Well woman care

Sir,

We read with interest the article 'Well woman care: whose responsibility?' (October *Journal,* pp. 490–491), which gave explanations for the preference many women show in attending a family planning clinic rather than their general practitioner. Perhaps your readers may be interested in an initiative which we hope will combine the advantages of both family practice and community care.

Our practice has recently opened a women's clinic which is run jointly by the general practitioner, the practice secretary who arranges bookings and reception, and two members of the Macclesfield Health Authority Community Mental Health Day Centres Team. At present, the members involved are a community psychiatric sister and an occupational therapist. Both have considerable experience with women's groups, counselling and stress-related problems. The clinic is open from 18.00 to 20.00 hours on a weekday once a month, and may open more frequently if necessary. Costs are borne equally by the practice and the Community Mental Health Department of Macclesfield District. Women are offered half-hour appointments and so far consultations have been concerned with severe premenstrual tension, obesity, depression, alcohol abuse and problems of sexual function related to contraception. Follow-up is arranged, if necessary, by the community health team or transferred to the health visitor attached to the practice.

Conventional well women care is also offered, such as pelvic examination, cervical smear tests and breast examination. However, the patients' real need seems to be for longer appointments, held at a time which is convenient for work or babysitting and an opportunity to discuss complicated and distressing problems in depth.

The title 'well woman clinic' was avoided so that women who regarded themselves as 'not well' may feel that they are welcome at the clinic.

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Variations in the night visiting rate

Sir,

Drs Brown and Hall (November *Journal,* p.539) are probably right when they suggest that the patient's and doctor's perceived need for a night visit ultimately determine that event. Their observations made in a single practice show wide variation between individual doctors' responses to night calls. This is not surprising as doctors are known to work in many different ways.[1] Furthermore, supply variables influence the night visiting rate in different practices.[2,3] Indeed, Cubitt and Tobias have already demonstrated both these points.[4] However, Brown and Hall's concluding criticism of our analysis is an unwarranted extrapolation of their findings; their data were obtained in a situation of constant average patient demand.

Our study (August *Journal,* p.395) examined the night visiting rate in 10 practices served by a single extended rota over two years, that is, by an 'average' Greenock general practitioner. Differences between individual practice night visiting rates must therefore have depended on differences between the patients in those practices which was our main conclusion.

Why this should be so is interesting. We were unable to identify any major demographic differences between the practices, and were left with the conclusion that the level of night time demand in each practice may have been a reflection of the relationship between the patients and the doctors with whom they interacted by day. Perhaps a relevant facet of this relationship was the patient's perception of their doctor's attitude to consultations for 'minor symptoms'.[4]

I believe the study of night visits to be of wider importance than the mere reliving of unpleasant experiences. They provide a well defined activity by the general practitioner, and the relevant literature provides a useful insight into the factors responsible for the wide variation in general practitioner workload. Brown and Hall have demonstrated this with their own results.

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3. Buxton MJ, Klein RE, Sayers J. Variations in GP night visiting rates: medical organisation and consumer demand. *Br Med J* 1977; **1:** 827-830.
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It had to happen

Sir,

Am I the only member of the College to be outraged by the advertisement in the October *Journal,* p.465? One more stab in the back for rational therapy, one more blatant piece of persuasion for blunderbuss treatment. Where are the high hopes for prescribing on 'rational and informed grounds' expressed in the editorial 'Preventing promotion' (September 1984 *Journal,* p.473)?

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Lorazepam-associated drug dependence

Sir,

I should like to draw attention to what, in my opinion, are the unequivocal risks of lorazepam-associated drug dependence and exaggerated withdrawal symptoms. In my experience, this can occur often with low dosage, short courses and for many months after cessation of therapy.

It is common to find other general practitioners and psychiatrists who share this view and there is also widespread lay awareness of the problem. For the last year and a half I have been communicating with the Committee on Safety of Medicines about the problem. They answer that they have received few yellow card reports on this problem.

My personal view is that this is because doctors do not realize that reporting an expected side-effect of a drug is as useful for epidemiological purposes as is reporting an unexpected side-effect for general scientific purposes. I should like, therefore, to appeal to all the general practitioners who must be seeing this problem, to report any cases to the Committee on Safety of Medicines.

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The myth of test tube embryos

Sir,

The debate on 'test tube babies' has been bedevilled from the start by careless talk about embryos. A clear definition of embryological terms and a short exposition of embryological facts may help to defuse many explosive arguments.

The creation of a human embryo begins during blastocyst implantation in the uterine wall; it does not begin at the time of conception in the ampulla of the oviduct. The fertilized oocyte in its natural 'culture medium' of the Fallopian tube