Outpatient Questionnaires

SIR,—I have read with great interest of Dr. G. H. Hall's experiences (1 January, p. 42) with outpatient questionnaires. At the BUPA medical centre we have been using for the past 18 months a branching questionnaire¹ covering past history, family history, personal habits, and current complaints. The questions are asked by a kind of modified teaching machine controlled by a computer. This records the answers and prints out a final report. Up to 200 questions may be asked and the whole process takes about half an hour.

I entirely agree with Dr. Hall that the majority of patients accept this sort of questionnaire without difficulty. Indeed, most of the complaints come on the rare occasions when the computer breaks down and the patient is deprived of the experience of working the machine. Many shy patients say they find it easier to confide their problems to an impersonal machine. Their replies to the questionnaire then provide the doctor with an unembarrassing entrée to some delicate problem.

About two out of every three of our patients see a doctor at the time of their visit. This doctor usually has a copy of the computer printout available at the time he sees the patient. After some initial resistance most of our doctors (who work part time at the centre and cover a wide range of specialties and backgrounds) accept the report and find it saves them time and trouble. However, a small number find it very hard to reconcile this part of modern technology with their own style of practising the art of medicine. The remaining third of the patients see only their own doctor, who is asked to tell us what he thought of the report and the whole procedure. Out of over 2,500 complete replies 28% of doctors thought the whole thing was of great value, 64% found it of some value, 7% thought it had no value, and 1% said it was positively harmful in causing anxiety to their patient.

It must be emphasized that in our present state of knowledge these questionnaires are purely a fact-gathering aid. They will always need amplification and critical evaluation by a doctor before a diagnosis is made or treatment prescribed. However, like Dr. Hall, we feel that it will soon be possible to use the replies to the questionnaire to select patients for certain extra tests. I am sure this approach to history-taking will enable the doctor to spend more time exercising his clinical skills rather than asking routine questions.—I am, etc.,

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1 Wright, H. B., *Community Health*, 1971, 3, 71.

Trial of Clofibrate

SIR,—The report by a research committee of the Scottish Society of Physicians on the use of clofibrate (Atromid S) in the secondary prevention of ischaemic heart disease (25 December 1971, p. 775) and the joint commentary on this and the Newcastle trial (25 December, p. 784) look for explanations of the beneficial effects of clofibrate not related to its cholesterol-lowering action, and rightly turn to the possibility of effects on other systems. However, the effects on platelet adhesiveness¹ and fibrinolysis² in

the studies quoted in the Scottish report were obtained with Atromid (clofibrate and androsterone). C. Dufault and colleagues³ have shown that androsterone causes a decrease in platelet adhesiveness, and further support for this has been presented by M. F. Oliver.⁴ It has also been shown that anabolic steroids increase fibrinolytic activity temporarily.⁵

The effects of clofibrate itself on platelet adhesiveness and fibrinolysis are by no means clear, contrary to the impressions given. Its effects on the former are probably only temporary⁶⁻⁸ or are absent.⁹ Clofibrate's effects on fibrinolytic activity are particularly complex.¹⁰⁻¹² They include possible short-term improvements which fade after about six months and are then even replaced by antifibrinolytic activity,¹³ a point that should at least be noted in connexion with the apparently adverse effects of clofibrate on deaths in the "infarct only" group of the Scottish trial.

In summary, favourable claims for clofibrate on platelet adhesiveness and fibrinolysis are not justified on present evidence, and it is essential that possibly mistaken claims for drugs that may influence the numerous mechanisms involved in occlusive vascular disease should not be accepted while substantial doubts remain.—We are, etc.,

