Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Health visitors and child health surveillance

Sir,

As a community paediatrician with an interest in primary care, I found the editorial by Kelsey and Robinson worrying (January *Journal*).[1] It does not, in my view, do justice to the complexity of the issues surrounding child health surveillance and health visiting presented in the conference proceedings from the NHSE National Screening Committee.[2]

The health technology assessment on hearing screening has reported in favour of universal neonatal screening.[3] This system includes health visitor follow-up and assessment of children missed by the screening programme, and includes universal surveillance during the first year. Health visitors will therefore still have a major role to play in hearing surveillance in children of pre-school age. Some health visiting time may be saved; although, with the development of hand-held technology, health visitors may be asked to provide the screening programme.

The authors recommend a randomized controlled trial (RCT) of health visiting interventions to assess the efficacy of child health surveillance and child protection. An RCT of home visiting and the prevention of child abuse has already been conducted in the United States and demonstrates lasting benefit.[4] Systematic reviews of home visiting are still being conducted in the United Kingdom,[2] and it is hoped that those reviews will be reported shortly. The third Hall report also lists many health visiting interventions that are of proven benefit in managing difficulties in childhood.[5]

The suggestion that identifying special educational needs can wait until school entry is misleading. A full assessment of a child's special educational needs takes between four and six months. The authors are therefore unrealistic to expect that a school will be able to provide instant help for a child with special educational needs if those needs have not been identified and assessed prior to school entry. Health authorities have a statutory duty to identify children with special educational needs as early as possible and notify the local education authority.[6] Health visitors may identify up to one-third of children with significant developmental delay (S Jayakumar: unpublished data).

In summary, it will not only be health visitors who object to whole-scale reductions of their service. Community paediatricians will point out that many health-visiting interventions are already evidence-based, and that health authorities and primary care groups have statutory duties that must be fulfilled.

CLIONA NI BHROLCHAIN

Child Health Directorate
Northampton General Hospital NHS Trust
Cliftonville
Northampton NN1 5BD

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Sir,

In the editorial about the systematic review of child health surveillance and the role of health visitors, Amanda Kelsey and Michael Robinson focus on the threats to health visiting. They discuss health visiting capacity being reduced by a proportion of time currently spent on undertaking child health surveillance because it is of unproven benefit. We have been locally reviewing health visitor services and see very much the need to expand their role in supporting public health in primary care. Primary care groups will need to undertake health needs assessments at a much greater level than previously carried out at a practice level. GPs as a professional group are heavily committed and will be searching for a professional group to assist in this process. Public health is very central to health visitors' training and experience, and we believe that they will have an important role in supporting public health activities within primary care, especially community-based needs assessment.

We have currently initiated a learning set for health visitors to support their understanding of needs assessment as a process, as well as piloting a new form of health visitor profile that most health visitors currently undertake. Health visitors working alongside their practice teams and being supported by health authority, public health, and health promotion professions could be a potent force for advancing public health at a primary care level.

TONY JEWELL

North West Anglia Health Authority
St John's, Thorpe Road
Peterborough PE3 6JG

Reference

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Epidural steroid injections for sciatica

Sir,

I read the paper by Hopayian and Mugford (January *Journal*)[1] with interest, particularly as I have spent many years dealing with pain of vertebral origin. My immediate reaction was that nowhere is mention made of any sort of diagnosis prior to treatment. Sciatica has, of course, numerous possible causes, some of which may be helped by epidural steroids and some are better subjected to other therapies. Similarly, when low back pain is included, the problem is exacerbated to the extent that analysis becomes almost meaningless: who is comparing what with which? Most of the references quoted in the article I have to admit to having not read, but I would like to briefly comment on four.

