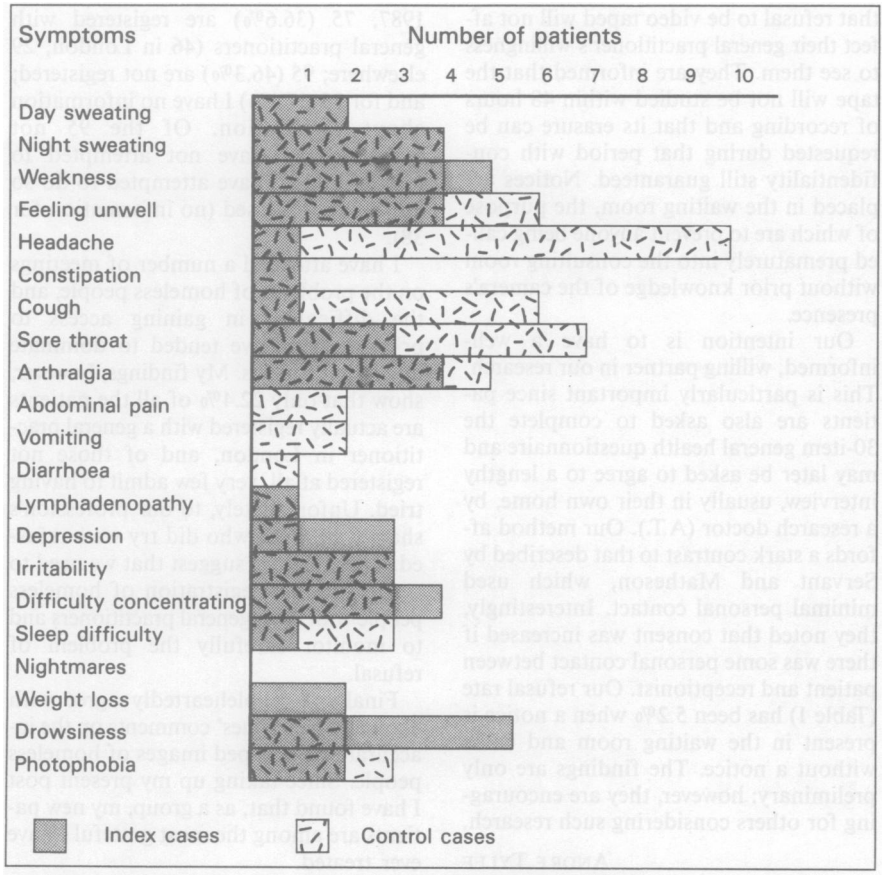

Figure 2. *Frequency of symptoms in male index cases (n = 6) and male control cases (n = 28).*

in all but one patient, as was C reactive protein. The sera of these same 18 patients were also tested for antibodies to chlamydia and found to have no significant titres; antibodies to farmer's lung antigen (*Micropolyspora faeni*) were also measured and found to be within the normal range. These latter tests were carried out for patients as a general assessment of immunological reaction. Immunoglobulin electrophoresis of 11 of the index cases showed nine to be normal while two were decreased in all bands.

A further clinical feature of note related to the obstetric history of six of the index patients. Their ages were such that only six had had babies about the time of the symptoms. One woman had a normal baby, the second had had two babies born prematurely, the first at 32 weeks that survived and the second at 28 weeks that died. A third woman had had two babies born prematurely and later a termination of pregnancy for psychosocial reasons. The fourth woman had had a termination of pregnancy for psychosocial reasons, later an inevitable abortion at seven weeks then a missed abortion at 27 weeks by dates (16 weeks by scan) and eventually a normal child in the fourth pregnancy. The fifth woman who had had a normal term baby prior to the onset of her symptoms then had two premature babies, each at 35 weeks, after her symptoms. The sixth woman had a premature baby at 34 weeks gestation after the onset of her symptoms.

I was subsequently able to present my study at the Scottish meeting of the British Society for the Study of Infections in December 1983 but in spite of a great deal of interest among the audience I was unable to clarify the aetiology of my patients' symptoms. In retrospect I have often wondered about the possibility of Coxsackie infection but was never able to fully investigate this. I would be interested to know if Dr Calder and colleagues have any serum remaining that could be tested for brucella antibodies? I would be interested to receive any comments about my group of patients.

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Personal versus shared lists

Sir,

The *Journal* is right to keep open this important debate with Dr Priestman's balanced editorial on personal versus shared lists (April *Journal*, p.147). Accessibility is a cornerstone of the quality of general practice and personal lists a key issue of accessibility.

Through working with young principals on a management course at the Manchester Business School, I have come to realize an important point in favour of personal lists hitherto unreported. Young principals, cut off from their familiar peer support and faced with established partners set in their ways, find it difficult to create a climate within their practice favourable for innovation and change. The thought of auditing a whole group practice or summarizing all the notes singlehanded (with the full knowledge others will not do their share) is overwhelming. Personal lists allow the young doctor to innovate, audit and produce change within his own list of patients. He derives the benefits personally and when his partners see the advantages, they may be tempted to follow suit. Goals are achievable for 2000 patients which are too daunting to attempt for 8000. I believe this is important buoyancy in the 'sink or swim' factor of early years in practice.

Dr Priestman correctly states that all systems are a compromise, no doctor is continuously available and we must all choose our position on a spectrum of availability. 'Getting the run around'[1] loses some force by overstatement but I doubt any of us can read this article without experiencing slight pain from a dart of truth — there is a case to answer.

