

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

References

1. Armstrong D. The emancipation of biographical medicine *Soc Sci Med* 1979; 13A: 1-8.
2. Binnie A. General practitioners and hospital staffing. *Br Med J* (suppl) 1962; 1: 2989-2990.
3. Kyle D. Disappearing general practitioner hospitals. *Br Med J* 1962; 1: 1071-1072.
4. Whitfield M, Bucks R. General practitioners' responsibilities to their patients. *Br Med J* 1988; 297: 398-400.

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

References

1. Forrest P. *Breast cancer screening*. London: HMSO, 1987.
2. UK Trial of Early Detection of Breast Cancer Group. First results on mortality reduction in the UK trial of early detection of breast cancer. *Lancet* 1988; 2: 411-416.
3. Frank JW, Mai V. Breast self-examination in young women: more harm than good? *Lancet* 1985; 2: 654-657.
4. Skrabanek P. The physician's responsibility to the patient. *Lancet* 1988; 1: 1155-1157.

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