I find it interesting that Yates (ref 15) does not consider local examination of the spine, nor do Matthews *et al* (ref 18), nor Kleenerman *et al* (ref 22). I know Melzack's work better (ref 23); indeed, Loïc Burn and I have made good use of it in our clinical work and in our basic, no frills teaching since 1983. In our view, it is of fundamental importance to attempt, by local examination, to identify as accurately as possible the state of origin of back pain at all levels (with or without sciatica or, for that matter, trunk, brachial, or head pain), though it is seldom possible to establish a true diagnosis. Such clinical evidence, as is commonly thereby obtained, is sufficient for the clinician to make a sound therapeutic decision. In view of the very common occurrence of referred pain, and in the absence of contraindications, it is well worth offering vertebral manipulation or local anaesthetic injection to the site of origin of the pain rather than to the site of its perception.

In spite of some teaching to the contrary, these are simple techniques readily learned and rapidly deployed in primary care, and, contrary to the belief of some, they are remarkably safe. If successful, as is commonly, though unpredictably, the case, they are likely to markedly reduce the necessity of resort to epidural injections. It seems unfortunate that appreciation of these facts should apparently remain so restricted, in spite of the CSAG report and that of the RCGP, and of our having provided substantial evidence in this respect on a number of occassions.[2-7]

JOHN K PATERSON

L'llot
Les Fitayes
13640 La Roque D'Anthéron
France

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Dutch GPs acknowledge the need for preconceptual health care

Sir,

The questionnaire survey conducted by Wallace and Hurwitz among English primary health care teams (PHCT) (January '98 *Journal*)[1] showed widespread agreement on the benefits of preconception care (PC).

Preconception care represents a typical example of primary prevention of adverse pregnancy outcome by screening for risks and diseases,[2,3] allowing for well-considered decision making, planning of pregnancy, and early intervention. The allocation of such care in the health service systems is, however, not clear yet. As GPs do meet women with childbearing potential and their families regularly, their contribution to the implementation of PC will probably be substantial. We therefore performed an inventory study among 100 Dutch GPs regarding the knowledge, presumed desirability, and preconditions present with regard to the concept of PC.[4] Some of the results are listed in Table 1.

Apparently, most Dutch GPs are acquainted with the concept of PC. As was reported by Wallace and Hurwitz, in our study the advantages are generally considered to outweigh possible disadvantages, such as the medicalization of pregnancy and decreased parental confidence in the birth of a healthy child.

How and when to reach the intended population most likely to gain from PC is still unclear. The risk perception of future parents is generally low, and proper timing of preconceptual advice seems crucial. Dutch GPs consider PC to belong to their job responsibility. Many already provide some PC advice that, however, is not structurally organized. In the study by Wallace and Hurwitz, the PHCT professionals considered PC to be best delivered opportunistically by nurses.

The structure and implementation of PC in the Netherlands is still strongly debated. Furthermore, the quality and extent of this care has not yet been studied. Dutch GPs indicate insufficient specific knowledge, which points to the need for education and postgraduate courses.

Further research is required regarding the type and frequency of the risk factors identified and the subsequent need for specialized counselling, as well as the methods of preconceptual health assessment (by history, questionnaire, or both). Also, the effects on the outcome of pregnancy have to be evaluated before general implementation should be considered.

ROLF CIKOT
MICHAEL GAYTANT
ERIC STEEGERS

Department of Obstetrics and Gynaecology

Table 1. The concepts and experiences of GPs concerning preconception care.

Question	Yes (%)	No (%)	No opinion (%)
Do you consider PC to belong to your job responsibilities?	93	7	0
Do you think that PC will lead to the medicalization of pregnancy?	25	74	1
Do you have enough time for PC?	70	30	0
Are you prepared to provide more PC in the future?	91	7	2
Do you have sufficient knowledge to provide PC?	42	58	0
Do you recognize the need for improved education and postgraduate courses concerning PC?	84	15	1
Do you have enough brochures about PC?	34	74	2
Would you refer patients to a specific outpatient clinic for PC?	59	39	2

University Hospital Nijmegen
St Radboud
PO Box 9101
6500 HB Nijmegen
The Netherlands

JOSÉ BRASPENNING

Department of General Practice and Social Medicine
Centre for Quality of Care Research
University Hospital Nijmegen
St Radboud
PO Box 9101
6500 HB Nijmegen
The Netherlands

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A bridge across the no-man's land

Sir,

It was good to read Chris Burton's 'Viewpoint' (November *Journal*; Back Pages),[1] suggesting a wider exploration of managed networks supported by specialist GPs. As such a beast, having previously been a generic GP for 15 years, I hope I can vouch for the value of such developments in my own field of HIV.

