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Unscheduled cervical smears

Sir,

I was interested to read the paper by Spence *et al* (September *Journal*) in which the question of the cost of unscheduled cervical smears was considered.

In our area, the local genitourinary medicine clinics are an important source of unscheduled smears. The problem is compounded by the fact that we are not informed of the results, nor are we able to obtain them on request. In order to attempt to meet our cervical smear targets we have no alternative but to offer the patient a further cervical smear. In many cases these further smears will not be clinically indicated.

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Research in primary care: the need to modify help-seeking behaviour

Sir,

I read with interest Professor Howie's paper on research in primary care (August *Journal*).[1] I too am concerned that current strategies may compromise the ability of 'curiosity-driven innovative' small researchers to gain the space and support needed to develop their ideas. I was, however, disappointed that he seemed resigned to this state of affairs. I feel that Howie is one of an increasing, but still small number of powerful academics in primary care who should have the ability to offer such support.

I also do not like his modification of Stott and Davis'[2] model of the potential content of a consultation, and did not feel that he justified such a modification. I agree that managing psycho-social problems is an essential part of any GP consultation. Using Stott and Davis' model, I have always assumed that components A and C from the original paper (Management of presenting problems and management of continuing problems) referred not just to physical problems, but to psychological and social difficulties. I am a little alarmed that someone as esteemed as Professor Howie could think otherwise. Indeed, when discussing these components the authors of the original paper emphasized that 'the integrated physical and psycho-social formulation is relevant to every specialty but is exceptionally important in primary care.'

Howie removes component B (modifying help-seeking behaviour) from the original model. This interests me because, since I was first introduced to the model, I have felt that practitioners have more difficulty with this part than with any other. I do not fully understand why. Again, referring to the original paper, this part of a consultation is not just about controlling workload in order to benefit the doctor; it is about patient empowerment. The aim is clearly to give people more control over their lives, to encourage them to be actively involved in their own health care, and to reduce over-medicalization. There is plenty of evidence that it can be done. Indeed, the current beliefs about health and medicine that exist in the population are a result of learning from our profession. If Professor Howie is keen to promote research in primary care, I think looking at how GPs manage component B of Stott and Davis' model would be a more suitable approach than simply removing it.

In the same edition of the *Journal* there were two original research papers on subjects very important to primary care: sore throats and deafness.[3,4] I have just finished reading Wilkin and Glendinnings' chapter in *A Primary Care Led NHS*[5] on applying research in primary care. They make a strong case for what seems obvious to me — making research more responsive and accessible to service needs. The two papers referred to could be laughable examples (were they not so tragic) of failures to do this.

Does F Dodds really believe his B-score system is usable or even understandable in the average consultation? I am not underestimating the intelligence of any of my primary care colleagues, though I am happy to admit I have struggled with Bayes theorem. The reality is, however, that in the average consultation in which someone presents with a sore throat, it is simply not feasible to use the table presented by Dobbs. If he believes it is important to identify and treat streptococcal sore throats, which is itself debatable, then a list of the top five identifying symptoms would be of far more value.

Again, Eeekhof *et al*'s paper on the value of the whisper test in diagnosing deafness is potentially very useful, but would be more valuable if it included a brief description of how to perform the test accurately.

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Improving the detection of psychological disorders

Sir,

In the July *Journal* Howe describes a brief educational intervention with exciting possibilities for improving detection of psychological disorders in primary care.[1]

Howe acknowledges that there is debate regarding the value of improving detection of depression using screening questionnaires. However, there is conflicting evidence whether simply informing the physician of the presence of depression or anxiety influences the outcome of the illness. The same question may be asked of the intervention described. There was a modest improvement in the detection of psychological distress in the intervention group. Does this lead to a change in practitioner behaviour or prescribing? Is the satisfaction and outcome for these patients influenced?

