

8. Repeat prescriptions can be the responsibility of the doctor initiating them.<sup>1</sup>

Neither a personal nor a combined list system is synonymous with quality of care. The operation of a combined list is adaptable, and personal care can be offered if and when required by the doctor or patient. Flexibility and cooperation form an essential part of the organization of general practice.

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Reference

- Pickworth KH, Melrose DM. Repeat prescriptions: safety and control. *Update* 1972; April: 961.

Sir,  
It is a pity that Dr Tant in his editorial on personal lists mentions only the advantages of the system. As this is a controversial issue it might have been better if he had stated the pros and cons, weighed them up and come to a conclusion. To redress the balance I here record some of the disadvantages of strict personal lists.

First, for the doctor the disadvantages are:

1. He has less awareness of his partners' ways of working and has less opportunity of learning from them.
2. He loses the stimulus and enjoyment of discussing patients; discussing cases is not quite the same thing.
3. There is likely to be less consensus over management and treatment.
4. Personal lists may lead to an unfair balance of work, both in general and on a particular day when the 'busy' partner may have to lower his standards.
5. The organization of surgeries will at times be very difficult for receptionists.
6. Partners will work different hours and be less likely to meet for discussion.
7. It is uneconomic for two partners to drive long distances to the same area.
8. It is difficult for training practices to provide a realistic list for the trainee.

Secondly, from the patient's point of view the disadvantages are:

1. He has no opportunity to sample the doctors and choose the one that suits him.
2. He has little chance of seeing a different doctor if he wishes.
3. He may have to wait longer for an appointment and longer at the surgery and may feel disgruntled at other patients apparently jumping the queue.
4. In an emergency he would prefer to meet a doctor who is not a complete stranger.

To my mind the answer is a compromise. This can either be called a personal list with wide powers of discretion or a combined list with patients encouraged to see a particular doctor. The logical conclusion of Dr Tant's approach is a group of individual doctors working in the same building for convenience. This, I submit, is not a partnership.

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Sharing problem cards with patients

Sir,  
I would like to support Peter Tomson's article 'Sharing problem cards with patients' (November *Journal*, pp. 534-535). In our practice we are about to computerize our records and when we have medical summaries available on computer we hope to have two summary printouts, one for the patient and one for the practice records.

I agree with Peter Tomson's list of four possible advantages of sharing problem cards with patients and I would add three more:

1. If a patient moves away and needs to register with another general practitioner he/she can present the problem card to the new doctor. In my experience it takes between three and six months for patient records to be transferred from one general practitioner to another through the family practitioner committees so that caring for

a patient with a complex or chronic illness becomes particularly difficult during this period. This is particularly relevant in an inner-city practice like ours with an annual turnover rate of 28%.

2. The patient can carry his/her problem card when travelling on holiday or attending hospital.

3. Fully patient-held records will probably become standard practice in the more distant future. The patient-held problem card seems an ideal intermediate stage.

Patient-held problem cards are to be welcomed.

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Printed record sheets in general practice

Sir,  
The opinion has been expressed that good records are an essential part of general practice.<sup>1,2</sup>

In an attempt to improve our records we have introduced printed record sheets for certain consultations. Our practice is based in a new housing estate where 22% of the population is under five years of age. Our most common presenting complaint is the febrile child and we have therefore introduced a paediatric febrile illness chart as shown in Figure 1.

We mainly use the chart for children under two years of age but sometimes for children over this age at the discretion of the doctor. We have now been using this