Officially an 'HIV Liaison Physician' within the local academic GP department, and on the payroll of the HIV Unit at the local NHS Hospital Trust, I feel, formally — and informally — very much a 'bridge across the no-man's land'. Much of my role is concerned with the education of GPs and other primary care workers about the subject of HIV, as it is (increasingly) likely to affect them, but also to support them in particular clinical cases (e.g. an action plan for the management of an untested patient that the GP feels may be presenting with an HIV-related symptom). I am also a visible general practice representative for the specialist HIV physicians, attempting to extol the virtues of primary care for patients unregistered or non-disclosing to their GPs, and of the need for appropriate communication with them.

Together with the invaluable and expert assistance of the relatively-unknown, community-based clinical nurse specialists or facilitators for HIV, we are now in a position to help all generic primary care workers develop skills and guidelines that will allow them to provide the high-quality primary care services to patients with HIV in the community that are, at present, the preserve of the secondary sector.

ANDREW P DUNFORD

Department of General Practice and Primary Care
Barts and the Royal London School of Medicine and Dentistry
Queen Mary and Westfield College
London E1 4NS
Email: A.P.Dunford@mds.qmw.ac.uk

Reference

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Relationship between new and return consultations and workload in general practice

Sir,

I noted with interest Professor Bain's finding (December *Journal*)[1] that GPs with higher weekly surgery workloads have a greater proportion of return consultations. His study is valuable at a time when increasing workload in general practice is of major concern to GPs and health service managers, and possible strategies to limit its continuing increase are welcomed.

The author infers from his study that, 'By reducing the number of return consultations, GPs could … alleviate the, oft quoted, stress induced by the perceived increase in demand for patient care.' In this statement the author suggests a link between return consultations, stress, and workload. While there is already evidence to link workload and stress in general practice,[2] and evidence from this article to link the return consultation and workload, there is insufficient evidence to link the return consultation and stress. A reduction in the number of return consultations may reduce a GP's workload, but not necessarily with a reduction in stress.

The return consultation may have a stress-relieving role. In a job stress inventory, GPs have cited 'worrying about patients' complaints' as a job stressor.[3] Could it be that the return consultation offsets the effect of this particular stressor? After all, diagnostic doubt features in many general practice consultations and generates feelings of uncertainty and anxiety; GPs may find that, by arranging a follow-up appointment, they can better manage the stress this creates, albeit at the expense of an increased workload.

The link between the return consultation, workload, and stress is more complex than the author suggests, and requires further work. If a GP reduces his or her workload by reducing the number of return consultations, would this be accompanied by a reduction in stress? This question remains to be answered.

HELENA ELKINGTON

Department of General Practice and Primary Care
Guy's, King's and St Thomas's School of Medicine
Weston Education Centre
Cutcombe Road
London SE5 9PJ

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Awareness of BACUP in primary health care: the potential of voluntary services

Sir,

BACUP (the British Association of Cancer United Patients) is the largest national cancer information and support service in the United Kingdom, providing a telephone and written information service; free information booklets for patients; a web site; and, in some areas, a counselling service. Many patients and their families find BACUP helpful,[1,2] but little is known of the views of health care professionals.

We sent a structured questionnaire to 200 GPs and 161 district nurses practising in the Lambeth, Southwark and Lewisham, and South Bedfordshire areas, to assess their knowledge of BACUP; 69% of GPs and 57% of nurses replied. Of the responders in London, 63% of GPs and 75% of nurses were aware of

BACUP, with respective figures of 36% and 58% in Bedfordshire. Sixty-four per cent of GPs and 80% of nurses understood that the organization is an information service for cancer patients, their families and friends. Fewer were aware of the information given to the general public (36% of GPs and 57% of nurses) or of the counselling service. The service for health care professionals was mentioned infrequently (14% of GPs and 26% of nurses). Twenty-three per cent of responders were both familiar with BACUP and had a telephone number for the organization. GPs in this group were more recently qualified, more often female, and worked within practices of three or more partners; but all except two came from different practices, implying a lack of information exchange.

