Out of hours work in general practice

SIR,—Drs Steve Iliffe and Ursula Haug suggest that general practitioners should be aware of their tendency to omnipotent thinking and behaviour.[1] I have analysed the need for consultations that I have carried out at different times.

Of 388 out of hours calls that I made in the past three years (1 July 1988 to 30 June 1991), I considered 194 to be essential and 194 of questionable importance or unnecessary. Of 241 home visits that I made during the day during the past quarter (1 April to 30 June 1991), I considered 216 to be essential and 25 questionable or unnecessary. Of 390 consultations at my surgery during June this year, 363 were essential and only 27 questionable or unnecessary. This shows that out of hours calls are often a source of particular irritation to me and probably detract from my performance the next day. I am not sufficiently omnipotent to perform such visits with equanimity.

Nevertheless, I believe that patients should have access to a general practitioner from their area out of hours. The present restriction on paying higher rate night visit fees only to doctors working in rotas of 10 or fewer principals is arbitary, and I can see no reason why it could not be extended to rotas of 30-40 principals. One general practitioner would normally be able to cover the 50 000 to 100 000 patients concerned during a night, but this task would occur sufficiently seldom for it not to impose excessively on within hours work.

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1 Iliffe S, Haug U. Out of hours work in general practice. *BMJ* 1991;302:1584-6. (29 June.)

SIR,—Drs Steve Iliffe and Ursula Haug recommend that general practitioners should no longer work at night but omit to mention several adverse consequences of this proposal.[1]

Firstly, more patients with general practice problems would be seen in accident departments. Such patients tend to be overinvestigated and overtreated, and many are admitted unnecessarily.

Secondly, there would be more emergency referrals to hospital. Although patients may be satisfied with the deputising services, those of us working in accident departments know that deputising doctors are more likely to make emergency referrals than the patients' usual doctor.

Finally, general practitioners would have to take a cut in pay. As junior hospital doctors have discovered, shorter hours mean less pay. The money saved would pay for the deputising service and for additional capacity in accident departments.

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1 Iliffe S, Haug U. Out of hours work in general practice. *BMJ* 1991;302:1584-6. (29 June.)

General practitioners' attendance at case conferences

SIR,—Dr Jonathan Charlton claims I have ignored the motivation of social workers to organise case conferences so that general practitioners can attend.[1] That was not the intention of my article.[2] As an inner city general practitioner attending frequent conferences I know only too well the frustrations of trying to get social services to take into account general practitioners' work pattern. As a member of our local area child protection committee I have been instrumental in beginning to establish guidelines for communication and procedures between general practitioners, health visitors, and social workers. One of the problems is the poor perceptions of other professionals' work. Until mutual trust and understanding are built up, the reality of sharing goals will be illusory.

Nevertheless, I suggest that non-attendance of general practitioners cannot just be attributed to logistic factors. The evidence from Lea-Cox and Hall of avoidance behaviour is impressive.[3] A study in the London Borough of Richmond in 1988 surveyed local general practitioners and changed venues and times of conferences to suit them but found no significant increase (15-17%) in attendance (T Earland, personal communication). Another small study in rural Sussex showed some increase in attendance (13-26%), but the figures were too small to be significant and the general practitioners did not receive invitations to child abuse case conferences as frequently as their inner city colleagues. Nor were the disincentives of shortage of social workers to whom to allocate cases on the "at risk" register and the general restriction of social services resources so severe as in urban areas. I suggest that these factors may influence general practitioners' decisions about the value of their attending such conferences in the same way that it has been shown that some referral patterns, such as for physiotherapy, are influenced by the availability of an attractive service locally.

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2 Harris A. General practitioners and child protection case conferences. *BMJ* 1991;302:1354. (8 June.)
3 Lea-Cox C, Hall A. Attendance of general practitioners at child protection case conferences. *BMJ* 1991;302:1378-9. (8 June.)

When sex is a headache

SIR,—Professor James W Lance's editorial, entitled "When sex is a headache," failed to emphasise the clinical dilemma of excluding subarachnoid haemorrhage, and his implication that computed tomography is sufficient to exclude subarachnoid haemorrhage is wrong.[1]

About half of patients presenting with subarachnoid haemorrhage will have experienced headache.[2] Identifying the subgroup of patients presenting with this common symptom who have a potentially life threatening condition is a difficult clinical challenge. About one in 25 patients with aneurysmal subarachnoid haemorrhage will have had their bleed precipitated by coitus.[2] When a patient presents with a headache associated with coitus most clinicians share the patient's alarm. Only when the headache has recurred several times over an extended period without sequelae can benign sex headache be diagnosed without investigations to exclude subarachnoid haemorrhage.

The correct management of coital headache starts with a decision on whether subarachnoid haemorrhage is in the differential diagnosis. If it is, the best initial investigation is computed tomography.[3] Patients with subarachnoid haemorrhage whose only symptom is headache, however, will have a 15·3% chance of having a normal scan, and five days after the haemorrhage 22·2% will have normal scans.[4] Lumbar puncture should be performed at least 12 hours after the event in patients whose scan is normal[5] and the supernatant examined spectrophotometrically for xanthochromia.[6] To do less than this is illogical and potentially disastrous.

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The health of the nation

SIR,—The Radical Statistics Health Group has pointed out the lack of a strategy for health of the nation; many critics have focused and will continue to focus on the lack of attention in the document to social inequalities as a reason for ill health. Such criticism seems to me to miss the point. It is poor social conditions, not inequality, that cause poor health. If the poorest in the country lived in decent housing, had jobs that gave them an adequate income and self respect, did not smoke, did not drink alcohol to excess, had an adequate diet, and took enough physical exercise it would not matter at all whether the richest lived in more or less similar circumstances or were immensely better off.

The consequence of this line of argument is that we need a strategy that ensures the poorest have what they need to be healthy. We also need more information (though we already have quite a bit) concerning the social conditions and lifestyles that are, in fact, necessary for health. The lack of attention in *The Health of the Nation* to altering environmental circumstances is deplorable and means that it is unlikely that meaningful targets can be set or met in the fields of childhood asthma and childhood accidents and in conditions related to lifestyle, such as coronary heart disease. But this is not because too little attention is given to the irrelevant concept of inequality.

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1 Radical Statistics Health Group. Missing: a strategy for health of the nation. *BMJ* 1991;303:299-302. (3 August.)

Rushing to work in Gothenberg

SIR,—I am afraid that your picture library has let you down—the people shown "rushing back to work in Gothenberg"[1] certainly have their task cut out for them because they are in fact pictured outside the concert hall on Hötorget in Stockholm, 300 miles away. The concert hall, designed by Ivar Tengbom, is the place for the Nobel Prize ceremony. Incidentally, Hötorget, which translated is Haymarket, is used to categorise inferior paintings—Hötorgskonst. The building on the right is the department store PUB.

Gothenburg is the port on the west coast, the industrial heartland of Sweden (source of Volvo cars, SKF ballbearings, and Hasselblad cameras) and also its sports capital (IFK Göteborg, twice winners of the UEFA cup). Its inhabitants are known for their wit. The less said about Stockholm the better. An old lady who was about to travel to Stockholm was asked what she most looked forward to. "Taking the train back to Göteborg."

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