 0ER

What sort of doctor?

Sir,

The authors of *What sort of doctor? Report from general practice 23,* have missed the main point of what makes a good doctor. Good doctors cure their patients: if there is no cure, at least they comfort them.

What is the point of being accessible if you are ineffective? What is the point of being a good communicator if you communicate the wrong message? What is the point of writing brilliant referral letters if you are referring the wrong patients? What is the point of examining patients if you cannot elicit their physical signs?

First of all we must be competent — only then does it make sense to strive to be sensitive. Therefore, any assessment of quality of care that does not contain questions like 'Can you feel this lump?' is vacuous.

The following idea aims to allow the direct testing of clinical acumen in a way which is neither threatening nor difficult to arrange. The idea is that the assessors should be chosen for the physical signs they exhibit and not for their enthusiasms for furthering College ideals.

With the large numbers of doctors now in the College, it should be possible to compile a register for all the most important physical signs. There must be hundreds of us with murmurs, retinopathy, jaundice and all the stigmata of chronic liver disease and so on. What a wasted resource! Now we have the College proposals for assessing quality we should inject them with a sense of clinical acumen by pooling our pathologies and conducting physical examinations on our assessors. This way of selecting assessors would, at a stroke, remove the prevalent notion that assessors are likely to be 'holier than thou' College enthusiasts. Since it is stated that there is no element of pass or fail in the assessment, any threat is removed and an element of unpredictable fun is introduced.

To start the ball rolling I offer my practice for inspection by anyone with a good physical sign for me to elicit.

M. LONGMORE

44 Ferring Street
Ferring
West Sussex BN12 5HJ