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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Patients' access to records

Sir,

Dr Marshall Marinker, in his editorial, 'Who owns the patient's record?' (October *Journal,* p.442), has chosen to attempt an analysis of the questions and a discussion of the values involved rather than simply to count votes.

Where the profession is evenly divided, it is becoming common for the Royal College of General Practitioners to attempt to produce a response based on an informal collection of personal opinions rather than to seek a position determined by a democratic vote of members.

The conference of local medical committees and the annual representative meeting of the British Medical Association this year discussed this question, and all the arguments for and against patient access to records mentioned by Dr Marinker were well rehearsed in open debate. Both conferences voted narrowly to oppose subject access, by 127:115 and 184:169 votes respectively.

If the British Medical Association and its craft conferences can only decide a policy on the issue after it has been debated by national representative meetings, how can the College throw its weight to one or other side of the argument without such open and informed evaluation?

Dr Marinker may think it simplistic to count votes but there are many who believe the College would be wiser to seek the views of its membership in a structured way on this and other current, contentious issues before making editorial statements such as, 'Perhaps we should earnestly hope that society will force this change on the profession'.

Personally, I am against subject access to the manual record for the many reasons cited in Dr Marinker's article but especially because such legislation will be retrospective and cover entries made by doctors before enactment, and because it will devalue one of the principal tools of my trade used to enhance patient care.

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General practitioners' awareness of the drinking and driving offender

Sir,

A recent edition of the *Journal* included an editorial and two papers on alcohol problems in general practice (September *Journal,* pp. 396, 407, 409). I would like to draw attention to one alcohol problem which does not receive adequate attention from general practice: the drinking and driving offender.

There are nearly 100 000 convictions annually for drunken driving and one third of offenders over the age of 30 years have an alcohol problem. The majority are unknown to their general practitioner and therefore have not been offered help. A conviction for drinking and driving offers a case-finding approach to alcohol problems in general practice.[1] Most local newspapers publish a list of convicted drivers allowing practitioners to identify their patients who have alcohol problems. In addition, those drivers who have an alcohol problem, shown by raised gammaglutamyl transferase levels at the time of arrest usually become worse after the ban from driving. These patients represent a particularly dangerous group of offenders, commonly with increased medical and social morbidity, as well as an increased risk of accidents.[2]

Studies conducted in Tayside found that general practitioners had prescribed benzodiazepines to patients without realizing that a pending court case for drunken driving was the underlying cause of the anxiety. This dual threat of alcohol and drugs to traffic safety demands attention. Apart from regarding a conviction for drinking and driving as an indicator of alcohol problems, general practitioners, when faced with unexplained anxiety, should ask the patient 'Have you been in trouble with the police recently?'

Since May 1983 the Road Traffic Act has recognized drivers who have two convictions with alcohol levels greater than 2.5 times the legal limit as 'high risk offenders'.[3] These drivers apply for their licences to be restored after their period of ban (usually three years) and the decision to grant a licence will be based partly on the information which the driver's own general practitioner gives to the medical advisers of the Driver and Vehicle Licensing Centre. General practitioners should, therefore, be aware which of their patients have been convicted for drinking and driving and be able to record the alcohol history during the period of ban with an accuracy that allows fair assessment of the driver's fitness to hold a driving licence.

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3. Departmental Committee, Department of the Environment. *Drinking and driving.* London: HMSO, 1976.

The MRCGP exam: what does it measure?

Sir,

I am a course organizer and I was recently invited to spend a day observing oral

examinations for membership of the Royal College of General Practitioners. It is often proposed that the examination is a suitable end-point for judging competance to practice as a general practitioner. At the end of the day I came to the following conclusions about what the MRCGP examination does and does not achieve.

The examination did demonstrate which of the candidates had something extra, by which I mean those who read about their work, care about it and above all have a willingness and ability to think about and even advance their discipline. The examination thus achieves its aim of identifying doctors who one would like to see as members of the College. It also picks out the doctors who will be able to lead and inspire future trainees. None of the oral examinees, however, appeared to be in any way unsafe to practice as principals. A proportion of the candidates get such low marks on the written papers that they are not invited to the orals. Obviously, I am not able to say anything about these doctors beyond noting that they have failed tests which concentrate mainly on knowledge rather than performance.

The conclusion is that as a measure of satisfactory albeit pedestrian competence as a general practitioner the membership examination is not appropriate; some other criterion of assessment needs to be found. To this end both the Joint Committee on Postgraduate Training in General Practice and the Association of Course Organizers are looking at continuous end-point assessment of vocational training.

My thanks are due to the examiners in general for having me and especially to Tom Dastur for all his kindness to me during the day.

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Marriage guidance counselling

Sir,

In her article on marriage guidance counselling in general practice (September *Journal,* p.424), Dr Corney states that many studies have indicated a decrease in the number of visits to the doctor by patients after cessation of counselling in comparison with the period before referral. She also comments on studies that have found a reduction in the prescribing of psychotropic and other drugs. I would agree that the papers that she lists do in fact come to these conclusions.

My recent survey, however, using a one-year follow up period, detected no major change in the number of prescriptions for psychotropic drugs or consultation rate during the years that counselling was available in the practice.[1] In the year after counselling, the number of psychotropic drug prescriptions actually increased, though this was accounted for by a small number of patients. A recent review of literature on counselling in general practice[2] came to the conclusion that it has yet to be proved that meeting patient's needs by counselling is better, cheaper, or in the long run more effective, than these needs being met by consultation with the doctor and the prescription of psychoactive drugs.

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2. Martin E. Counselling in general practice. *J R Soc Med* 1985; **78:** 186-188.

Primary care services

Sir,

We note that in the September *Quality in Practice Bulletin* College Council has issued a statement of the basic range of services that should be made available to patients by every practice in the United Kingdom. We assume that any resemblance between this list of services and our list published in the *Lancet* in February[1] is purely coincidental.

Nothing we have seen or heard in the debate about primary health care services, before or since the publication of the Government's green paper[2] has led us to change our views. We believe that a guaranteed minimum service comprising traditional demand-led service, continuity of care, care of certain common chronic conditions and specific preventive programmes, would give general practice a much needed sense of direction. We believe practices rather than individual practitioners should be made responsible for providing such a basic range of services. Furthermore, the development of a computerized information system for the activities of anticipatory care would allow health authorities, family practitioner committees and practices to concentrate their efforts on areas of need such as inner cities. Local medical committees would have the major constructive role of advising on appropriate annual targets for the care of specified chronic conditions, and for the various preventive measures.

This approach to the provision of primary health care follows the World Health Organization's philosophy of 'health for all', and could be the basis of a new contract for general practitioners. It could go some way to solving the major difficulties that beset general practice — namely, lack of direction, relative lack of accountability, poor measurement of outcome, inconsistency of service provision and difficulty in marrying the salaried community health service with the independent general practitioner service.

We welcome the College Council's statement.

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2. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care — an agenda for discussion (Cmnd 9771).* London: HMSO, 1986.

Fees and allowances

Sir,

The College has rejected the government's proposal to shift remuneration from basic practice allowance to capitation fees. This is understandable as we would not want a return to the oversize lists of the past. However, in some areas patients have difficulty getting a doctor to take them on even though lists are smaller than in the past.

The structure of our fees and allowances means that the highest rate of pay per patient is for the list of 1000 patients. Below that level basic practice allowance is cut, but once over 1000 patients the extra for each patient registered falls from over £20 to about £8. This leads to a dual population of general practitioners. Those with outside commitments with lists just over 1000, who are reluctant to take on extra patients, and full timers with lists of 2000 or more.

I would propose different thresholds for