Prescribing again

Sir,

Patients may not share the current enthusiasm among doctors for practice formularies. It is sensible to have a restricted formulary so that clinicians can become familiar with fewer drugs. A formulary other than a national list is difficult since patients move from area to area and they also attend hospitals where drug treatment may be initiated. I report on a study which highlights the difficulty of persuading some patients to change their medication voluntarily.

Hypnotic drug prescribing was studied in my practice as part of a study on the treatment of insomnia,[1] three years before the introduction of the Government's limited list. This study had revealed the size of the practice population regularly taking hypnotic drugs and had shown the large variety of hypnotics used. Some of these drugs were far from ideal and despite direct intervention during the study, we had little success in our attempts to stop or modify patients' medication. The study was repeated three months after the introduction of the limited list of drugs. The practice population of hypnotic drugs takers had changed little, but the number of different hypnotics had decreased from eight to the three drugs on the limited list.

This showed that while it had proved difficult to persuade patients to change their hypnotics voluntarily, the imposition of the limited list was accepted by them. This was perhaps disappointing since altering a drug should surely by based on clinical not political grounds.

PETER ELLIS

Medical Centre
255 Eastcote Lane
South Harrow
Middlesex

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Sir,

I do not agree with Dr Marriott (July *Journal,* p. 351) that the introduction of the limited list seems to have caused few problems. Several problems have arisen in my practice, the main one owing not strictly speaking to the limited list but to generic prescribing.

There are a significant number of patients who find that the substitution of nitrazepam for Mogadon (Roche) is unacceptable. In the main they find nitrazepam stronger, sometimes to the point that they are drowsy during the day. Also a significant number of people find coproxamol not the same as Distalgesic (Dista). Although the quantities of the active constituents are the same, they are perhaps made up or absorbed differently. It would certainly be interesting to know if any other doctors have found the same. I have not noticed any other significant problems with generic substitution.

With regard to the limited list itself, I have written to my Member of Parliament on several occasions and each time one of the ministers responsible has replied saying that the advisory committee is sure that all patients' clinical needs would be taken care of. I am sorry to say that I do not agree with this. There are a number of areas where drugs for which there is a need have not been allowed. The mucolytics we know about as there has been considerable publicity in the press; this is supposed to be under consideration but is taking a long time to resolve. Another example is xylometazoline. I do not know if the committee asked an ear, nose and throat surgeon but I think if they had they would have been told that the spray (which is not now prescribable) is a more effective preparation than the drops (which are prescribable) and both preparations are very cheap.

M.M. SUNDLE

25 Edgwarebury Lane
Edgware
Middlesex HA8 8LJ

Sir,

As a strong advocate of generic prescribing, I must say that having attended the conference on prescribing on 13 September I was disappointed that the Department of Health and Social Security were unable to answer the worry about product liability with generic prescriptions expressed by the General Medical Services Committee representatives.

It seems clear to me that all companies that sell to the DHSS or to pharmacists must accept product liability or their drugs should not be approved for sale.

In the case of generic scripts issued by doctors, and supplied by pharmacists the prescription should be endorsed with the name of the company from whom it was purchased. In the case of imports from East European countries, if there was doubt about acceptance of liability by those companies it should be the responsibility of the regulating body to accept this.

DAVID A. GREGORY

13 Claremont Street
Spital Tongues
Newcastle upon Tyne NE2 4AH

Frequent attenders, workload and optimum list size

Sir,

Dr Westhead (July *Journal,* pp. 337-340) is mistaken when, in an otherwise excellent article, he says that there had been only two 'controlled' studies of frequent attenders before his. My study anticipates much of his method and conclusions by almost 20 years.[2-9] The main difference between the studies is that Dr Westhead identified his frequent attenders retrospectively while I used prospective methods. Westhead's criterion for classification was based on his own practice figures while mine was based on the reported results of contemporary studies. The subclassifications used in the studies also differ. Westhead identifies a particular group of patients from his practice records and then compares them with a standard group matched by age and sex, applying the psychological and sociological tests that he selected to each group after identification. In contrast, I identified a sample of patients by random selection of surgery attenders and applied his psychological and sociological tests as part of the admission interview. These subjects were followed up and every contact with them, made in the year following immediately after admission to the study, was recorded. They were allocated to the appropriate attendance category from this research record.

Both Westhead and myself used the Eysenk personality questionnaire and came to the conclusion that frequent attenders have higher scores on the 'N' (neuroticism) scale than the 'standard' patients. We both argue that the neurotic personality indicated by the questionnaire is a characteristic which identifies a particular reaction and behaviour pattern which should not be confused with a pathological situation. However, Westhead's frequent attenders had lower 'E' (extraversion) scores, and from this he argued that frequent attenders were also more introverted than 'standard' patients.