More than two-thirds of responders would encourage a patient to use an information booklet. BACUP also sends 5000 copies of *BACUP News* to general practices annually, although this is aimed primarily at patients and fund-raisers. Treatment regimen fact sheets are also now available. However, we found that only 30% of nurses and fewer than 10% of GPs read all their postal information.

There are a multitude of services for patients and health care professionals — in a health service trying to balance ever-increasing demands and limited resources, such organizations are important — however, staff were often not sufficiently aware of relevant organizations for maximum benefit to be obtained. Although general awareness of BACUP was high, there was a lack of the more detailed knowledge needed for optimal use. Ease of contact and a prior knowledge of the facilities provided are essential.

Primary health care centres are an untapped resource, and specific and concise information on BACUP for health care professionals is required.

M STONE
M S HIGHLEY
P G HARPER

Department of Medical Oncology
Guy's Hospital
St Thomas Street
London SE1 9RT

D POOLE

Ebenezer House
Kennington Lane
London SE11

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Stigmatization of sufferers of mental disorders

Sir,

I am delighted that the Royal Colleges of Physicians and General Practitioners are collaborating with the British Medical Association on this important initiative concerning the stigmatization of sufferers of mental disorders. I think it is important to bear in mind that the issue here is not just about stigmatization, but also about discrimination. I hope that the campaign has the political will to pursue change in attitudes and legislation in this arena also.

Professor Crisp (January *Journal*)[1] says it all when he states, 'Our training as doctors, whether we be GPs or psychiatrists, is sometimes patchy in some of these areas, to say the least ... we must get our own house in order at the outset.' I think that is as near as an academic comes to saying that the situation is three-fold mediocre, at best disastrous, with fickle rates of diagnosis and management, high rates of CPN burn-out, and, in some 600 posts, no consultant psychiatrist at all. Even if the guideline says to refer a particular patient, there may be no one or no service there to refer to.

In order to 'get our own house in order', I am equally delighted to be able to announce the formal launch of PRiMHE (Primary Care Mental Health Education). This is a multi-sponsored initiative that will serve the sufferers of mental disorders and those who care for them at a primary care level by being the principal beacon around which we can all gather. Never before has there been such an organization with so much opportunity at primary care level. Mental health is key to all consultations, and mental illnesses are the engine for many of the investigations, tests, and admissions to hospitals. Those with diabetes and asthma have benefited hugely from such enterprises, and PRiMHE has the same aim. Worthy words are not going to sort the situation out. We all have need of our mental well being, and PRiMHE is now here to help. With the help of a dedicated magazine, scientific meetings, educational initiatives, and the development of a network of those 'fired-up' in this subject area, the situation can be improved.

The Colleges also need to remember that many studies have shown high levels of stress and depression among caring professionals. The National Health Service and those working in it have become sicker over the past 6–10 years, and at last the crisis can be seen for what it is. If stigma needs to be tackled anywhere, it is within the medical profession itself.

CHRIS MANNING

Co-chairman PRiMHE
Email: 100044.411@compuserve.com

Consulting with a cough

Sir

Cornford (November *Journal*)[1] is to be congratulated for producing more results[1,2] to help us understand patient consulting behaviour in the context of cough. This research is of daily benefit to all consulting GPs who wish to identify their patients' concerns using the themes 'abnormal cough', 'social roles', and 'worries'. The fact that consulters were more likely to believe they needed antibiotics, complements the results of Butler *et al*,[3] who found that one-third of patients consulting with sore throat expected to be prescribed antibiotics.

While the use of qualitative methods when conducting research of this nature is clearly appropriate, we felt that the results tended to focus disproportionately on the views of the consulters. Further discussion of both groups' views may have also provided an important insight into the way consultation behaviour related to smoking, for example. It may also have contributed to our understanding of patients' general attitudes towards consulting, or not consulting, their GPs.

