Ancoloxin and meclozine have been very extensively used in the treatment of nausea and vomiting in pregnancy, and there are bound to be cases in which they have been used where foetal abnormality has occurred or will occur. Of course, this does not implicate ancologin or meclozine unless supported by statistical proof.

As an example, in my own practice during the last three years, out of 58 home confinements of which I have full records there were three cases of deformed babies. One of these, a bilateral calcaneovalgus, followed the use of ancologin. The other two cases were a bilateral talipes equinovarus and a case of exomphalos, and in neither case was an anti-emetic drug taken by the mother during the pregnancy. It would appear that on the basis of a similar proportion Dr. Watson calls the notice of the profession to "this mounting evidence against the safety of ancologin in pregnancy."

On analysing my own cases further I find that, in 58 cases of pregnancy, 19 expectant mothers took ancologin or meclozine and only one of these gave birth to a deformed baby. This is exactly the same proportion as in the pregnancies where no drug was taken. I realize that this small number of cases proves nothing at all, and the very point I wish to make is that statistical proof is essential. This should be provided by a larger series of cases such as Dr. Watson's, provided all the facts are given and properly analysed.

There is another point I should like to make. There must be a vast amount of most useful data in the records kept by general practitioners, but for a busy G.P. to extract any of this is very difficult as it takes so long. For example, I was asked last year to report on all cases of malignancy in my practice, and I found it quite impossible at the time as I should have had to examine the medical records frequently in order to avoid missing a case. It is extraordinary how this can happen if one relies on one's memory, especially in this area in the case of skin cancers, which are common among the older men.

Could not the B.M.A. or the College of General Practitioners train a few medical secretaries to do this very job? If a small number of people could be trained in this way and backed up by a statistician I think some really useful information could be obtained on a number of different subjects. In this matter of ancologin and meclozine it is obviously essential to find out one way or the other whether the drug is safe. Carefully kept records in a sufficient number of practices should give this information, provided they are properly checked and analysed.—I am, etc.,

St. Ives, Cornwall.

T. E. BARWELL.

SIR,—Search of over 1,000 maternity records from the past ten years shows that of 54 women prescribed meclozine ("ancolan") in the first 12 weeks of pregnancy, three were delivered of abnormal babies: (1) Branchial sinus (meclozine prescribed on 43rd day of pregnancy); (2) pyloric stenosis (meclozine prescribed on the 37th day of pregnancy); (3) partial fusion and malformation of fingers and partial fusion of toes (meclozine prescribed on 47th day of pregnancy).

Of three women prescribed "ancologin" (meclozine and pyridoxine), one has had a baby with partial fusion of two toes. (Ancologin prescribed on 59th day of pregnancy.)

The corresponding figures for cyclizine are 55 patients and two abnormal babies: (1) Pilonidal sinus (cyclizine

prescribed on 40th day of pregnancy); (2) haemangioma of face (cyclizine prescribed on 51st day of pregnancy).—I am, etc.,

St. Paul's Cray, Kent.

JOHN WOODALL.

"Panorama" and General Practice

SIR,—On November 19 "Panorama" chose to discuss the abysmal state of general practice. Since then Dr. R. F. Baird (December 8, p. 1539) has written to reaffirm his faith in it. May I be allowed to support him in this? And may I also try to dispel some of the misunderstandings of general practice that are current in teaching hospitals?

I recently had the pleasure of doing several locums in general practice after four years of working in various hospitals. My conclusions are based on this, admittedly brief, experience.

General practitioners are often (and rightly) thought of as mere sorting-houses. So are we all. Surgeons refer gynaecological problems to gynaecologists; physicians do not remove prostates, nor radiologists treat tuberculosis. Sorting is a necessary part of specialization. The specialist knows the limited field of his interest, in which he keeps up to date, and in whose management he excels. He refers other conditions to other consultants.

This, too, is the function of G.P.s: to choose their specialty, and to refer patients outside this to other specialists. Their specialty is no more the whole of medicine than is any other, but it is very much harder to define, as it is not sharply bounded by limits of anatomy, or physiology, or operability. It comprises the common diseases of childhood and old age (because these patients react badly to hospitalization); most psychoneuroses (because the patients trust their doctor, he knows their background and can see them easily); other aspects of gynaecology, dermatology, family planning, antenatal care, very minor traumatic surgery and medicine that special training (and continued interest) allow him to do; and, most importantly, the whole treatment of his patients, who are being fragmented by hospital specialists' care.

In practice I found that there was a considerable amount of real pathology and a great deal of human interest. The number of patients needing to be referred were remarkably few—few more than those that a houseman has to refer to departments other than his own.

Nor is good medicine impossible. I worked in one practice (with a full list) whose patients were trained to go to an examination room after their history had been taken and there to get appropriately undressed.

Only a fool would believe that all is well with any field of medicine. Reform is needed. The gap between the different parts of the Health Service should go; better reward should be given to conscientiousness; and training for general practice should not be the financial and marital sacrifice that a long series of house jobs now are. But rewarding practice does exist and I have seen it.—I am, etc.,

Freedom Fields Hospital,
Plymouth, Devon.

