

Transfer of medical records

Sir,

In response to Dr Hall's letter regarding transfer of medical records (*July Journal*, p.323), I thought it may be interesting to review the results of a brief survey conducted in the Cheshire practice where I am a trainee.

The figures were taken from registration dates between 1 June 1987 and 30 May 1988. Of the total 517 patients registered, 418 (81%) of the records had been received within one year and 99 (19%) were still to be received.

The times elapsed before receipt of the 418 records were as follows:

0-3 weeks	32%	(26% of the total)
4-12 weeks	49%	(40% of the total)
13-25 weeks	18%	(15% of the total)
26-52 weeks	1%	(1% of the total)

Of the 99 records still to be received the times elapsed since they were requested were as follows:

0-13 weeks	63%
14-25 weeks	24%
26-39 weeks	7%
40-52 weeks	6%

On examination of the registration data there were no common features of either age, distance moved or particular family practitioner committee.

Previous work carried out by Graham and Livesley¹ shows an average time of 141 days (about 20 weeks) for the transfer of medical records, compared with eight weeks which we found. However, all newly registered patients were included in our study. It often takes less than a week for newly born babies to be registered and this would account for the much lower time of eight weeks.

I consider that a system in which only two-thirds of all the records are received by three months is inefficient, and it is hoped that with the increase in computerization by family practitioner committees this will be improved.

So in answer to Dr Hall's question (is 14 years a record?) the research did not go back that far, but I should hope that Cheshire family practitioner committee is more efficient than North Yorkshire.

S. CHANTLER

Lache Health Centre
Hawthorn Road, Chester CH4 8HX

Reference

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General practice in Italy

Sir,

In his editorial (*August Journal*, p.341) Professor Horder states that the Italian government has taken no steps to control

the entry of students to medical schools. However, this is no longer the case. Recent government legislation in Italy requires fixed entry quotas of students to each medical school. All medical schools must comply with this legislation by the academic year 1989-90. Some smaller medical schools have already enforced the quota system. For example, Pisa university has taken a quota of 200 students this year, compared with an intake of 1200 students in 1978.

Although a cohort of excessive numbers of doctors will be present for many years, one would hope that in the long term general practice in Italy will have been helped by this legislation.

R. SCAFFARDI

54 Duke Street
Nottingham NG5 6GQ

Coronary heart disease prevention

Sir,

Dr Fowler's editorial on coronary heart disease prevention (*September Journal*, p.391) was thought-provoking and stimulating. As indicated in the final paragraph, few general practitioners will be able to make much impact on the problem unless a team approach is adopted. However, the editorial is largely based on a mechanistic model of disease; the risk factors mentioned are selective, and I fear that the outcome of policies based on such risk factors would be disappointing.

Nixon and colleagues at the Hammersmith Hospital have pointed out that the standard risk factors 'are implicated in less than half the cases of coronary heart disease'.¹ Furthermore, a study in Massachusetts suggested that the most important prognostic indicator for surviving heart disease 'was not non-smoking, normal blood pressure, or low cholesterol levels but job satisfaction'.²

Nixon and colleagues go on to suggest that the physiological disturbance caused by hyperventilation may be a significant factor in many cases of sudden cardiac death.¹ Such hyperventilation may be a result of inappropriate adaptation to stress. As this may be developed early in life, Nixon suggests that breathing exercises and 'something of what is taught in the martial arts' should perhaps be introduced to schools.

The assumption of the purely mechanistic approach is that we, as physicians, will be able to go on refining the 'tuning' of the individual human machine, that is, our patients, *ad infinitum*. I fear that such an approach is flawed. Recently I was almost shocked to read these words, written more than 25 years ago:

'The gap between human need and the capacity of the allopathic strategy to meet that need widens daily. That is why allopathic medicine is a passing stage in the evolution of medicine'.³

Some of us may reject such a view outright; yet the potential futility of having to treat people with mild hypertension for an average of 425 person years before preventing a stroke⁴ brings home the limitations of some of our current practice.

We must attempt to embrace a wider concept of preventive medicine that can be achieved solely by measuring blood lipid levels and so on. Albert Einstein once said: 'The unleashed power of the atom has changed everything except our way of thinking ... We need an essentially new way of thinking if mankind is to survive'. Perhaps we need a new way of thinking regarding preventive medicine in general and coronary heart disease in particular. Several years ago Patrick Pietroni wrote: 'As the importance and fundamental value of the educational model is appreciated, then certain basic changes in patterns of work will alter. Patients will be seen together in a "classroom" setting. The architecture of our health centres and hospitals will alter to allow for these activities, including the provision for a meditation or quiet room'.⁵

This appears to be the right direction to be going in; but if we are to avoid medicalizing relaxation, perhaps much of such therapy should be introduced outwith the hospital and primary care setting.

