guidelines to reduce the need for hospital attendance. It would have been interesting to apply these guidelines prospectively as there would appear to be intrinsic difficulties in the suggested protocol.

The main difficulty would be in obtaining the information necessary to apply the guidelines. This is demonstrated by the data presented; epileptic patients are unlikely to carry any information about themselves and, as half the fits occurred outside the home and less than half the cases had transport arranged by relatives, there may be no one to speak for them. Elderly epileptic patients are likely to live alone and even a well-meaning neighbour, who might call an ambulance, could not be expected to have the information required. Finally, patients who are having a fit, or are even post-ictal may not be able to cooperate.

Drs Hunt and Touquet have formulated an idea for the better management of epileptic patients. It would appear that the most crucial improvement would be for all epileptic patients to carry up-to-date and detailed information about their condition.

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Teams for tomorrow

Sir,
Dr Brook's article (June *Journal,* p.285) says nothing new, and those of us who have a continuing interest in primary health care have continually tried to draw attention to the failure of the present system.

It is obvious that no one profession can cope alone and I have stated that there must be a new approach to primary health care.[1] I have advocated a system in which there is complete surveillance of every household in each community provided by three new categories of members of the primary health care team, supported by the general practitioner. The new categories proposed are clinical associate, community nurse and nursing aide, each with well-defined training programmes and roles.[2]

I have also addressed the question of team work in primary health care.[3] It is essential that all the professional members of the team are equal, but the doctor must assume overall responsibility for that is his legal brief. Professional equality allows ideas to be proferred, discussed and rejected or accepted on merit. However, is it of any value talking about a primary health team when the goals of primary health care have not been clearly defined?

Dr Brooks has failed to address the financial implications of the present primary health care system, and of any proposed changes to it. After consideration, I have come to the conclusion that where cost-benefit and cost-efficiency are of prime importance the basic services of primary health care are potentially better provided by suitably trained paramedical staff.[4]

I have recently been in general practice in Alva, Clackmannanshire and I have no doubt where a caring, cost-effective, all-embracing, comprehensive primary health care system lies in the future — certainly not with the general practitioner, as at present.

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Ethical guidelines for sick doctors

Sir,
It became apparent at a recent postgraduate meeting on ethical problems in general practice that family doctors of all ages experience great difficulties in coping with the problems posed by illness within their family or their partnership. A wide range of views also exists regarding self-diagnosis and -treatment.

No one present was aware of any guidelines, either from the College or elsewhere, on ethical behaviour in such circumstances. We believe that such guidelines would provide a framework within which better care for sick doctors and their families could be provided. Our recommended guidelines are as follows:

1. Doctors should be registered with a general practitioner who should not, except in exceptional circumstances, be a partner.
2. Doctors' families should be similarly registered.
3. Doctors should not refer themselves directly to a consultant for an opinion except in circumstances where any other patient would do so, for example venereology clinics or family planning clinics.
4. Doctors should be wary of self-diagnosis and should not initiate treatment with 'prescription only' medications, including antibiotics, for themselves or their families.
5. In general, sick doctors should act as model patients. Any special consideration shown by colleagues caring for them should be regarded as a privilege and not as a right.

These recommendations should not be regarded as comprehensive or restrictive. They are intended to help those who choose to care for sick colleagues to provide the same high standard of medical care we would wish our other patients to receive. We would urge family practitioner committees to forbid the registration of a principal on his or her own list of patients.

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Caritas, quality and general practice

Sir,
Primary health care — an agenda for discussion,[1] the Government's green paper, raises major clinical, educational and political issues. The faculties are discussing this document to enable the College to make an informed contribution towards the Government debate.

However, the document asks more questions than it answers; what constitutes good practice is still uncertain, although a good practice allowance is now being talked about. The College has considered quality in general practice in detail. Indeed the recent policy statement[2] raises many of the same issues as the Government's green paper. The policy statement is an excellent discussion about quality in primary care and its importance, and follows on naturally from the College's consultation document

Towards quality in general practice and the launch of 'What sort of doctor?'[3] and the 'quality initiative'.[4] Indeed the practical application of 'What sort of doctor?' has been attempted quite enthusiastically by some faculties[5] and can be seen as a major step towards assessing the quality provided for patients by everyday general practice.

