perusal of medicine bottles and repeat prescription cards. In only 2% of cases was there any difficulty and even in these cases it was possible to provide adequate emergency care based on clinical findings at the time. From a practical point of view therefore, general practitioners and deputies alike can manage perfectly well without seeing the records in approx 98% of emergency calls.

On the subject of continuity of care I think it is important to point out that the provision of continuity in out of hours care is not the prerogative of the group practice. Some of us who work as full-time deputies can claim continuity ratings roughly comparable. My own figures might be of interest. A study of 300 consecutive calls showed that I had recollection of previously visiting the homes of no less than 36% patients seen. Were I to repeat this study now that I have been nearly nine years in my present post, then I would anticipate a figure in excess of 40%.

Continuity is simply a reflection of time in post and the number of doctors providing the service. Obviously lower ratings would be recorded by those services employing large numbers of casual deputies, just as would be the case where calls were seen by trainees, new partners, locums and those from other practices working a large rota. There really is no difference.

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Surveillance of the over 75s

Sir,
Paul Wallace's editorial on surveillance of over 75 year olds (July *Journal*, p.267) was most discouraging as it was based entirely on theory and selected references. Doctors are not well served by the current negative thinking about reorganization, as this leads only to further discouragement.

I was glad he considers the eight parameters for surveillance, which I put forward to the RCGP in January 1988, to be appropriate. However, he then erects a number of barriers based upon theory, and not experience. Let us consider first the problem of intrusion into a patient's privacy. Such a phrase implies a barren doctor–patient relationship. My own experience of assessing over 70 year olds in my practice indicated that the older the patient the more likely it was that my visit would be welcomed. With the 30% of patients who lived alone, the difficulty was in ensuring that the visit had a medical as well as a social content. Wilkin and Williams'[1] excellent study of 17 771 consultations with patients aged over 65 years undertaken by 201 general practitioners showed that the mean time spent with each patient per year was 25 minutes divided between about five consultations — possibly not long enough to deal with complex medicosocial problems. My own figures showed that before my screening programme there were 6.6 consultations per patient per year in the 70 years and over age group. This figure fell to 3.8 in subsequent years so not only was much time saved, but the frustration of random symptom-oriented visits was avoided.

Dr Wallace quotes data from specialists which suggest that the full assessment would take 60–90 minutes. I found that, with practice, my examination took 20 minutes per patient on average, and was fully structured to geriatric anatomy and pathology. A standardized recording form is helpful both as an *aide-mémoire* and for research — my record had space for identification data by the receptionist, the doctor's examination, the social worker's or rehabilitation officer's home assessment, and the nurse's record of urine results, blood tests and blood pressure.

Dr Wallace considers it unlikely that any other member of the existing primary health care team will have time to take on the additional workload. In my practice we were perhaps fortunate in that senior nursing officers knew of our programme, and appointed appropriate personnel. In addition, time devoted to home confinements in the past became available as this work became hospital oriented. The district nurse and I often visited together to plan future management with patients, having found case conferences to be a time-wasting autocracy without the patient's presence. Such joint visiting still seems to be a rare practice.

So far as materials are concerned, I have made my record system available for many years. However, the RCGP has now produced a screening record card for the elderly.

When Dr Wallace suggests the need for training in the appropriate use of instruments and record forms I assume that he does not mean for general practitioners but for 'link workers'. However, the use of link workers would once more push the elderly to the back of the queue. The differences in doctors' perception of their role, result in a wide variation in the pattern of care provided for older patients. Many doctors still recoil from the social dimension needed in geriatric practice. Without this, however, practice would be very dull.

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Reference

1. Wilkin D, William EI. Patterns of care for the elderly in general practice. *J R Coll Gen Pract* 1986; **36:** 567-570.

Involvement of clergy in patient care

Sir,
It was refreshing to read the report by Ward Jones (July *Journal*, p.280) concerning the attitudes of general practitioners to the involvement of the clergy in patient care. Although the paper is a welcome contribution to this neglected area of study, the method used is somewhat unsatisfactory.

The principal difficulty is the use of the word religious without any definition being offered. The use of a letter from the Bishop of Bristol's advisory group in the study implies that the study was cast within a Christian context. However, given that the survey was located mainly in the city of Bristol, one can safely assume that many of the general practitioners and the patients they treat would belong to other religious groups. This factor, we believe, would have affected both the response rate and the answers received. Although the author may have wished to set the study in a Christian context, lack of data on the beliefs of the doctors themselves adds to the confusion.

Again, little distinction was drawn between religious practice and spiritual belief. This undervalues a spiritual belief whereby a person may not adhere to any particular religious practice but, nevertheless, may search for existential meaning within the experience of illness. This is not a minor quibble; some form of spiritual belief is much more common in the population than religious practice. It is a pity that no attempt was made to determine whether the general practitioners understood this distinction and how it might have related to their willingness to refer patients to the clergy.

