pharmacist in the supply chain.

No pharmacist would disagree that patient records are confidential. However, patients discuss their problems with others, including the pharmacist. Again, two professionals are better than one. It is clear that patients like to discuss their problems with pharmacists, not to challenge the doctor but to reassure themselves that they have understood the message they received.

The pharmacy undergraduate course nowadays includes aspects of pathology and therapeutics which equip pharmacists for the wider role of health carer for minor problems. Pharmacists supply household remedies and provide advice on minor complaints, such as cuts, colds and indigestion. This service is available locally, 10 hours a day, six days a week and in many places, for more than 12 hours a day, seven days a week. Although doctors are on call 24 hours a day, 365 days a year, how many would like to deal with such minor problems outside surgery hours? In fact, how many would feel it was their role to deal with these problems at all? If pharmacists were to disappear, would doctors be able to fulfill these functions, indeed would they want to?

Finally, as does Dr Roberts, we must consider the end user — the public. Pharmacists provide free advice on health subjects during extensive hours of trading. They are not overpaid and are part of the social structure of the community. Society would suffer if they were to disappear.

DEREK BALON
NORMAN EVANS
RUSSELL GREENE

Department of Pharmacy
King's College London
Chelsea Campus, Mauresa Road
London SW3 6LX

References

1. Committee of Enquiry in Pharmacy. *Pharmacy: a report to the Nuffield Foundation.* London: Nuffield Foundation, 1986.
2. Ley P, Whitworth MA, Skilbeck CE, *et al.* Improving doctor–patient communication in general practice. *J R Coll Gen Pract* 1976; **26:** 720-724.
3. Bertakis KD. The communication from physician to patient: a method of increasing retention and satisfaction. *J Fam Pract* 1977; **5:** 217.
4. Svarstad BL. *The doctor–patient encounter.* PhD thesis. University of Wisconsin, 1974.
5. Webb B. The retail pharmacist and drug treatment. *J R Coll Gen Pract* 1976; **26** (Suppl 1): 81-88.
6. Cockburn J, Reid AL, Sanson-Fisher RW. The process and content of general practice consultations that involve prescription of antibiotic agents. *Med J Aust* 1987; **147:** 321.
7. Austin R, Dajda R. Ancillary-written prescription errors. *J R Coll Gen Pract* 1980; **30:** 417-419.

Response to the white paper

Sir,

The majority of general practitioners object to many of the proposals contained in *Working for patients*[1] and to the speed with which the government wishes to implement its plans.

College leaders have a golden opportunity to unite general practitioners and to ensure that the government and patients are aware of their objections. It is clear that this government does not want the proposals to succeed but is aware that implementation will drive many patients to the private sector. When the National Health Service finally collapses the government has its scapegoat ready — the general practitioners who are only concerned about their wallets.

I hope that the College will provide a clear lead and help to preserve and improve the NHS.

DAVID I. JEFFREY

The Health Centre
Merstow Green, Evesham
Worcs WR11 4BH

Reference

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.

Sir,

It is only right that patients should be able to make an informed choice of doctor. It is reasonable that doctors who provide extra services should be rewarded, as should those who take advantage of postgraduate education. It is arguable that this should be at the expense of other doctors.

Of grave concern to all doctors are the government's proposals for family practitioner committees. The local medical committee is to be rendered redundant and local representation is to be removed from the family practitioner committee. A small group of people appointed directly by the government will therefore have far-reaching powers. They will have influence over the appointment of replacement partners; the power to take sanctions over prescribing; the power to monitor referral rates and the reasons for referral; and the power of veto over the general practitioner's place of residence.

There seems to be no obligation for the family practitioner committee to act upon or even take independent medical advice, which they can commission from a varie-

ty of sources. In addition there is no mention of right of appeal.

The government obviously intends to emasculate the profession as a prelude to complete removal of independent contractor status and as in previous conflicts they will use the tactic of divide and rule. In this case the potential wedge is between the College and the British Medical Association, but both organizations have much to fear from the erosion of professional status.

We must unite to fight for the power of self-regulation, and resignation would not be too strong a measure. If we concede to regulation by lay administrators then we simply cease to exist as a profession.

L.J. BURNS
M.J. RAMSDEN
G.H.J. HANCOCKS
H.P. WATSON

Upper Warrengate
Wakefield WF1 4PR

Sir,

I understand that the College is urgently preparing its position on the government white paper. Each member of the College is a general practitioner whose opinion should be expressed through his or her local medical committee and thence through the General Medical Services Committee. Has the College not yet realized that it does not represent general practice at all? Its officers are not elected by all general practitioners, only by members and fellows who presumably elect officers to run the College for the purpose of encouraging research and educational policies to help individual doctors improve standards of care.