All the documents and discussions about quality reaffirm the importance of general practice, while looking for some consistency in the quality of service to patients. Unfortunately many of us still feel that quality of care has not been defined — indeed we are unsure how to measure it. This problem is not peculiar or unique to general practice.[6] We can measure quality in terms of structure (practice profile, members of staff attached and employed, building and surgery hours), process (what we do in consultation and prescribing) and outcome (changes in health of the individual or population).

Any attempt to raise the standard of patient care must be welcomed. The underlying principles of objective inquiry into structure, process and outcome, followed by standard setting with concensus and local peer assessment merits serious consideration.[7] However, we find ourselves caught in the trap of measuring those things which can be easily measured, and transferring this measurement to all aspects of care. A variable that is measurable may make it sensitive but it does not make it valid.[8]

Can we really measure 'good care', and indeed can we even agree on a definition of 'good care'. The biggest criticism of all the various documents discussing quality is that they have more to do with the doctor and his quality, than with the care of patients. For many of us patient care is of paramount importance: 'Personal satisfaction is derived from doing the job of general practice well-fostered by the doctor/patient relationship'.[4] We can aim for high standards and the College is appropriately involved with this.

I can look objectively at my infant immunization rates and note that nearly 100% has been achieved. I can look at my prescribing figures and note a low prescribing rate — but is low prescribing necessarily good medicine? I can look at my referral rate and be surprised at the low referral pattern — but is low referral necessarily good medicine? However, being confident about these figures does not help me with the care of individual patients.

How do I feel about the young lady with the breast lump that I felt sure was benign; after my initial reassurance, referral resulted in a mastectomy for breast cancer. How do I feel about the medicines I prescribe that I do not really believe in? The penicillin I sometimes prescribe for sore throats seems more likely to produce allergy than to stop any associated streptococcal problem.[9]

Even more important are the reluctant patients — those who do not come to see me because I do not understand them, or because they find me difficult, insensitive or too sensitive. How do I feel about the young girl who is still depressed five years after her mother's death, but who would not come to see me? Fortunately she discovered that one of my trainees was rather easier to talk to about her feelings. But how many more of these patients are there?

Evidently we still have not decided what we mean by quality in general practice. If we concentrate on measuring the measurable items in general practice, we will improve something. But surely there is far more than that to good everyday general practice.

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Do women bother about their cervical smear results?

Sir,
The women most in need of cervical screening are the least likely to attend of their own accord. It was the death of a single woman that provoked a public debate over the responsibility for notifying an abnormal result.[1] Fifteen per cent of invasive carcinomas of the cervix have been attributed to failure of follow-up of abnormal cytological results;[2] failure to implement treatment being one problem of the cervical cytology screening programme in Britain.[3] In Scotland recommendations have now been made that every woman should be notified of her cervical smear result.[4,5]

In our inner city practice, which has a strong bias to social class 5 patients, we hold two well-woman sessions per week. We also do opportunistic case-finding cervical smears during surgery consultations.

Whenever a patient has a smear taken she is told to collect the result, either in person or by telephone, from the receptionist after four weeks. The reports are taking on average four weeks to be returned by the laboratory. The date the smear was taken and the message to be given to the patient, for example 'clear' or 'see doctor', are entered in the practice results book when we receive the report; the 'message' is ticked off in the results book when the patient has collected her result. No laboratory or X-ray report can be filed until signed by both partners and the 'patient message' entered in the book. The results book is kept with the receptionist at all times.

When the smear is taken, we stress to the patient that it is her responsibility to collect the result as a fail-safe in view of previously publicized problems in other areas. She is also told that if the result is not available when she telephones, she must ask weekly until she has it. Whenever further action is required the woman is routinely sent an appointment for surgery attendance.

Between 1 April 1985 and 1 April 1986 a total of 205 smears were taken, of which 81 were eligible for item-of-service payment: 71 women requested and were given their result; four of them had abnormal smears requiring further action. However, 134 women did not request their cervical smear result and seven of these required follow up.

Despite a results information procedure which is simple and easy to operate, two-thirds of the screened women, who have been sufficiently motivated to have a smear taken, do not bother to ensure their own follow up. We consider this to be an important consideration in patient management.

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