immunization (eight), minor ailments (four) and nappy rash (three). Six of those presenting their child for treatment of candidiasis had been referred by a health professional, such as a health visitor or midwife, visiting the home. In babies attending the clinic for reasons other than candidiasis, candida infection had been noticed by the health visitor while weighing the baby. Of the affected babies, 94% were bottle fed. Antibiotics had been taken by 28% of infants in the two weeks preceding the onset of candidiasis.

Of the 41 occurrences of oral candidiasis, 38 were treated with nystatin suspension, two with miconazole gel and one child was referred to the general practitioner. Of the 74 episodes of perineal infection, 34 were treated with Timodine® cream (Reckitt and Colman), 33 with nystatin cream, three with miconazole cream, and four children were referred to their general practitioner. The facial infection was also treated with nystatin cream.

This study shows that 9% of child health clinic attendances had clinical candidiasis requiring treatment. No comparable community studies could be found but a Liverpool study of hospital admissions showed an incidence of 7%.[2] Extensive use of dummies[2,3] and usage of antibiotic may be associated with candidiasis.

The high incidence of candidiasis justifies a policy of having treatment available at child health clinics, as described by Polnay.[4] Community child health clinics are likely to continue in deprived areas for the foreseeable future, as Hart's inverse care law is likely to apply to health promotion activity as in other areas of work.[5] Informal discussion with local general practitioners confirm their support for this service as they have no desire to increase their inevitably high consultation rates any further. Travel costs and inconvenience to parents would also increase if they had to attend their general practitioner for a prescription. Pharmacy dispensing fees would add to National Health Service costs.

The potentially divisive nature of the new contract for general practitioners and the reforms in the NHS should not be allowed to interfere with the current cooperation between general practitioners and community doctors in providing an effective service to disadvantaged parents and children.

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References

1. Russel C, Lay KM. Natural history of Candida species and yeasts in the oral cavities of infants. *Arch Oral Biol* 1973; **18**: 957-962.
2. Manning DJ, Coughlin RP, Poskitt EM. Candida in mouth or on dummy? *Arch Dis Child* 1985; **60**: 381-382.
3. Sio JO, Manwalla FK, George RH, Booth IW. Oral candida: is dummy carriage the culprit? *Arch Dis Child* 1987; **62**: 406-408.
4. Polnay L. *Manual of community paediatrics.* London: Churchill Livingstone, 1988: 216.
5. Gillam SJ. Provision of health promotion clinics in relation to population need: another example of the inverse care law? *Br J Gen Pract* 1992; **42**: 54-56.

Diverticular disease

Sir,

Diverticular disease is a common condition and occurs in 50% of patients aged over 50 years.[1] The disease is often discovered incidently as it remains asymptomatic in around 90% of the population.[1] However, its symptoms of abdominal pain with or without change in bowel habit are not pathognomonic and can be ascribed to other more serious diseases of the distal large bowel. Similarly, both diverticular disease and colonic neoplasms have an average age of diagnosis that is in the seventh decade.

In my general practice two patients with recently diagnosed descending and sigmoid colonic carcinoma had undergone a barium enema examination within the previous eight years which had demonstrated diverticular disease. In July 1992, the records of all patients with a current diagnosis of diverticular disease were, therefore, examined to determine the clinical management of patients with this condition and to identify other pathologies occurring within this group. The total practice population is 9974 and of these 3097 (31%) are aged 50 years or over.

Sixty three patients with diverticular disease were identified (2% of total practice population aged 50 years or over). The mean age of these patients was 71 years (range 48–95 years), only one patient being under 50 years of age, and the male:female ratio was 1:2.7. Forty seven patients (75%) had undergone barium enema investigation of which four had been normal (these four patients were diagnosed clinically), 37 had shown diverticular disease and six had revealed diverticular disease and colonic polyps. Eleven patients (17%) had been diagnosed purely on clinical grounds, no radiology or other investigation having been performed. In five patients other investigations revealed coexisting colonic carcinoma (two patients), ulcerative colitis (one), irritable bowel (two) and gallstones plus peptic ulcer (one).

Thus, 11 of the 63 patients had a coexisting pathology, the most common being adenomatous polyps (six patients). Four patients had later suffered a serious complication of diverticular disease — haemorrhage (one patient), peritonitis (two) and perforation (one). Fifteen patients (24%) had been referred for secondary care.

Diverticular disease is a condition most commonly found in the distal colon of elderly women. However, it is not a disease without serious complications. Nor can the diagnosis be made purely on clinical findings — 17.5% of patients with diverticular disease may have a coexisting condition, not always diagnosed on barium enema alone.

It is too simplistic to expect to investigate a patient's symptoms appropriately, reveal a condition which may be the cause of those symptoms and then to ascribe all future symptoms to the condition diagnosed. When diseases can occur coincidently, with similar symptoms and signs, we should always be prepared to review a diagnosis critically and reinvestigate to discover the true cause.

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Reference

1. Clark M, Kumar P. 'Doctor I have a pain in my stomach'. *Gastroenterology in Practice* 1992; **7**: 6-8.

Chronic mental illness in general practice

Sir,

Goldberg and Jacksons' attention to improving liaison between primary care and the specialist in the context of mental illness is very welcome (editorial, July *Journal,* p.267). They contrast the widespread use of protocols and shared care plans for patients with chronic physical illnesses with the lack of proactive approaches to patients with long term mental illnesses in the community.

