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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