References

1. Albright SD. Treatment of skin cancer using multiple modalities. *J Am Acad Dermatol* 1982; **7**: 143-171.
2. Wolf DJ, Zitelli JA. Surgical margins for basal cell carcinomas. *Arch Dermatol* 1987; **123**: 340-344.
3. Colver GB, Dawber RPR. Cryosurgery — the principals and simple practice. *Clin Exp Dermatol* 1989; **14**: 1-6.

Doctors and pharmacists — working together

Sir,

I wish to concur with the suggestion of Beswick and Elliot (letters, June *Journal,* p.259) that the drug information needs of general practitioners may be fulfilled by liaison with local community pharmacists, supported by drug information services. Indeed, this arrangement may be the only feasible solution to the probable escalation in drug information needs that may come about through the indicative prescribing scheme and its sequelae. It seems unlikely that there will be enough drug information pharmacists or clinical pharmacists when all practices are devising and updating their own formularies. General practitioners and community pharmacists could be brought together under the auspices of the family health services authority, with whom both are already in contract. The liaison could and should be led by medical and/or pharmaceutical advisers.

There are large gains beyond simple information sharing, for both participants. For community pharmacists it would bring them into a working relationship with local general practitioners which would be one of cooperation rather than antagonism. For general practitioners, the local community pharmacist may be seen as a relevant and useful information source, for example, in knowing which drug packaging is most suitable for elderly people. Such a new liaison would allow general practitioners to exploit the largely untapped resource that is the knowledge base of pharmacists.

This has already been proposed in one district known to me and is, hopefully, to be progressed through the local pharmaceutical and local medical committees, with the backing of the family health services authority and medical adviser. This may well be a model worthy of application more widely.

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What patients think of the way their doctor dresses

Sir,

I was very interested to read the paper on what patients think of the way their doctor dresses (July *Journal,* p.275). Unfortunately this study is flawed in several ways.

Some classic research from Oxford[1] showed that videos of 'still' subjects with and without spectacles were given different IQ ratings. When an interview of the same subjects was shown the IQ difference disappeared. I would contend that the comparison of still photographs, as used in McKinstry and Wang's study does not provide an adequate basis for assessment.

There are also problems with the images presented. For example photographs F, G and H of the woman doctor are different in more ways than simply her style of dress. The background in the three photographs varies slightly, with a stethoscope visible in photographs F and G, but not in photograph H. Advertisers use such subtle differences all the time.

This study has aroused a lot of interest in the medical and popular press and may have undue influence on the way in which doctors present themselves to their patients. I hope that it will prove possible to extend this study, perhaps to videotaped standard consultations in which the only variable is what the doctor wears. This should provide some interesting results.

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Reference

1. Argyle M, McHenry R. Do spectacles really affect judgement of intelligence? *Br J Soc Clin Psychol* 1971; **10**: 27-29.

General practitioners and work in the third world

Sir,

I was interested to read the letter on British doctors serving in developing countries (July *Journal,* p.304) and entirely agree with the points made by Dr Morris on the need to encourage and fund doctors from the United Kingdom to serve overseas.

In the 1980s when working in India, I discussed with the Joint Committee on Postgraduate Training in General Practice the idea of posts in developing countries being accredited as equivalent experience for vocational training. I would encourage others to follow up this idea. The Royal College of General Practitioners or the Overseas Development Administration could be encouraged to pay a grant to those successfully applying for such posts, each of which would need to be visited and accredited for suitability.

With regard to the need for umbrella organizations to facilitate overseas medical experience, readers might like to know that several such organizations are actively involved in the placement and care of doctors working abroad. The Bureau for Overseas Medical Service maintains a database of overseas posts, and runs excellent introductory courses for those planning to work overseas. The Medical Missionary Association publishes a regular list of urgent staffing needs in christian hospitals and health programmes overseas. Finally, InterHealth is a relatively new organization which offers a specialist screening, clinical, advisory and immunization service for those serving overseas and currently acts as medical adviser to many christian missions. It includes on its staff several physicians and psychiatrists with first hand overseas experience. I would gladly supply more information to anyone interested.

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Useful addresses

Bureau for Overseas Medical Service, Africa Centre, 38 King Street, London WC2E 8JY.
Medical Missionary Association, 224 Camden Road, London NW1 9HE.

Stroke and the carer

Sir,

I read with interest the recent editorial on stroke and the carer, by Cassidy and Gray (July, *Journal,* p.267) and agree wholeheartedly with the authors' plea for support for carers and adequate provision of information and counselling.

In my local area, concern was expressed by carers about the lack of user-friendly information, and to help remedy this, Forth Valley health board have produced a video entitled *Stroke: caring for someone at home.* As part of the pre-production planning, a number of carers were interviewed and they all emphasized their need for information on a continuing basis. Interestingly, the majority expected this to come from their family doctor.