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- 1 Gilbert, J. B., and Mustard, J. F., *Journal of Atherosclerosis Research*, 1963, 3, 623.
- 2 Srivastava, S. C., Smith, M. J., and Dewar, H. A., *Journal of Atherosclerosis Research*, 1963, 3, 640.
- 3 Dufault, C., Tremblay, G., Nowaczynski, W., and Genest, J., *Canadian Medical Association Journal*, 1961, 85, 1025.
- 4 Oliver, M. F., *Lancet*, 1962, 1, 1321.
- 5 Fearnley, G. R., and Chakrabarti, R., *Journal of Clinical Pathology*, 1964, 17, 328.
- 6 Chakrabarti, R., Fearnley, G. R., and Evans, J., *Lancet*, 1968, 2, 1007.
- 7 Carson, P., et al., *Journal of Atherosclerosis Research*, 1963, 3, 619.
- 8 Carson, P., et al., *British Heart Journal*, 1966, 28, 400.
- 9 O'Brien, J. R., and Heywood, J. B., *Thrombosis et Diathesis Haemorrhagica*, 1966, 16, 768.
- 10 Sweet, B., Rifkind, B. M., and McNicol, G. P., *Journal of Atherosclerosis Research*, 1965, 5, 347.
- 11 Cotton, R. C., and Wade, E. G., *Lancet*, 1969, 1, 263.
- 12 Goodhart, J. M., and Dewar, H. A., *British Medical Journal*, 1966, 1, 325.
- 13 Hocking, E. D., Chakrabarti, R., Evans, J., and Fearnley, G. R., *Journal of Atherosclerosis Research*, 1967, 7, 121.

Future of Community Medicine

SIR,—Dr. G. M. Reynold's article (11 December 1971, p. 670) was informative and interesting, and I would like to make brief observations on three matters which I believe to be basic for satisfactory community care.

Much has been said about medical care outside hospital yet this has not attracted its share of resources since the introduction of the National Health Service. Expenditure on the hospital service has increased from 54.9% in 1950 to 61.2% in 1969. During the same period expenditure on general medical services has declined and expenditure on local health authority services has increased by only 2.2%. Much more money needs to be channelled into community care before any improvement can be made. Many persons are still in hospital because of inadequate community provision.

The total hospital staff from 1949 to 1969

(England and Wales) increased by 72%. During the same period the total population increased by only 10.3%, the total hospital beds decreased by 6%, and the average length of stay was reduced by 20% from 15.6 to 11.1 days. The number of patients treated and outpatient attendances increased, possibly because of inadequate facilities in the community.

There is now an urgent need to expand all facilities to enable more patients to be cared for in the community. In this county it is planned to have joint meetings shortly with groups of general practitioners, the county health department staff, and, I hope, the director of social services to find out what services are lacking and what improvements can be made in existing services. The views expressed will then go to the local medical committee and the local authority.

I believe there should be community hospitals or peripheral hospitals which would be complementary to the new, costly district general hospitals. They would serve populations of 30,000-50,000 and have from 80 to 100 beds. They would be general-practitioner hospitals with day-hospital facilities, a consultant clinic, facilities for straightforward x-ray examinations, pathological services provided by a group laboratory, and medical ancillary services. Good community hospitals would be an extension of community care.

I also think it is important and urgent for general practitioners to have good working arrangements with the new departments of social services and not to wait to forge links when the Health Service is unified in 1974. By then the new social service departments will have developed their methods of working and it will be more difficult to establish effective links than during the present formative period. General practitioners should have a say in what social services are provided and, what is possibly more important, should have ready access to those responsible for the services in their locality.

If we get together now and press for new and improved services to enable more persons to be medically cared for in the community we will find the transition in 1974 less traumatic, unification more effective, and, I hope, less hospital orientated.—I am, etc.,

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Thyrotrophin Immunoassay

SIR,—The author of your erudite leading article "Thyrotrophin Immunoassay" (25 December, p. 761) rightly emphasizes the importance of an elevated serum thyrotrophin (TSH) level to confirm the existence of the condition which he calls subclinical hypothyroidism. We were guilty of inventing a new word "premyxoedema" when first describing the stage of autoimmune thyroiditis (A.I.T.) where hypercholesterolaemia is a sole finding and when conventional tests of thyroid function are normal.¹ The term borderline hypothyroidism is misleading since it suggests equivocal tests of thyroid function. For example, a group of patients with myxoedema had an average serum TSH level of 77 μ /ml, a patient with borderline hypothyroidism an average serum TSH of 50 μ /ml, while a group with premyxoedema had serum TSH levels varying