The intervention, however, may well prove to be of great value for two reasons. First, physicians are more likely to commence treatment for depression when they have made the diagnosis themselves, rather than when the diagnosis has been made by a screening instrument.[2] Secondly, there is evidence that improved consultation techniques result in improved health outcomes, particularly with regard to reduced anxiety.[3] Thus, by improving

consultation skills, there may well be benefits for the patient both in terms of receiving appropriate treatment and as a result of the therapeutic value of the consultation.

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You can't mishear what is written

Sir,

The article by BH Smith and RJ Taylor (April *Journal*)[1] and the editorial by AF Wright (January *Journal*)[2] emphasize the importance of stories and writing as an integral part of general practice.

In Sheffield there is a continuing medical education course entitled 'Reflections in writing for general practitioners'. As one of the members wrote:

> It is easy for GPs to work in almost total professional isolation, even in a friendly partnership, and it can be hard to admit to mistakes, vulnerability, sadness and even occasionally joy. If you can commit some of these thoughts to paper, then not only can it be personally therapeutic, but by sharing with others you may bring insights that can strike a chord and be of benefit to others.[3]

Also in Sheffield, a pilot project, funded by the Royal College of General Practitioners, centres on therapeutic writing for patients with anxiety/depression. The benefits of such a project are expressed by Purdy:

> 'If only GPs who are so quick to prescribe instant tranquillisers to silence distress would suggest the cleansing therapy of putting pen to paper instead. It's healing in rejection, grief, heartache or despair. It can clear our heads when we're faced with choice and indecision. It doesn't make you fat, sick or wreck your liver. And since nobody can possibly know more about us than we know ourselves, [it's] infinitely superior to any psychiatrist.'[4]

Stories, with their beginning middle and end, and poetry, with its clean spareness, offer a structured form and a secure enough process for exploring and expressing both personal and professional material. Redrafting to hone the image to needle-sharpness can focus the writer's mind — an intensely self-educative process.

All this helps the practitioner 'recognise (and address) internal conflicts, frustrations and stress',[1] joys, laughter, and successes, and to share them with others. Another member of the CME group has said: 'Writing... is a ritual that I know will help me sort out and organize my feelings about the subject. The next stage is to bring the contribution to the group to share... and we have arrived at levels of intimacy that are indeed supportive.'[5]

The two Sheffield projects would be enriched by the experience of others. We are also planning to publish a book of doctor's stories, to inform the Health Service, medical students, and patients about the workings of general practice. Please send us writings, or information about your experiences.

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Predictive value of ultrasound in threatened miscarriage

Sir,

May I answer Dr Lindsay Smith's comments on our article on the above subject (January *Journal,* 1996). First, he complains that we do not quote the gestative age of the pregnancies when bleeding occurred. The data are available but we felt that they were of little practical or statistical importance because the overall loss in the viable pregnancies that looked normal at the first scan was only 2.7% (3/112). Supposing the range of loss was 0–5% depending on the gestational age, it would require a very large survey to show a significant difference at each different week. At the end of the investigation would it be of value (as he suggests) to 'practisicing GPs' if the loss did vary by this small amount?

Secondly, we did not use a Doppler (or a fetal stethoscope) to identify fetal viability as most of the pregnancies were earlier than the twelfth week, when a Doppler is only 73% reliable. A fetal stethoscope is not useful until the sixteenth to the twentieth week. Ultrasound, on the other hand, is dependable by the eighth or ninth week.

Thirdly, when we said that early arrangements could be made for for the care of those women with a non-viable pregnancy, we should have said 'earlier than if no ultrasound had been done'. I have always felt that routine evacuation of the uterus was wrong, and Nielsen's[1] article merely confirmed what most general practitioners know already — that in the absence of heavy bleeding many women do not need to be admitted to hospital with a threatened miscarriage if their general practitioner feels confidents to care for them at home.

Finally, I cannot agree that ultrasound should be delayed for two weeks after the onset of bleeding, as recommended in the otherwise excellent Dutch protocol on this subject.[2] Ultrasound has given us[3] the ability to provide a rapid and reliable answer to every woman's question, 'Is my baby alive?' Women deserve better and more effective care than they are getting at present. Further research in general practice is urgently needed.

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