It is clearly unrealistic to expect all general practitioners to be up to date with every available source of practical, social and emotional help for carers. I wonder whether it may be possible to encourage increased liaison between general practi-

tioners and the statutory and voluntary agencies (including social work departments, Crossroads care attendants scheme, and the Chest, Heart and Stroke Association) to provide specific information areas in health centres for carers of disabled people of all ages.

As Cassidy and Gray point out, the planned increase in community care is likely to increase the burden on informal carers who need and deserve assistance and support.

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General practitioners and psychiatry — a need for cooperation

Sir,

I read with interest the editorial on general practitioners and psychiatry (June *Journal,* p.223). As psychiatric practice becomes more community oriented and as large mental hospitals are closed, it is essential that general practitioners become involved in the care of mentally ill patients for whom they will have to take on responsibility.

However, some important aspects seem to have been forgotten in the wave of change in psychiatry. With the advance of medical science, there has been specialization and the general practitioner is asked to know about and also to cater for all specialty needs. We are at a risk of inadvertently increasing the burden of general practitioners who already have a heavy workload. They are asked to hold hypertension clinics, diabetic clinics, mother and baby clinics, and numerous other clinics; now they will be expected to hold neurosis clinics and psychosis clinics as well.

The general practitioner may be the most important person for the patient, understanding the patient's problems better than anybody else. General practitioners may be able to treat a psychiatric condition, but a specialist is in a better position to do so. Psychiatrists should ask for the cooperation of general practitioners, not for the total management of these patients in their clinics, but for appropriate and prompt referral.

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Determination of social class

Sir,

I am a Voluntary Services Overseas doctor currently working in Luwingin in Zambia as the district medical officer. I wish to take exception to part of a letter on knowledge of common inherited disorders among family planning clinic attenders (June *Journal,* p.257). The letter states that the average age of the women was 32 years and that '... based on the occupation of their husband or partner, 70% were in social class 1, 2 or 3'. Does this indicate that even mature women in the United Kingdom (London-based) are still subordinate to their male partners? What is happening in the UK? Is there a need for some health education of the type we use in Zambia, that women have some rights themselves? I look forward to any replies or comments and, with some apprehension, to my return to the UK.

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Cervical smears: reaching the target payment level

Sir,

The cervical cytology target in the 1990 general practitioner contract may not be as profitable for general practitioners as it first appears. Many practices go to great lengths and expense to remove patients from the list who are no longer dependent on the practice for care in order to reach the target for cervical cytology. However, once at the 80% target payment level, a general practitioner must maintain this, as failure to do so results in severe financial loss. It may be wiser for many practices to go for the lower 50% target payment.

Health authorities have not been very successful in improving levels of cervical screening in the United Kingdom and the new general practitioner target system has relieved them of a task they did not relish. By removing patients from the practice list who are no longer dependent on the practice for care and submitting target claims general practitioners have also saved the health authorities money.

The target system is very crude since it favours the urban practice in an economically advantaged area. It will not target those most likely to benefit from a cervical smear. To improve the system we need a lower target, of perhaps 70%, with additional payments staged in units of 2%, 3% or 5%. All practices should, as part of their terms of service, submit their cervical cytology rate to the family health services authority each quarter, whether or not they attract a payment. This might act as an incentive to improve performance. The cost of enumerating the targets should be recognized and paid for. The penalty for smears performed outside the practice should be reduced or removed altogether.

Deprivation payments in their present form militate against improving standards in general practice. Practices receiving deprivation payments should be given lower targets to attain, and the payment should be continued indefinitely at the lower rate, provided a reasonable effort is being made by the practice.

My advice to many practices would be to make a reasonable effort to ensure that the target population have had cervical smears but do not aim for the higher target unless you are sure it will be easily maintained. We have removed patients from the list who are no longer dependent on the practice for care to reach the 80% target for cervical cytology, but I do not think it was a good management decision.

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Irritable bowel syndrome

Sir,

In reply to Dr Gowen's letter (August *Journal,* p.347) addressing the association of irritable bowel syndrome with spondylosis and regional pain syndrome, perhaps the answer to the association is the HLA-B27 histocompatibility antigen. Other associations include ankylosing spondylitis; sacroiliitis; Achilles tendinitis; plantar fasciitis; colitis and other inflammatory bowel diseases; psoriasis; Reiter's syndrome; chronic prostatitis; anterior uveitis; aortic regurgitation; conduction defects; apical pulmonary fibrosis; amyloidosis; and myelopathy associated with atlanto-axial subluxation.

I wonder if there is a familial association among the patients suffering from the conditions Dr Gowen mentions to add weight to this theory?

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