Working as a general practitioner in the NHS for the past 10 years I too have often used the analogy of the juggler: all the balls are not equal—more harm is caused if we drop some balls than if we drop others. I together with many of my colleagues have become demoralised and exhausted juggling with so many balls. Every so often someone throws yet another ball our way. We are finding that it is less and less enjoyable to juggle—what is more, we are dropping more and more balls and too many are getting damaged.

In my metaphor the balls represent medical condition-treatment pairs. An imagined contract with our patients might go like this: would you allow us to drop breast reconstruction after mastectomy so that we can guarantee that we will always be able to treat triple vessel coronary disease within three months? By advocating explicit rationing, I am suggesting that we health workers drop some of the balls so that it becomes a joy to juggle again. The consequence of this is that the balls which really matter will stay in the air.

DENNIS COX
General practitioner

Bluntisham,
Cambridgeshire PE17 3LT

- 1 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309:184-8. (16 July.)
- 2 Honigsbaum F. *Who shall live? Who shall die? Oregon's health financing proposals*. London: King's Fund College, 1994. (King's Fund College papers No 4.)
- 3 Hunter DJ. *Rationing dilemmas in health care*. Birmingham: National Association of Health Authorities and Trusts, 1993. (NAHAT research paper No 8.)
- 4 Macara AW. Reforming the NHS reforms. *BMJ* 1994;308:848-9.
- 5 Calabresi G, Bobbitt P. *Tragic choices*. New York: Norton, 1978.

Electronic health records

EDITOR,—Dipak Kalra mentions strategies for entering clinical data in the context of advanced informatics in medicine projects, including the possibility of—"further into the future—voice input."¹ As the result of a collaborative project between Belfast City Hospital, the directorate of information systems (Management Executive, Northern Ireland), and IBM we can directly input radiology reports by using voice recognition technology. We have used the IBM speech server series software and a specially developed radiology dictionary and language model for one year. This operates on personal computers and is directly integrated into our existing radiology management and computer system (Northern Ireland radiology system), which was developed by the directorate of information systems. As a result, voice input reports can be viewed on remote terminals throughout the hospital as soon as they have been produced.

J T LAWSON
Consultant radiologist

Department of Radiology,
Belfast City Hospital,
Belfast BT9 7AB

- 1 Kalra D. Electronic health records: the European scene. *BMJ* 1994;309:1358-61. (19 November.)

War pensions

EDITOR,—Clare Dyer reports that a war pension has been awarded for "desert fever."¹ This is incorrect.

Both British and American authorities have maintained a close watching brief on the health of personnel who participated in the Gulf war. Despite considerable study the existence of a discrete entity—Gulf war syndrome or desert fever—has not been confirmed. Research is continuing, and in Britain the Ministry of Defence has

a programme for investigating participants in the Gulf war who are suffering apparently unexplained symptoms.

The British war pensions scheme is generous in its provisions. To succeed, a claim for a war pension needs to relate service factors to the cause or course of the claim disablement. For claimants who have recently been released from service the legislation is particularly generous. There is no onus on former service personnel to prove their case. For a claim to be rejected the department must prove, beyond reasonable doubt, that service factors played no part in the cause or course of the medical condition(s) giving rise to the claimed disablement.

So far no war pension has been awarded for Gulf war syndrome or desert fever. All pensions currently being paid to personnel who participated in the Gulf war are in respect of recognised medical conditions.

P CASTALDI
Chief medical adviser

Benefits Agency Medical Services,
Department of Social Security,
Leeds LS2 7UA

Careers in academic general practice

EDITOR,—Although an occupant of the corner so clearly fought for by Aly Rashid and colleagues in their recommendations on the need to increase general practitioners' contribution to teaching and research,¹ I am concerned that those in other corners will view their paper as a polemic, or at best a case of special pleading. Historically, general practice has been service dominated. The opportunity for rapid attainment of principal status (compared with consultant status) has made acquiring research experience in junior academic posts unattractive financially. With respect to teaching, however, the vocational training grant "buys" protected teaching time, and the service contribution of trainees is not insignificant. To imply that specialist academic colleagues have it easy and do not face the same difficulties in balancing teaching research, and service demands is unnecessarily divisive.