In planning a strategy of care for patients with chronic mental illness an essential first step is to define the scale of the problem. In our practice a medical student (S H) carried out a study in October and November 1991 scrutinizing the notes of all the practice patients (3986 at the time of the study) and identifying those patients aged over 16 years with chronic mental illness. The following categories of patients were used, that seemed to generate the principal burden of work for

general practitioners, although many such patients are not seen by specialists: a diagnosis of schizophrenia or psychosis; the use of long term maintenance medication, such as lithium, even if the patient was not actively ill; patients with disrupted work or social relationships caused by chronic mental illness, particularly those requiring long term sick certification in general practice; documented affective disorders such as anxiety or depression present for longer than six months (this included patients taking regular medication for the prevention of such disorders); and dementia.

Drug and alcohol abuse and chronic uncomplicated benzodiazepine use were excluded as they have different management problems. Morbidity from short term psychological disturbance was also excluded by including only those patients who had had problems for at least six months.

At least 119 (3% of the practice population) could be considered to have a chronic mental illness. This may be an underestimate because some affective disorders may go unrecognized when a patient presents with physical symptoms only (somatization[1]). Furthermore, even when recognized, some chronic mental illnesses such as dementia or chronic neurosis may not be clearly documented as such in general practice notes.

Physical illnesses such as diabetes require not only physical care, but a holistic approach to care which must include attention to the psychological and social aspects of a patient's illness. The reverse is also true of patients with mental illnesses: their physical health must also be attended to. In the second part of the study, record keeping of the measurement of risk factors was compared between patients with chronic mental illnesses and the next age and sex matched patient on the file who did not have a chronic mental illness. The patient with a chronic mental illness was more likely to have his or her notes summarized than age and sex matched controls (94% versus 78%). The former group of patients were less likely to have blood pressure recorded in the notes in the last five years (64% versus 73%), less likely to have smoking habits recorded (24% versus 36%) and less likely to have alcohol habits recorded (23% versus 31%). This suggests that general practitioners may focus too narrowly on the psychological component of chronic mental illness and more attention should be paid to routine screening measures.

Appropriate teamwork between the specialist psychiatrist and primary health care team is essential but the difficulties should not be underestimated. Specialist psychiatric services, including community psychiatric nurses and clinical psychologists, are usually based away from primary care, and may not develop a clear understanding of the potential and constraints of general practitioner care. Also, in an inner city practice such as our own, with high patient mobility, there is a risk of fragmentation of care and a lack of continuity. In central Manchester close links are being developed between the psychology department at Manchester Royal Infirmary and general practitioners, and the liaison psychiatry model[2] has been used to good effect.

The liaison psychiatry model and studies of general practitioners trained using video feedback[3] show that general practitioners' consultation skills can be improved and this could also improve their care of the mentally ill. To develop this further, planning to improve community services for mentally ill people should include continuing medical education of general practitioners and the primary health care team. There should be an emphasis on two way learning between general practitioners and specialists. Detailed case discussion can build on the general practitioners' strengths, including their knowledge of the patient, family and community and a unique awareness of the impact of mental illness on family members, as well as helping specialist services to learn more about primary health care, making their services more appropriate.

Developing explicit management aims for patients with chronic mental illnesses, combining the skills of specialists and of general practice, and monitoring standards could help to improve services for chronically mentally ill patients. The purchaser–provider split must not prevent the development of strong coordinated, multidisciplinary mental health services firmly based in primary health care settings.

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References

1. Grol R (ed). *To heal or to harm. The prevention of somatic fixation in general practice.* Third edition. London: Royal College of General Practitioners, 1988.
2. Creed F, Marks B. Liaison psychiatry in general practice: a comparison of the liaison-attachment scheme and shifted outpatient clinic models. *J R Coll Gen Pract* 1989; **39**: 514-517.
3. Gask L, McGrath G, Goldberg D, Millar T. Improving the psychiatric skills of established general practitioners: evaluation of group teaching. *Med Educ* 1987; **22**: 132-138.

Flourishing process — floundering care

Sir,

I reject almost in its entirety Geoffrey Marsh's chilling vision of a truly holistic community based caring system (editorial, July *Journal*, p.266). What is described is process and only process. No mention is made of outcome, whether defined by the patient or the doctor.

I have grave doubts about much that we do. I have even greater doubts about the benefits of much of the work of health visitors,[1] physiotherapists, speech therapists, community psychiatric nurses and social workers. The thought of grouping all these workers together in the name of progress is frightening. New buildings, smart uniforms and medium and high technology facilities are attractive, but I hope we can see beyond these material things to what is truly important.

The job of general practice is to respond to, and where possible help the patient who perceives him or herself to be ill. Patients turn to their doctor for care. This means interest, understanding, concern and where possible help, and all of these must be provided dependably. If we dilute this care with sub-specialization in disease, with management responsibility, and with even more patients, we will have created a monster. The monster would be pleasing to the eye and attractive to the powerful, the healthy and the opinion formers, but alien to the poor, the sick and the confused.

While abroad I have worked in such an institution. It had 20 doctors, two of whom were not seeing patients but managing, a laboratory, an x-ray department, a physiotherapy department and an ophthalmology department. I saw the future and I found it wanting. I fled to a small practice and later accepted the secretaryship of the Small Practices Association.

No amount of welfare can make good the deficit of a parent. Now I know with equal certainty that no amount of management and technology, no amount of resources or support will make good any degradation of the patient–doctor relationship. We must endure this time of uncertainty and reject any superficially attractive goal which could detract from basic personal care.

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Reference

1. Hall DMB (ed). *Health for all children (Hall report).* 2nd edition. Oxford University Press, 1991.