Over the past few years the College appears to have been reluctant to accept that good general practice can only be assessed by careful examination of individual practices both at quiet and at busy times, and that even this method can be beset by problems. Measurable criteria are superficial and may be misleading. The idea that a good practice is one which has all its patients' blood pressures, smear results and serum cholesterol levels on record is simplistic in the extreme. In addition, the idea that workload measures reflect the hard work of the doctor in any meaningful way is equally naive.

I am disappointed at the lack of thorough critical evaluation that has been shown in the pursuance of measurements of quality and of the place of screening techniques in the promotion of health care. I expect far more of a College which should be the fount of highest wisdom about our profession and its activities. Instead the College seems to be over concerned with prevention and assessment and seems to have given much lower priority to educating us so that we can improve our quality of care to the sick, injured, disabled, mentally handicapped, mentally ill and worried patients who continue to need our services and will do so for a very long time no matter how many screening tests we do.

It requires no great imagination to guess where the government's simplistic notions have come from. The College does not represent the profession. It should realize that it has done enough damage already and should advise the government that there is a well established democratic system for negotiating with the profession and advise its members to use this system in the best interests of doctors and patients.

D.W. DINGWALL

Glenwood Health Centre
Napier Road, Glenrothes KY6 1HL

Sir,

Members of the College who are also readers of the *British Medical Journal* cannot have failed to note Dr Julian Tudor Hart's letter[1] and to have read that letter with deep distress. He breaks the confidentiality expected of council members and to name other council members with whom he disagrees is more than bad manners, for in this case he let us all down by seeing the government's review of the National Health Service in simplistic black and white terms. This behaviour is unworthy of a man who has distinguished himself academically.

Dr Hart's letter is impoverished by the use of politically coloured language in order to persuade us to give a complete rebuttal of the white paper. We may object strongly to proposals, such as larger lists and competition for patients, that divorce doctors from their patients or produce difficulties for young doctors and women doctors finding work. But the white paper contains a series of proposals which incorporate such excellent ideas as medical audit, annual reports, and what one of us (M.K.T.) has urged for years in an ageing society, the regular structured assessment of those aged over 75 years. As doctors, we need to listen, to discriminate and weigh evidence. Instead, we have a spokesman who alleges that 'the entire package has been cobbled together by people who fear their Prime Minister more than they respect evidence' which is neither true, nor indeed important. What Dr Hart has done is to support the government's tactic of dividing the profession by undermining our faith in our own representatives, and even our president. We cannot excuse Dr Hart on the grounds of his passionate interest in the evolution of general practice as he sees it. His cup has run over, and he must learn that ideas engendered and fostered in Glycorrwg are not applicable generally for a National Health Service.

A minister is expected to respect discriminating comment, based on professional experience. If he fails to do this, then he deserves not only the united opposition of professionals, but also of the electorate. Dr Hart has long been a critic of our education system and the need for a new kind of doctor. Let us hope that he read the letters by Dr Pilling[2] and Dr Martin,[3] which provide evidence from hospital and general practice respectively of the benefits of budgets.

M. KEITH THOMPSON

28 Steep Hill
Stanhope Road, Croydon CR0 5NS

BASHIR QURESHI

32 Legrace Avenue
Hounslow West, Middlesex TW4 7RS

References

1. Hart JT. NHS review. RCGP's reaction. *Br Med J* 1989; **298:** 888.
2. Pilling JR. NHS review. The benefits of budgets. *Br Med J* 1989; **298:** 889.
3. Martin E. NHS review. The benefits of budgets. *Br Med J* 1989; **298:** 889.

Transfer of medical records

Sir,

The government's review of the National Health Service[1] intends that we should be more subject to the discipline of market forces. They hope that making it easier for patients to change their doctor will help to make this happen.

When patients change their general practitioner the shortcomings of our medical records become more noticeable. Early in 1988 I carried out a study of medical records coming to our group practice from 60 different doctors. There was a mean delay of five weeks for records coming from within our family practitioner committee area and 17 weeks when patients had moved from another area. Hospital letters were secured in date order in 42% of the records and 23% had record cards secured. I found that 15% had a history summary, 7% a record of repeat medication and 27% an immunization record. These last three percentages can be compared with 23%, 15% and 39%, respectively from Mansfield's study in Exeter.[2]

The majority of records in this study were from the midlands so it suggests that records are worse here than in the south west of England. Patients moving from one general practitioner to another risk having the continuity of their care disrupted.

T.F. DENT

Pinfold Health Centre
Bloxwich, West Midlands WS3 3JJ

References

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.
2. Mansfield BG. How bad are medical records? A review of the notes received by a practice. *J R Coll Gen Pract* 1986; **36:** 405-406.