The general health questionnaire had not been developed when I was working on this subject but Westhead's finding that his frequent attenders scored high on this questionnaire confirms my clinical observation that a higher proportion of such patients had frank neuroses. I also employed an intelligence test and found that frequent attenders on the whole scored badly. There was evidence that the patients' intelligence status modified their attendance patterns. We both agree on the importance of marital breakdown as a social factor associated with frequent

attendance, and also agree substantially on our morbidity findings.

The two studies were conducted in dissimilar practices and Westhead's attendance rate is lower, even at current (1984) levels than my own. This provides an opportunity to assess the validity of the conclusion that a high 'N' score indicates the presence of a factor associated with a high attendance rate. Although no formal statistical comparison between the two practices is possible here, it is clear from the difference between the high scoring groups in Westhead's practice and the low scoring groups in my practice — 9.00 and 9.78 in the former and 23.6 and 24.7 in the latter — that it would be consistent with the observations to argue that my practice has higher work rates because of a larger proportion of people with a high 'N' score. In this respect the two practices have different proportions of people who have this type of vulnerable personality.

Westhead defined his frequent attenders as the top 10% of his practice and found that they were responsible for 30% of the total practice work. I calculated the equivalent figures from my sample and concluded that 15.7% of the practice population was responsible for 40% of the practice work. These proportions are similar.

The two studies provide a logical explanation for the anomalous finding that the number of consultations made by a practitioner is not related in a linear way to list size[10] and that reducing list sizes would not necessarily result in a reduction in workload which was directly proportional to the change in list size.[11] The minimum requirement would be that all practices should have equal proportions of frequent attenders.

The phrase, 'frequent attender', is simply a convenient label to categorize people according to the demands they make on their practitioners. The 'N' dimension of personality is only one factor which can put an individual into this group. Westhead's and my studies together confirm that there is no reason to assume that the proportion of vulnerable personalities is the same in every practice. This conclusion is supported by Shepherd's earlier finding[12] that minor mental illness was distributed unevenly among the London practices in his survey, and that this inequality was not an artefact produced by the different diagnostic habits of his contributing doctors.

These variables in patient characteristics may not be easily quantifiable but this is no reason to ignore them. Further work on this subject is required as a matter of urgency because a thorough understanding of the factors involved in producing demand/need for medical attention is an essential prerequisite to a successful search for high quality general practice.

ALBERT JACOB

10 William Street
Dundee DD1 2NL

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Family planning: general practice and clinic services

Sir,

I would like to reply to the three points made by Dr Watson (August *Journal,* p.396) about my article on family planning services (April *Journal,* pp. 199-200).

She is indeed fortunate to work in the Lothian area of Scotland which is well-known for its high standard of family planning service provision and excellent coordination of the hospital, clinic and general practitioner services. South of the border, only one-fifth of district health authorities had proposals to coordinate clinic and general practitioner services after the 1982 NHS reorganization.[1]

While Dr Watson is correct in thinking that the concept of the specialty of medical gynaecology has not so far been accepted by the Royal College of Obstetricians and Gynaecologists, the final word has not yet been said on this subject. I believe that an RCOG Working Party on Women in Gynaecology is shortly to present a report to the RCOG Council. Also a 1982 RCOG Working Party report on Further Specialization within Obstetrics and Gynaecology recommended specialized training and consultancies in the field of fertility and infertility. I understand that a new book specifically on medical gynaecology is shortly to be published.

I stated quite clearly that it is not necessary for all clinic doctors to work full time. The very part-time doctors I referred to comprise about one-half of the 3500 or so post-holders in the United Kingdom, who work for four family planning sessions or less a month.[2] Approximately 2% of all clinic doctors hold no recognized family planning qualification.[2] Such doctors in my view are unlikely either to attain or maintain the knowledge and skills commensurate with staffing a secondary centre to which difficult problems can be referred by general practitioners who hold the Joint Committee on Contraception certificate.

Dr Watson implies that female doctors are more likely to be able to empathize with patients than male doctors. This is surely a highly subjective judgement. While as many as half of clinic attenders express a preference for a woman doctor, there are other qualities of a clinic which rank higher in the eyes of the consumers.[3,4] Isobel Allen has shown that the friendliness of the staff and the expertise offered in the choice of methods and treatment are the main reasons for satisfaction with clinic services.[5]

SAM ROWLANDS

35-37 The Baulk
Biggleswade
Bedfordshire SG18 0PX

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Prevalence of disability in an Oxfordshire practice

Sir,

I read Dr Tulloch's paper on the prevalence of disability observed in a practice (August *Journal,* pp. 368-370) with interest, yet I was disappointed by his failure to fulfil his stated study objectives. This