In an otherwise balanced editorial, I was surprised to see terminal care grouped with acute disease as not requiring the continuity of one physician and I believe in reality shared lists do not give freedom of choice to all patients because of the varying popularity and accessibility of doctors within a group.

Let the debate proceed.

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Reference

1. Anonymous. A patient: getting the run around. *Br Med J* 1984; **289**: 357-358.

Sir,

I would like to congratulate Dr Priestman (April *Journal*, p.147) on his thoughtful editorial about personal versus shared lists. He reminds us that there is no one right answer to this dilemma now that doctors in group practice are generally not as available as patients would like. It is particularly valuable to point out that different groups of patients benefit from the two systems.

One sentence brought me up sharply: 'when a patient has to be seen by another doctor they meet as strangers, to their mutual disadvantage, and the consultation is regarded as a stopgap' [in a personal list

system]. I think this is overstated. While some patients may indeed be taken aback if they cannot see their own doctor Cartwright and Anderson[1] demonstrated several years ago that many do not mind and it may often be very valuable for a patient to meet a different doctor.

How can patients choose a doctor that suits them unless they can see several and choose? There are some group practices operating personal lists that actively discourage patients from changing to another doctor in the same group — such a policy is clearly aimed at the group of patients who 'work the system for their own purposes', to quote Dr Priestman, while others wishing to make an informed choice after meeting several of the partners are denied this possibility. Thus judgements have to be made about individual patients rather than standard policies applied to all. Unfortunately, this sort of decision cannot be delegated and inevitably doctors will be drawn into a dialogue with patients about the organization of the practice just as Dr Priestman implies in his last paragraph.

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Reference

1. Cartwright A, Anderson R. *General practice revisited.* London: Tavistock, 1981: 23.

Video recording in general practice

Sir,

Our study of the recognition of depression in general practice sponsored by the Mental Health Foundation is the multicentre study mentioned by Dr Roberts in his letter (March *Journal,* p.134). We wish to clarify any misconceptions about our methods and to report our rates of patient refusal to video taping of their consultations for comparison with those of Servant and Matheson (December *Journal,* p.555).

Our methods conform to the requirements of the Wandsworth district ethical committee. A research psychologist (H.M.) speaks to every person before they see the general practitioner being video recorded. The purpose of the study is described, the video taping procedure is explained, and what the tape is used for is described as well as who will view the tape. The patient is then given a consent form and left to decide not only whether to consent but how to complete it. The form allows the patient to choose how any recording will be used and emphasizes that refusal to be video taped will not affect their general practitioner's willingness to see them. They are informed that the tape will not be studied within 48 hours of recording and that its erasure can be requested during that period with confidentiality still guaranteed. Notices are placed in the waiting room, the purpose of which are to prevent anyone being called prematurely into the consulting room without prior knowledge of the camera's presence.

Our intention is to have a well-informed, willing partner in our research. This is particularly important since patients are also asked to complete the 30-item general health questionnaire and may later be asked to agree to a lengthy interview, usually in their own home, by a research doctor (A.T.). Our method affords a stark contrast to that described by Servant and Matheson, which used minimal personal contact. Interestingly, they noted that consent was increased if there was some personal contact between patient and receptionist. Our refusal rate (Table 1) has been 5.2% when a notice is present in the waiting room and 6.2% without a notice. The findings are only preliminary: however, they are encouraging for others considering such research.

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Table 1. Proportion of patients refusing or agreeing to video recording according to whether a notice was placed in waiting room (number of doctors = 22).

	Number agreeing	Number (%) refusing
With notice	997	55 (*5.2*)
Without notice	209	14 (*6.3*)

GP registration among homeless people

Sir,

As one of the two salaried general practitioners employed in London to provide primary health care to homeless people, I would agree with many of the points made by Toon and colleagues (March *Journal,* p.120).

I too have been looking at the registration details of the patients I see, but have asked those who said they were not registered if they had in fact tried to do so.

Of 205 consecutive new homeless patients seen between January and March 1987, 75 (36.6%) are registered with general practitioners (46 in London, 29 elsewhere; 95 (46.3%) are not registered; and for 35 (17.1%) I have no information about registration. Of the 95 not registered, 47 have not attempted to register and 10 have attempted to do so but were all refused (no information for 38).

I have attended a number of meetings on the problems of homeless people, and the difficulties in gaining access to primary care have tended to dominate discussion periods. My findings, however, show that only 22.4% of all the patients are actually registered with a general practitioner in London, and of those not registered at all, very few admit to having tried. Unfortunately, to our profession's shame, all those who did try were refused. These figures suggest that we need to try to increase registration of homeless people with local general practitioners and to monitor carefully the problem of refusal.

Finally, I wholeheartedly agree with Toon and colleagues' comments on the inaccurate stereotyped images of homeless people. Since taking up my present post I have found that, as a group, my new patients are among the most grateful I have ever treated.

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Long term benzodiazepine use

Sir,

The paper by Salinsky and Doré (May *Journal,* p.202) argues that long term benzodiazepine users are a distinct sub-group of the population because they record higher scores on the Crown–Crisp index than matched controls. The authors state that 'The suffering is unlikely to be the consequence of their reliance on tranquillizers as dependence produces symptoms only when the drug is withdrawn', but produce no evidence for this. The implication seems to be that development of a withdrawal syndrome is the only way in which long term benzodiazepine use could affect the mental state of the user. This is very far from the truth and ignores much published evidence to the contrary. Chronic use has been shown to cause depression, paradoxical increase in anxiety levels, endocrine effects[1] and personality changes.[2] Most people who have helped patients to come off long term tranquillizers will have personal experience of the often dramatic changes in personality which can occur.