Certainly core funding for research is a problem as it is for most non-undergraduate NHS teaching hospitals—also non-recipients of the service increment for teaching research (SIFTR). An equitable redistribution of the service increment for teaching (SIFT) will be welcomed by all those involved in undergraduate teaching, not just general practitioners. The research component of the service increment will be under the management of regional research and development directors, and the Culyer report makes a commitment to equity in funding research and development in primary care.²

Most importantly, although Rashid and colleagues assert that the achievements of academic general practice have been considerable, they paint an unnecessarily gloomy picture of its current status. By quoting outdated research on obtaining higher degrees from general practice they fail to acknowledge the considerable improvements occurring. The Royal College of General Practitioners recently published an impressive (yet incomplete) list of doctors recently qualified as MDs.³ Nor do the authors mention the burgeoning number of MSc courses specifically for, or relevant to, general practitioners. Finally, the statements about continuing separations of undergraduate and postgraduate general practice are surely too pessimistic. Surprisingly, Rashid and colleagues do not mention the Conference of Academic Organisations in General Practice, which has representation from all aspects of the discipline. This body is working with some success towards coordination of academic activity in general

practice.⁴ In my own department we have a shared agenda, including joint appointments, with the regional adviser's department. The "long term objective" of integration of departments is laudable, but this should not be to the exclusion of integration with colleagues in other disciplines. We are not seeking islands of general practice academia, but a strong primary care base within the whole of academic medicine.

The tide is already starting to run in favour of academic general practice. We need to grasp the opportunities that are presenting themselves and show others that we can deliver, rather than plead for our share of preferential treatment.

SEAN HILTON
Head

Division of General Practice and Primary Care,
St George's Hospital Medical School,
London SW17 0RE

- 1 Rashid A, Allen J, Styles B, Pereira Gray D. Careers in academic general practice: problems, constraints, and opportunities. *BMJ* 1994;309:1270-2. (12 November.)
- 2 Culyer report. *Supporting research and development in the NHS*. London: HMSO, 1994.
- 3 Royal College of General Practitioners. MD theses. *Connection* 1994;Octvii.
- 4 Conference of Academic Organisations in General Practice. *Research in general practice*. London: Royal College of General Practitioners, 1994.

Out of hours care

Cultural change is necessary

EDITOR,—David K Cragg and colleagues found that the reason most commonly cited by patients for not attending out of hours primary care centres was not having a car available.¹ This was despite population statistics showing no difference in car ownership between electoral wards of attenders and non-attenders. One interpretation of this is that, although patients did have access to a vehicle, other priorities or unwillingness to attend for other reasons were more relevant. I wish to report data from a current study of unselected patients requesting home visits out of hours via the deputising service in Southampton, an urban conurbation broadly similar to the conurbations in Cragg and colleagues' study. A policy of visiting all patients specifically requesting a visit is adopted; at the time of the study an out of hours assessment centre was not generally available as an alternative.

Patients were not questioned about issues such as transport before the visit, but at the end of the consultation the visiting doctor administered a brief questionnaire to collect data. On 1023 consecutive visits we found that 395 (39%) patients or families did not possess a car. This compares well with the overall figure of 40% reported by Cragg's and colleagues. Furthermore, 204 patients did not have a telephone in their home, 258 lived in council blocks of flats or bedsits, and half were in social classes 4 and 5. These figures confirm the substantial use of out of hours services by those in poorer socioeconomic circumstances, who indeed have difficulties of access to health care—an issue that will remain a problem for planning in urban areas particularly.

One hundred and thirty nine patients in our study had seen another doctor within the previous 24 hours, and three quarters of this group required only reassurance or advice about over the counter treatment. Furthermore, there was no overall statistical relation between the type of level of treatment started and factors such as social class. This indicates that perceived need is the dominant factor and supports the conclusion that a major cultural change will have to occur before out of hours centres become more acceptable.

A Z KADRI
General practitioner

St Peter's Surgery,
Woolston,
Southampton SO2 9AL