gist within three months (patients needing diagnostic clarification for their non-cardiac chest pains should, we are told, be seen in the same way).[1] In which Royal College of Physicians publication is the manpower basis for this standard set out? Simplistically, to achieve this standard we would need more cardiologists or less coronary heart disease. Neither is likely immediately, so for the moment rationing must persist in some nebulous and ill-defined way, with precisely the same uncertainties that general practitioners cope with in every surgery. To set up protocols for such intimate clinical management decisions is tempting, but dangerous. One wonders how the British Geriatric Society might comment on patients aged 70 years or over not meriting access to that same cardiologist in those same three months?

In the United States of America, where the cardiologist per head of population ratio is much higher, are morbidity and mortality rates any less unnerving, despite the more frequent invasive investigation/cardiac surgery profile?[3]

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Prescribing lipid lowering agents

Sir,

Evans and colleagues draw some wide-ranging and bold conclusions concerning the adequacy of general practitioner training and decision making and the use of clinical guidelines (January *Journal*, p.15). However, their methods of data collection seem to give a shaky foundation for such views.

General practitioners taking part in the study were asked individually to make quantitative estimates, from 0% to 100%, of their likelihood of prescribing a lipid lowering drug to a hypothetical patient. This was a complex task, based on background data and information on 13 variables (for example, whether there was a family history of coronary heart disease) displayed on a computer screen. The general practitioners repeated this exercise 130 times, presumably during their spare time in an ordinarily busy working day. This contrasts with the setting in which real treatment decisions are made: the 8–10 minute consultation with a patient who is usually already known to the general practitioner, where ideas, concerns and expectations are aired, and information gathered and summarized, to allow a joint decision about treatment to be made. The experimental setting was very different from this, and therefore not a reliable basis for the authors' speculation, despite their statistical wizardry in the analysis of the results.

The suspicion is that the methods used by Evans and colleagues did not allow any meaningful study of doctors' decision making; at best, the researchers elicited some attitudes of doctors. The format and amount of information that was presented carried the danger that the design of the study was irrelevant to everyday practice — as they may have found if they had piloted it first in general practice. The complexity of the problem of prescribing lipid lowering agents, particularly at the moderate cholesterol concentrations quoted, was not done justice by the simple approach adopted. This was made especially difficult by the rather arbitrary removal of the option of seeking advice from a consultant physician.

On the subject of clinical guidelines for the use of lipid lowering drugs, the authors seem to work from the premise that guidelines represent some sort of ultimate truth. However, the several sets of guidelines on this topic produced by various agencies over the last 10 years give widely varying advice on risk factors, reflecting the fact that there are still more questions than answers in this area.[1-4] Perhaps the general practitioners who took part in the study were wise to be sceptical.

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Health records

Sir,

I read the letter from J Alison Summers (March *Journal*, p.160) with a sinking heart. The parent-held, personal child health record was a welcome innovation, although I feel it to be of inferior quality and comprehensibility and with less useful advice for parents than those used in New South Wales, Australia.

When I see a child in a clinic, I am already making a computer record and a Lloyd-George card record of the consultation. Would Summers really want me to eat into my time with the patient by making a third record?

In East Sussex we are lucky that our child health surveillance forms have a copy which can be filed in the parent-held, child health register books, but do we have to record in three places each consultation for otitis media? The General Medical Services Committee annual report has already reminded us that we should keep duplicate records of our consultations entered in patient-held maternity records.[1]

With every new development in general practice we have to ask ourselves, is this really the best way I can use my time with my patients?

Perhaps now would be a suitable point to request a moratorium on questionnaire-based papers and letters. I have seen few which would change my practice, and dread the weekly arrival of the latest five-page questionnaire, with heavily loaded questions. Let us see some original research.

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