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Budget holding

Sir,
Not being a member of the RCGP I obviously have little to lose from Dr Sykes' recommendations (April *Journal* p.170). However Dr Sykes has obviously not considered the future of general practice in

terms of health care management and provision in the decades to come.

One interpretation of the future of general practice is that it is going to follow the lines that other major businesses have followed in recent years. The rapid introduction of change is a result not only of political pressure, but also the realization that a pyramidal structure of management has never worked efficiently and is never likely to work efficiently. Such a structure has led to the managers being distant and isolated from the customer and from the employee or practitioner who actually comes into face to face contact with the customer. In general practice, the customer and client is usually the patient and his or her carers. Thus the management needs to be devolved to that level. The new management system inherent in the development of the new National Health Service and in the securing of its future is that of a series of interlocking management doughnuts†. In the new NHS there is a central management unit consisting of a group of general practitioners and/or their managers. Alternatively the centre may be the family practitioner committee. The central management liaises directly with the consumers of the service through the ill-defined flexible communications it decides upon as best meeting the needs of the managers and the clients. Good local communication ensures that appropriate services can be delivered.

The regional health authorities act as the central managers of another doughnut in which the clients (general practitioners, primary care teams and district services) are linked by the family practitioner committees.

Various other levels of management doughnut may be defined to suit the specific needs of the community. The whole process allows more direct involvement of management with the providers of care and therefore with the consumers.

The district health authorities are changing in that they are no longer the providers and paymasters. Their role is changing initially to being purchasers of medical care from a number of sources and their role is expected to diminish further with time as more and more general practitioners become direct purchasers of services.

The general practitioner, in meeting his or her role of the future, will need to be able to plan and manage his ability to deliver health care — a responsive system will become an accountable system. Those practitioners who feel that they are unable to bear such responsibility will have little choice but to become employers, directly responsible to their paymaster (the family practitioner committee) and delivering selective services only.

Better systems of communication and diversification in the technological side of general practice will allow the general practitioner to manage a disease or illness with little recourse to secondary care. If he does require such help, then he will have the controlling influence over its selection and management. The Department of Health will gradually take more of a backseat in the provision of health care, acting only as a planning unit for long term strategy. The better managed the primary care unit, the more freedom and independence it will achieve.

If general practitioners continue to avoid looking into the future of health care provision, opportunities to develop will be missed and they will find that management will be imposed upon them, both clinically and administratively. We have already witnessed the fallability of our 'contract'.

I submit, in contrast to Dr Sykes, that all practitioners should prepare plans for holding a budget under the proposed practice funding initiative in order that a better balance is achieved when the outcome of the first two year experimental period comes to a close. Failure to take part will result in future budgets being set pro rata to the needs of previously 'successful' practices.

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†A management doughnut is a sphere containing a defined centre of management separated from its outer periphery by a very flexible area. The peripheral surface of the doughnut is the contact with the clients.

Misunderstanding of 'audit'

Sir,
I was somewhat disheartened to see that the *Journal* has added to the confusion surrounding the term 'audit'. The paper by Gillam and colleagues (June *Journal*, p.236) demonstrates the misuse of the term today.

Audit is a cyclical process.[1] Present practice is identified and compared with a standard which can be either implicit or explicit. Action is then taken to alter practice to approach the desired standard. The cycle is completed by reviewing the activity under scrutiny at a later date and assessing the effectiveness of change. The process should be continuous, allowing for steady improvement in practice. Audit can be applied at any level, from individual to hospital.

Gillam and colleagues provide the descriptive background for an audit project and this is correctly identified by the authors as 'this descriptive study ... to examine the reasons for late presentation of congenital dislocation of the hip.' This in itself, however, does not constitute audit.

Audit is a powerful tool to improve the practice of medicine. We should not allow it to be diluted and its fundamental feature of feedback lost.

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Reference

1. Fowkes FGR. Medical audit cycle. *Med Educ* 1982; **16:** 228-238.

Referrals by optometrists to general practitioners

Sir,
I read with considerable interest Dr Peter Perkins' paper on the outcome of referrals by optometrists to general practitioners (February *Journal*, p.59). I agree with his claim that general practitioners filter and direct patients along the pathway between optometrists and ophthalmologists. However, I question whether general practitioners are effective in such filtering. I would like to refer him to an earlier study we conducted where 10% of patients were lost somewhere along this pathway between the optometrist, the general practitioner and the specialist.[1]

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Reference

1. Kljakovic M, Howie JGR, Phillips CI, *et al.* Raised intraocular pressure: an alternative method of referral. *Br Med J* 1985; **290:** 1043-1044.

Benefits of developmental screening

Sir,
Having spent many hours as a community medical officer in unproductive screening of pre-school children, I strongly support Professor Bain's views as expressed in the *Journal* last year.[1] Most of the abnormalities discovered, with the exception of visual and hearing problems, are either irremediable or already recognized or both. Dr Hooper's letter (July *Journal*, p.303) only serves to confirm this opinion.

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1. Bain DJG. Developmental screening for preschool children — is it worthwhile? *J R Coll Gen Pract* 1989; **39:** 133-135.