PAED FEBRILE ILLNESS		Date:	Where Seen		S. H.V.	Seen by		
<input type="checkbox"/> Positive or Abnormal <input type="checkbox"/> Negative or Normal <input type="checkbox"/> Not Applicable or not Evaluated								
P.C.								
HISTORY	<input type="checkbox"/>	Fever	EXAMINATION	<input type="checkbox"/>	Pyrexia	LABORATORY	<input type="checkbox"/>	MSU
	<input type="checkbox"/>	Irritability		<input type="checkbox"/>	Colour		<input type="checkbox"/>	Urinalysis
	<input type="checkbox"/>	Feeding		<input type="checkbox"/>	Alert/Active		<input type="checkbox"/>	Throat swab
	<input type="checkbox"/>	Taking Fluids		<input type="checkbox"/>	Neck stiffness		<input type="checkbox"/>	Other - specify
	<input type="checkbox"/>	Medication		<input type="checkbox"/>	Bulging fontanelle		<input type="checkbox"/>	Heart
	<input type="checkbox"/>	Medicine allergy		<input type="checkbox"/>	Abnormal lethargy		<input type="checkbox"/>	Rate =
	<input type="checkbox"/>			<input type="checkbox"/>	Dehydration		<input type="checkbox"/>	Sounds
	<input type="checkbox"/>			<input type="checkbox"/>	(R) T/M		<input type="checkbox"/>	Murmurs
	<input type="checkbox"/>	Pulling at ears		<input type="checkbox"/>	(L) T/M		<input type="checkbox"/>	Abdomen
	<input type="checkbox"/>	Nasal congestion		<input type="checkbox"/>	Nasal Passages		<input type="checkbox"/>	Tenderness
DIAGNOSIS	<input type="checkbox"/>	Otitis Media	TREATMENT	<input type="checkbox"/>	Tonella	<input type="checkbox"/>	Guarding	
	<input type="checkbox"/>	Tonsillitis		<input type="checkbox"/>	Inject <input type="checkbox"/> Exudate <input type="checkbox"/>	<input type="checkbox"/>	Hernia	
	<input type="checkbox"/>	URT		<input type="checkbox"/>	Glands	<input type="checkbox"/>	Skin	
	<input type="checkbox"/>	Chest Infection		<input type="checkbox"/>	<input type="checkbox"/> Cervical <input type="checkbox"/> Spleen	<input type="checkbox"/>	Rash - describe site and form	
	<input type="checkbox"/>	Gastroenteritis		<input type="checkbox"/>	Chest	<input type="checkbox"/>		
	<input type="checkbox"/>	Croup		<input type="checkbox"/>	Tachypnoea	<input type="checkbox"/>		
	<input type="checkbox"/>	UTI		<input type="checkbox"/>	Indrawing	<input type="checkbox"/>		
	<input type="checkbox"/>	Primary HSV		<input type="checkbox"/>	Adventitia	<input type="checkbox"/>		
	<input type="checkbox"/>	Other - (specify)		<input type="checkbox"/>		<input type="checkbox"/>		
	<input type="checkbox"/>			<input type="checkbox"/>	Specify	<input type="checkbox"/>		
		<input type="checkbox"/>	Antibiotic	<input type="checkbox"/>	R/V	<input type="checkbox"/>	Report progress by phone	
		<input type="checkbox"/>	Oral decongestant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If not settling	
		<input type="checkbox"/>	Cough syrup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date given	
		<input type="checkbox"/>	Ear drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharged	
		<input type="checkbox"/>	Nose drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Antipyretic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
COMMENTS - (include any relevant family or social history)								

Figure 1. The front of the paediatric febrile illness chart. The reverse side has space for details of follow-up.

chart for nearly a year and have found the following advantages:

1. Legibility.
2. Standardized recording of both positive and negative data.
3. Standardized approach to a common problem.
4. Can be used for audit.
5. Occasionally acts as an *aide-mémoire* for some important point omitted from history or examination.
6. The sheet could be used for research purposes, for example, mean time between onset of symptoms to presentation. Indeed the importance of research in general practice is emphasized in a recent College publication.<sup>3</sup>
7. The sheet could provide convenient format for computerization of data.

The disadvantages are:

1. The cost.
2. Suitable at present for A4 files only.
3. Practical problems arise as to where to store in A4 file.
4. Some parts of the chart are restricted in space.

Overall our experience has been favourable and we feel that the advantages far outweigh the disadvantages. Printed sheets of this kind are used extensively in some parts of the USA where I first encountered their use. We are pleased with the limited introduction of our printed sheets and hope ultimately to expand their use to some other common presenting complaints.

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#### References

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2. Tulloch AJ. Record requirements. *J R Coll Gen Pract* 1984; 34: 68-69.
3. Royal College of General Practitioners. *Quality in general practice. Policy statement 2*. London: RCGP, 1985.

