51% stated that they routinely invited all girls aged 10–14 years on their practice list to attend for vaccination, while 63% stated that they opportunistically checked the girls' rubella vaccination status when they attended surgery.

Of the respondents, 97% offered a family planning service to their patients. However, 30% of these general practitioners did not appear to ask women attending for family planning advice about their rubella vaccination status, thus missing a golden opportunity to identify women at risk. Furthermore, only half of the respondents had a policy of checking rubella antibodies in women who have not been vaccinated.

In Brent and Harrow and many other areas, general practitioners are not routinely informed of the rubella vaccination of their patients either by the school medical service or by local authority family planning clinics. We believe that such notification would assist general practitioners in identifying their female patients at risk for rubella infection. We should therefore like to recommend that any other agency carrying out rubella vaccination should be responsible for informing both the patient and her doctor of her rubella status so that the general practitioner can keep definitive records of this important information.

We also suggest that the current family planning payment claim form (FP1001) should include a box stating that the rubella status of the patient has been assessed and that this should be ticked in order to claim payment.

We have circulated the results of our survey to the general practitioners in Brent and Harrow and plan to carry out a repeat survey after one year. The results will be analysed to determine whether there has been any change in policy regarding rubella vaccination by the general practitioners concerned.

We should like to thank all those general practitioners in Brent and Harrow who completed the questionnaire and the North West London Faculty of the Royal College of General Practitioners who funded the study. We are grateful to Dr C.I. Dellaportas for his assistance with analysis of the data.

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Weight reduction in the management of hypertension

Sir,

Croft and colleagues have shown the importance of weight reduction in the management of hypertension (October *Journal*, p.445). In the clinics of the Kupat Holim Sick Fund in Israel hypertension follow-up clinics are run by practice nurses. Hypertensive patients are seen monthly and all aspects of their treatment are reviewed, including their weight. In a retrospective study of nine of these clinics in the Netanya area it was demonstrated that over 50% of the patients lost over 3 kg and maintained that weight reduction for the three years of the study (Table 1).[1] The nurses work in consultation with the doctor but without the assistance of a dietician and they use protocol type diet sheets as well as weighing the patients monthly.

Table 1. Percentage of patients losing weight (initial n = 132, 2% drop-out after three years).

	Weight reduction (kg)		
	3–5.9	6+	Total
After one year	*31.7*	*14.4*	*46.1*
After two years	*39.4*	*18.9*	*58.3*
After three years	*36.4*	*18.2*	*54.6*

Reisen and colleagues found that each kilogram of weight loss was associated with an approximate drop in diastolic and systolic blood pressure of 3 mmHg.[2] Thus the weight losses achieved in the Netanya study were of an order of magnitude which could make drug treatment unnecessary.

We attribute the success of weight reduction at our hypertension clinics to the persistence of the nurses and doctors and to the community based approach employed, all primary care activities being carried out in the same clinic.

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Can general practitioners teach other general practitioners?

Sir,

Although many postgraduate lectures to general practitioners are given by 'experts', attendance at these lectures has not been shown to alter the way people work.[1] A topic review presented by another general practitioner who has a special interest in the subject will have more relevance to general practice,[1] and can also provide an opportunity for peer review.[2]

One of us (I.F.) presented a lunchtime postgraduate education lecture entitled 'Terminal care in general practice'. We wanted to ascertain whether the key points of the lecture had been appropriately targeted to the audience's practical problems. Of 30 attenders, the 19 general practitioners who had signed the attendance register legibly were contacted by telephone less than one week after the lecture. An independent researcher (R.B.) discussed a short standard questionnaire with them about the lecture, to ascertain whether they had found the lecture useful and if they were currently practising the key points.

Eighteen general practitioners answered questions: the majority (16) had found the lecture useful (13) or very useful (3); one 'did not learn much' and one found it 'no use'.

Knowledge of drug use varied widely (Table 2). All attenders appeared confident in prescribing morphine sulphate tablets Continus (Napp), but one-third were unaware of the use of morphine to control dyspnoea from lung secondaries and only two general practitioners were aware that haloperidol was an antiemetic that could be prescribed 12-hourly. The use of laxatives to prevent constipation, or even bowel obstruction in patients with bowel tumours, was a new concept to one-third of general practitioners. Half of the doctors knew that dexamethasone in high doses could reduce raised intracranial pressure from secondaries, but did not use it in practice. The role of the domiciliary physiotherapist for intermittent limb-sleeve compression (Flowtron) therapy was unknown to 14 general practitioners.

