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.

P.J. SAINE
JEAN COUPE
HELEN JOHNSON

The Waterhouse
Bollington
Near Macclesfield SK10 5JL

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.

T.P. USHERWOOD

Health Centre
Duncan Street
Greenock
Renfrewshire

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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)?

D.G. WILSON

9 Banhams Close
Cambridge CB4 1HX

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.

MICHAEL ROSS

Princes Park Health Centre
Bentley Road
Liverpool L8 0SY

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

begins to cleave into two, four and eight equal cells which do not separate, but remain yoked together to form a zygote. The zygote continues cleaving until it reaches the stage of a mulberry-like ball (morula). On day four after fertilization the morula is gently pushed into the uterine cavity to land in a new 'culture medium' supplied by the glands of the uterine mucosa in the secretory phase of its monthly cycle. Here dramatic changes occur. Fluid enters the solid ball of 64 to 128 equal blast cells (from the Greek *blastos* meaning bud or stem) thus inducing their differentiation into two cell groups of quite different properties and potentials. The large outer cell mass is called trophoblast (from the Greek *trophikos* meaning nourishment), and these overactive cells will form a nourishing chorion (later placenta). The tiny inner cell mass is called an embryoblast because the cells are the potential bud cells of a future embryo. The potential embryo may never come into existence unless the rapidly dividing trophoblast invades the uterine mucosa, erodes the blood vessels of the deeper layers and embeds the whole blastocyst in the uterine wall. Only after successful implantation has secured a constant supply of maternal blood will the embryoblast come to life and begin to lay down the three primordial germ cell layers — ectoderm, endoderm and mesoderm — from which all the tissues and organs of an embryo will arise.

This creation of the human embryo by blastocyst differentiation and implantation, during the second week, has been completely ignored in discussions on *in vitro* fertilization. The world's leading experts on this topic, at their meeting at Bourn Hall,[1] discussed 'Embryonic culture *in vitro*', 'Embryonic growth *in vitro*', 'Replacement of cleaving embryos' and 'Implantation of embryos'. At the meeting it was claimed: 'We have grown some embryos to blastocysts at five days of growth, before replacing them in the mother'.[1] The *in vitro* fertilization technique was explained to general practitioners,[2] by describing 'the implantation of the fetus' via a cannula passed through the cervix into the uterus, adding the information that 'the fetus is usually at the eight-cell blastula stage'. Another expert[3] considered the 'transfer of cleaving embryos into the uterus'. Microphotographs were shown with the caption: 'The dividing embryo at the two-, four- and eight-cell stages'.[3] No wonder that Enoch Powell was quoted as protesting against 'fertilization of a human embryo outside the womb'.[4]

The sloppy use of embryological terms not only misled the public into believing that 'little human beings' were maltreated in test tubes, it misled the experts themselves into false interpretations of their work and erroneous claims about its prospects. I suggest that in future debates, in the media or the House of Lords, the unjustified claims of tissue culture workers be rejected on scientific grounds before appealing to moral convictions.

I suggest that the case for studying embryos *in vitro* and of obtaining their parts through an open glass window is closed and can be dismissed as pure science fiction. Cells of the embryo proper are first recognizable at the beginning of the third week, that is at a time when *in vivo* implantation of the blastocyst has been successfully completed. *In vitro* implantation of the blastocyst would imply malignant trophoblast invasion of a glass wall.

I also suggest that keeping pluripotential blast cells in tissue culture for more than five days is a sure way of producing pathological structures, such as disorganized, and possibly malignant, blast cell masses with faulty differentiation and bizarre pattern formation.[5]

FRITZ MICHAEL LEHMANN

34 Glasslyn Road
London N8 8RH

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Doctors and nuclear war

Sir,

General practitioners are becoming increasingly concerned about progressively rising arms expenditure at the expense of health needs. Nationally, there is increasing difficulty in providing even basic medical services as a result of lengthening inpatient and outpatient hospital waiting lists, inadequate cervical cytology and breast screening services and financial constraints on neonatal care and renal dialysis programmes. As a nation, the UK spends proportionately less on its health services than other European countries, and, according to a Government white paper, National Health Service funding as a proportion of gross national product will actually fall in 1986, 1987 and 1988.

Planned Government expenditure of over £10 billion on the Trident weapon system over the next few years can only compound the increasing difficulties of providing adequate health care. Statistically, there is an inverse relationship between arms expenditure and health indices. There is already clear evidence that Third World countries which have reduced arms spending show a corresponding improvement in health. Medical Campaign Against Nuclear Weapons, in its forthcoming campaign, 'Treatment not Trident', plans to increase public awareness of the direct connection between increased arms spending and deteriorating health standards, and to encourage diversion of UK Government spending from arms to health. This is in keeping with the British Medical Association's policy.

It is hoped that general practitioners, with their special concerns for patients' health and welfare, will lend their active support to the campaign.

IAN W. FINGLAND

West House
Edinburgh Road
Greenlaw, Duns
Berwickshire TD10 6XF

Sir,

Dr Holden writes in his letter (October *Journal*, p.497) that the College's refusal to commit itself in favour of his solution to the dilemma of the prevention of war in any form is shameful.

Although the views of Dr Holden and his colleagues in the Medical Campaign Against Nuclear Weapons are indeed one solution to a very complex political problem, they are held neither by the country at large nor by all of their colleagues, as evidenced by the ballot box and by opinion polls.

It would therefore be invidious for the Royal College of General Practitioners to align itself with this particular pressure group, no matter how praiseworthy their intentions. Council are to be congratulated on their excellent and balanced response to this attempt to involve them in the political field, and I hope that they will continue with this attitude in the future.

R.M. RIDSDILL SMITH

241 Woodlands Road
Aylesford
Kent