W. J. TROWELL.

Better General Practice

SIR,—No one will doubt the service which Dr. John Fry has done and is doing for general practice, but I feel obliged to comment on one point he and his co-authors make in the article "Towards Better General Practice"

(November 17, p. 1311). To state that 33 "good general practitioners" answered unanimously that there is no abuse of the National Health Service suggests a situation where there are no murmurings of discontent with the current system of availability of doctors to their patients.

Surely, Sir, the question in this form is "loaded," since there can never be an abuse of a "free" service any more than it could be an abuse of free transport if every train and bus were full inside with an overflow of the fit and idle sitting on the roof.

The crucial question is whether the responsible, diligent body of G.P.s is having its professional potential eroded by attending the trivial. It does not assist the solution of this problem to insist that the trivial and unnecessary is a constant and continuing proportion of our work and that no abuse is involved.

Our critics will say that whenever we thus comment it is implicit that we regret our declining status or resent having to work hard. I would answer for myself that I do not understand the meaning of status in this context; I have the status of a doctor, just as my grocer has that of a grocer. The outcry to retain and increase G.P. beds and hospital units, together with the growing interest in surgery improvement and organization, savours more of desire to improve on the standard of service offered than an opting out of professional responsibilities.

In the ultimate analysis the overall standard of treatment and care is conditioned not only by professional integrity but by the collective sense of responsibility of the patients themselves. They can safeguard their own service by allowing maximum benefit to those most deserving of time and attention. This sub-contracting of responsibility becomes mandatory in the best interest of any "free" service, but has not, I submit, been propounded in official and public terms. Should we go it alone, our wives are labelled "dragons at the gate," so I suppose we have no option but to contrive to attend at any hour to patients who wake and can't drop off to sleep again—burly workmen who wouldn't have troubled you except the foreman insisted he should send for the doctor immediately . . . we all have our favourite stories.—I am, etc.,

Gravesend, Kent.

BRIAN HAWKES.

Routine Visits to the Aged

SIR,—A high proportion of social and medical problems in the aged are to be found among those who live alone: of these, aged 70 and over, there are roughly 12 per 1,000 in the average practice, though considerable variations will occur. But they form a group which is numerically manageable. The majority of these old people live on the borderline of insufficient food and fuel, and when they slip over to the wrong side of that line unaided recovery is rare and deterioration often rapid.

It seems likely that much good could come from a scheme, as a special addition to the N.H.S., by which the family doctor would be able to visit annually and "examine" all his patients in this special group, for which service, after rendering a report, he would be able to claim a special fee of perhaps a couple of guineas.

October and November suggest themselves as being the best months for a number of reasons. The extent of the "examination" must be left to the doctor, as individual patients vary so much in their reactions, but it should include the laboratory estimation of the blood sugar and haemoglobin. The medical report to be

completed would be short and simple, but space would be provided for incidental "social" observations: by carbon-interleaving the doctor would keep a copy for reference. More work will arise than at first appears, but an incentive will be provided and these older patients will in time come to expect and prepare their homes for this special visit.

At the commencement the aim should be single-minded—to ensure that these old people are not overlooked until too late, as they tend to be, and to recognize that their special needs are likely to arise as much from their standards of living as from an organic disease. We cannot hope to prevent the problems which attach to ageing, but we should be doing what we can to lessen their occurrence in the coming years when there will be so many more frail aged.

These domiciliary visits would in many cases be continually fruitful, because every old person likes to feel that somebody is caring, and those around 70 are at an age when help and guidance are usually still acceptable. The family doctor who is seeking to help, and who has at his bidding the health visitor, district nurse, assistance and welfare officers, home helps, blind and deaf visitors, chiropody services, and the like, can see as no one else can what need exists and how it best can be filled.—I am, etc.,

Shipton-under-Wychwood,
Oxford.

GORDON SCOTT.

Porritt Report

SIR,—The Porritt Report¹ has produced at least one suggestion of value in recommending closer integration of the tripartite Health Service structure. There is at the moment no close liaison in planning or administration between hospital boards, executive councils, and local authorities, and consultation tends to be desultory and concerned with trivia.

The future trend in medicine is undoubtedly towards the community care of mental and physical illness. The immense range of problems which will arise in this connexion will be insuperable without a major change in attitude towards liaison or the fusion of the three bodies concerned.

I would suggest that an essential part in galvanizing progress in this direction would be played by the formation of professional liaison committees in each local area composed of consultants, G.P.s, and medical officers of health. There has been a crying need for such a statutory body since 1948 to deal with the many problems which have plagued the Service and in particular the G.P., and which in many cases have not been solved for lack of an appropriate channel.

The appeal from Sheffield (*Supplement*, November 24, p. 185) for a rational conference of maternity liaison committees is an example of the impetus and potential which such bodies could contribute to the stagnant and inefficient administration of the Service. In many areas these maternity committees were not welcomed by consultants or M.O.H.s but are now seen to be indispensable.

There are unfortunately numerous committees, but without the one I have suggested as a vital link I feel that progress in building an efficient community health service will be slow and painful, especially for the G.P. who is going to be expected to shoulder most of the burden without proper help and support.—I am, etc.,

Belfast.

S. E. BROWNE.

REFERENCE

- ¹ *A Review of Medical Services in Great Britain*, Report of the Medical Services Review Committee, 1962. Social Assay, London.