The lecture was deemed 'useful' by the majority of the attenders and had introduced new concepts to those present. The general practitioner who thought the lecture to be of 'no use' went on to state he had learned three specific new concepts; the general practitioner who felt the lecturer had not taught him much new information, learned two new concepts from it.

Table 2. General practitioners' knowledge and use of techniques in terminal care ($n = 18$).

	No. of respondents		
	Know about and use	Do not know about	Know about but do not use
Subcutaneous diamorphine	9	–	9
Haloperidol as antiemetic	2	13	3
'Dioctyl' (Medo) to prevent intestinal obstruction	10	7	1
Prophylactic laxatives when opiate prescribed	12	6	–
Morphine for dyspnoea	10	6	2
High dose dexamethasone	7	2	9
Rectal diazepam	9	6	3
12-hourly morphine sulphate tablets Continus	18	–	–
Flowtron apparatus	2	14	2
Patient's drug chart	11	4	3

There is a place for general practitioners, especially those who are not trainers and therefore have little opportunity to teach or lecture, to be actively involved in the postgraduate education of their peer group. Course organizers and postgraduate tutors should make more use of the resource of knowledge and teaching skills among their local general practitioners; the preparation of a lecture is a challenge and becomes an education in itself for the presenter.

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'There's a lot of it about'

Sir,

Clinicians can understand more about their thinking processes from articles such as Dr A.S. Dixon's (October *Journal*, p.468) which reflects the extensive study of this topic in North America.

Why, indeed, do we regard the rapid problem-solving approach of family practice as 'cutting corners' compared with the exhaustive interviewing style we learned in medical school? I believe this is largely because of the sheer weight of our nineteenth-century inheritance both in theory and in method. We revere the physicians of that era, who, using living subjects, developed teaching hospitals as laboratories for the refinement of the concepts and classifications derived from morbid anatomy.[1,2] While we increasingly see the causes of ill-health as multifactorial, the belief in diseases as discrete entities dies hard. (So for instance, if we think of asthma in traditional terms as spasmodic wheezing, then this will impede effective treatment for the large number of 'atypical' cases.)

If classical clinical method arose from a taxonomy of disease increasingly ill-fitted to present problems then of course we must evolve a distinctive approach. Behavioural disciplines will be more useful than biomedical fields in refining our clinical reasoning, especially in incorporating patients' (as well as doctors') feelings, beliefs and values.[2-4]

Dr Dixon suggests several important functions for diagnostic labels. The patient may be helped to cope by giving 'a name for the illness', as Balint put it.[5] While some vagueness may be therapeutically helpful here, it has its limits. Cassell describes the deeper understanding made possible by understanding the precise meanings people attach to significant words in medical encounters.[6] Obviously phrases like 'there's a lot of it about', are unlikely to advance medical knowledge about disease, but even here ordinary language may help. After all, a generation ago doctors clarified their understanding of chronic bronchitis through a definition using everyday words.[6] Is there any important lesson here for developing more meaningful clinical research in primary care?

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Nursing homes

Sir,

As someone who is actively involved in the registration and inspection of nursing homes under the 1984 Act I was interested to read the detailed review of the situation in North Wales by Humphreys and Kassab (November *Journal*, p.500).

The mushrooming of nursing homes presents large problems for those of us who are involved in the planning and development of services for the elderly. The siting of a nursing home is based purely on the wish of an individual to develop a nursing home, subject to fulfilment of planning authority and health authority requirements. It is my experience that most nursing home owners are not altruists but in it for the money.

It is therefore a regrettable fact of life that the care of our old people is subjected to a market economy, and thus vulnerable to changes in market forces. To obtain inpatient residential care in a private institution all that is necessary is the wherewithal to pay the fee. There is no assessment of need or of the suitability of the placing. Very often the choice of home is made by a relative.

The worrying aspect of this of course is that it is conceivable that more old people than necessary are entering institutions. It is ironical that the government is pursuing a rigorous community care policy in the areas of mental illness and mental handicap and at the same time employing policies which encourage institutionalization of the elderly. Furthermore, one does not have