IAN R.F. ROSS

The Exchange Buildings
41 Constitution Street
Leith, Edinburgh EH6 7AU

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Medical knowledge: a 'clinical drift'

Sir,

In the editorial by Dr Styles (*September Journal*, p.389), we learn that the Committee for Postgraduate Medical Education has advocated that experience in general practice would be of benefit to doctors intending to pursue a hospital specialty and Dr Styles outlines some of the arguments in favour of this. There are more fundamental reasons, however, for

advocating a training period in general practice for future hospital doctors.

Traditionally, the two main branches of the medical profession were divided by the referral system. This process limited what constituted the 'responsibility' of a general practitioner and by extension defined the content of his work. The hospital doctor created what comprised medical knowledge and the referral system perpetuated this, as general practitioners acted as a filter for the hospital. This system successfully maintained and supported the hospital view of medicine and its knowledge base.¹

Despite the creation of the NHS real medicine and clinical responsibility were still seen to reside in the hospital and a role for the general practitioner in the hospital was argued for. This would confer both status and responsibility on them.² In addition, the maintenance of general practitioner hospitals was also advocated in the columns of the *British Medical Journal*.³

From the 1950s onwards, with the establishment of the College of General Practitioners, the developing academic status of general practice and the absorption of ideas such as those of Michael Balint gave rise to the redefinition of the clinical content of general practice and to changes in the nature of clinical responsibility. This redefinition and change involved a rejection of the hospital dominated view of medicine. The basis of clinical responsibility for patients was being renegotiated according to new diagnostic categories, and symptoms were reinterpreted in terms of holistic medicine.

As the nature of medical knowledge is now being defined in general practice, rather than by the hospital model of illness, it is important for future hospital doctors to be aware of how this process is created in general practice and the implications this has for the type of medical problems which are referred to the hospital. Gradually, if future consultants absorb the 'new knowledge' which general practice is producing, a 'clinical drift' of medical knowledge will be a two way process.⁴

RUTH SHAW

21 Hogarth Hill
London NW11

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Breast self examination

Sir,

Dr Robertson (October *Journal*, p.470) suggests that leaflets about breast self examination should be widely available in surgeries. She supports her plea with a reference to the Forrest report.¹ The report makes a curious statement on the subject: 'There is no evidence to show that BSE is effective in reducing mortality from breast cancer ... Lack of evidence on its effectiveness should not, however, discourage women from practising BSE'.

The latest UK results showed that women invited to classes to learn breast self examination had higher breast cancer mortality than women in control districts. This evidence of no effect of breast self examination was based on 400 000 women years observation.²

Offering advice to the healthy population, when there is some evidence that it is harmful,³ and no evidence that it is useful, is indefensible.⁴

PETR SKRABANEK

Department of Community Health
Trinity College, Dublin

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Records and performance review

Sir,

ACT (Anticipatory Care Teams) is a society recently established, with membership open to all members of primary health care teams. Its aim is to promote the development of primary care teamwork.

Following an inaugural conference in York in 1987 six working parties have been established, one of which is on 'Records and performance review'. We are particularly concerned with developing comparable methods of practice audit, and helping practices to make use of such data. We would like to hear from anyone who is working on a method of audit or provision of information which is transferable between practices or districts. We are particularly interested in the whole practice team approach, and in preventive and chronic disease management.

Our aim is to combine our experience with that of others in order to develop coherence in the rapidly evolving field of performance review, and then to promote

and publicize successful methods. We also feel it is very important to identify realistic performance indicators before external ones — perhaps unrealistic — are imposed.

We intend to present work at the ACT conference in October 1989, and to organize a conference dedicated to performance review late in 1989 or early 1990.

MARTIN LAWRENCE

Department of Community Medicine
and General Practice
Gibson Laboratories Building
Radcliffe Infirmary
Oxford OX2 6HE

Whither WONCA?

Sir,

A glance at the programme for next year's WONCA conference in Jerusalem gives a preview of some of the topics in store for the participants: 'Quality of life and functional status indicators', 'The biopsychosocial perspective and the outcome of pregnancy' and 'Sentinel practice network, what is the next step?'

As a tolerably intelligent doctor I have great difficulty in making out what will be discussed at these sessions and I feel that the late Sir Ernest Gowers would have had the same difficulty. Straightforward communication is surely the cornerstone of good general practice and one only hopes that this is remembered at the WONCA conference.

J.D. WIGDAHL

High Orchard
Chequers Lane, North Runcton
King's Lynn, Norfolk PE33 0RF

Acne vulgaris treatment

Sir,

On two occasions recently I have seen patients with acne vulgaris whose considerable improvement on oral oxytetracycline therapy has suddenly halted. I was not able to explain this, and was on the verge of altering their medication to a more expensive alternative, when I discovered that they were taking oral zinc tablets. These have been advertised as being beneficial for acne, and are now sold and publicized widely. However, zinc is well known to inhibit the absorption of chelating drugs such as tetracycline. Discontinuing the zinc produced a considerable improvement. Doctors treating patients with acne would be well advised to enquire about self medication with zinc.

DAVID HASLAM

The Health Centre
Ramsey, Huntingdon
Cambridgeshire PE17 1NB