## Infant immunization and Reye's syndrome

Sir,

I was interested to see in the current *1985 Members reference book* two adjacent articles on infant immunization<sup>1</sup> and Reye's syndrome.<sup>2</sup>

Like the practices involved in the study on infant immunization, I used to recommend junior aspirin or paracetamol for the minor side effects of immunization. However, the second article on Reye's syndrome reminds us of the possible association between aspirin ingestion in young children and Reye's syndrome:

*The drugs and therapeutic bulletin* (8 October 1984) contains an article on this possible association and I quote their conclusions:

'The possibility of an association between aspirin and Reye's syndrome has been raised and cannot be ignored, although the case is far from proven. While the issue remains unresolved, it seems sensible to recommend paracetamol rather than aspirin as an antipyretic in infants and children. Further epidemiological and laboratory studies are in progress.'

I would be interested to know what effect this has had on other practices' prescribing habits. My own view in spite of the association being unproven is that it is better to be safe than sorry.

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#### References

1. Floyd CB, Freeling P. Infant immunization side-effects. In: *The Royal College of General Practitioners 1985 members' reference book*. London: Sabrecrown Publishing, 1985: 339-341.
2. Hall S, Bellman M. Consider Reye's syndrome. In: *The Royal College of General Practitioners 1985 members' reference book*. London: Sabrecrown Publishing, 1985: 343-344.

## Report of a case of adder bite with near fatal result

Sir,

This case report is made to emphasize the need for a wider awareness of the management of adder bites.

*Case report.* The patient, a retired general practitioner in his sixties, was alone at a holiday caravan in the Yorkshire dales on a warm day in July. He knelt in the rough grass beside the caravan and immediately experienced severe pain in his knee. He inspected his knee and saw two tiny adjacent marks in the infrapatellar region. He then looked in the grass but saw nothing. During the following 12 hours his entire leg become grossly swollen and painful, and he felt nauseated, weak and faint. The following morning he still felt extremely unwell and decided to drive home to seek help. Not far from the caravan he blacked out and the car overturned causing severe damage to the vehicle but fortunately no injury to the driver. He was seen by a general practitioner who empirically prescribed hydrocortisone and then by a consultant surgeon at home. Neither doctor nor surgeon suspected the diagnosis of adder bite which was made two days later by a doctor with previous

experience of snake bites. Recovery was slow but uneventful, the leg taking two to three weeks to return to normal.

*Comment.* This patient almost certainly suffered an adder bite to his knee with resulting severe symptoms of envenomation. It is of interest that three different doctors did not initially suspect the diagnosis of adder bite.

Although adder bites are rarely fatal they can be the cause of considerable morbidity.<sup>1</sup> This case demonstrates the need for both general practitioners and hospital doctors to be aware of the symptoms and management of adder bites especially in those areas of the country in which adders may be prevalent. Perhaps this could be achieved by circulating the information contained in an excellent review article by Reid.<sup>2</sup>

There are grounds for introducing a system of notification of such bites so that the true incidence of the problem may be assessed and the distribution of stocks of Zagreb antivenom organized effectively.<sup>2</sup>

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#### References

1. Anonymous. Treatment of adder bite. *Lancet* 1976; 2: 185-186.
2. Reid HA. Adder bites in Britain. *Br Med J* 1976; 2: 153-156.

## Level of immunity to rubella in several group practices in Ireland

Sir,

Nine trainees in our final year on a three-year vocational training course in Ireland studied the immune status for rubella in females attending our practices in the age groups 14 to 40 years.

Two hundred and thirty-seven women were studied over a six-month period. Our results showed that 94.5% of all the women studied were immune to rubella. This is comparable to previous studies in the UK — for example, Rowlands<sup>1</sup> found 88% immunity and Rose<sup>2</sup> found 96% immunity to rubella. In our survey 4.9% of those who claimed to have had previous vaccination were non-immune.

The women's level of knowledge about the dangers of rubella on the fetus was found to be high and this was so throughout all age and socioeconomic groups. However, in the 14-20 year age