However, we disagree with the last sentence: '…the sensitive use of antibiotics in upper respiratory tract infections by GPs … does fit in with patient beliefs and may therefore help many patients cope better with their illness.' First, we do not know the diagnostic mix of the patients studied to say whether they had upper respiratory tract infection or to justify the 'sensitive' use of antibiotics. Secondly, given the context of rising antibiotic use[4] and antibiotic resistance,[5] surely the author is giving GPs more insight to address patients' *real* concerns, allowing GPs the freedom *not* to prescribe antibiotics.

ALASTAIR HAY

Department of General Practice and

Primary Health Care
University of Leicester
Leicester General Hospital
Gwendolen Road
Leicester LE5 4PW

CATHERINE EXLEY

Department of Primary Care and General Practice
Medical School
University of Birmingham
Edgbaston
Birmingham B15 2TT

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Domestic violence: the general practitioner's role

Sir,
The recently distributed booklet on domestic violence is to be commended for its clarity and guidance, and will become a useful practice reference. I am, however, alarmed about the omission of violence suffered by the male partner in some relationships, which can be just as alarming as that suffered by the female, but is often more difficult to discover owing to the enormous degradation these men suffer. It is important that the Royal College of General Practitioners recognizes domestic violence can occur to both sexes. The author needs to be aware of the danger of publishing material that is too biased towards one group of individuals, and by omitting references to male abuse opens herself to criticism and damages the credibility of the entire publication.

G HAYES

Ashby Clinic
Collum lane
Scunthorpe
North Lincolnshire
DN16 2SZ

Author's response

Sir,
In a short booklet, it is not possible to do full justice to all forms and patterns of domestic violence. The evidence available to date suggests that violence against women and perpetrated by men is by far the most common form of domestic violence, affecting about one in four women at some time in their lives. The evidence further suggests that serious health consequences are most likely following this type of violence, both in terms of physical injury and in terms of subsequent psychiatric morbidity. For these reasons, the recent RCGP booklet concentrates exclusively on this particular form of domestic violence. The first sentence was intended to make clear the scope of the booklet and was not intended to be taken as an exclusive definition of domestic violence. I accept that it could have been worded better and apologize for the misunderstandings that have resulted. I had no intention to minimize the suffering of anyone exposed to violence, only to concentrate on by far the most commonly abused group.

IONA HEATH

Caversham Group Practice
4 Peckwater Street
Kentish Town
London NW5 2UP

Medical students in GP consultations

Sir
O'Flynn *et al* (January *Journal*)[1] report on the effects of having medical students sitting in on consultations, with about one-third of patients feeling unable to talk about personal matters in these situations. This is an important area of research, given the increasing proportion of undergraduate medical education taking place in the community. The authors conclude that further work is needed in determining how patient care is affected by changes in medical education.

A recent concern of mine, precipitated by my involvement in interviewing prospective medical students, is the number of sixth-formers who have spent a week or more in general practice before they apply to study medicine. In order to demonstrate that they have explored the nature of their intended profession, pupils are encouraged to shadow junior doctors, attend operating sessions, and spend some time in primary care. The last of these activities includes sitting in on consultations and going on home visits as well as working in reception.

In view of the fact that medical students cause alterations in the way in which patients consult with their doctors, what might be the effect of even younger and less experienced observers? I am not convinced that the benefit to the pupils offsets the probable intrusion on patients' consultations. Moreover, I wonder if patients are given adequate time to express their consent, or otherwise, to the presence of school children, and whether they are properly informed of the nature of the observer's position. Sixth-formers are likely to find placements in surgeries near to their schools or homes with subsequent problems of confidentiality.

I think we are beginning to take our patients' good nature for granted and, in future, this may jeopardize the community-based teaching programmes of our universities.

JE THISTLETHWAITE

Department of General Practice
20 Hyde Terrace
Leeds LS2 9LN

Reference

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Correction

In the March *Journal* we published a letter featuring a telephone number for the Doctors Support Network. We would like to apologise for printing the wrong area code for the number, which should have read 07071 223372.