Children with special educational needs

Sir,
It was good to see Dr Ní Brolcháin's interesting study of children with special educational needs (February *Journal,* p.56). They form a small but important subgroup of a practice child population. I suspect these children and their families may well have higher consultation rates than a control group without special educational needs. I trained for general practice (including nine months in acute hospital paediatrics) without learning about the 1981 education act but hopefully course organizers are now including it in their programmes.

I would like to emphasize a few practical points about the education act:
1. Any person who is concerned that a child may have an educational problem may request an assessment under the act (parents, teachers, doctors and so on).
2. The district health authority is obliged to inform the education authority about children who may have such needs.
3. Three professionals have to assess and report on the child's needs: a teacher, an educational psychologist, and a doctor with experience in educational medicine (a community paediatrician or senior clinical medical officer). Others may also be asked to make an assessment.
4. Parents are involved at all stages and can have copies of all reports made under the act.
5. Assessment is often a long and daunting process for both parents and children.

General practitioners have an important role to play in the early detection and care of these children and their families and Dr Ní Bhrolcháin illustrates the range of handicaps suffered. Specialist knowledge may be required in order to arrange for a radio hearing aid to be provided for a deaf child in a junior school or to diagnose the cause of deteriorating performance in a secondary school child. Effective liaison between the different agencies is essential if good care is to be achieved.

Dr Ní Bhrolcháin has probably underestimated the number of children with special needs as many may not be identified under the terms of the 1981 act. As many as 20% of children will have special educational needs at some point and only 2% undergo formal assessment.

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Can general practitioners counsel?

Sir,
Dr Rowland and colleagues' discussion paper (March *Journal,* p.118) raises several issues which need addressing.

The article quotes, without qualification, the British Association for Counselling's definition of the counselling process. These rather vague goals are common to many different schools of counselling: directive, informative, confrontational, cathartic, catalytic and supportive. The therapeutic models are based on psychodynamic and behavioural theory whose definitions are some way removed from the commonsense concepts of help, empathy and listening.

The emphasis placed by the authors on the distinction between counselling skills and the process of counselling side-steps the basic unresolved question of whether the 'talking therapies' (including psychotherapy) constitute effective modes of treatment. The authors, however, make the assumption that the efficacy of the counselling process is proven, but there is no body of research which is not predominantly anecdotal that supports this claim. In particular, the use of counsellors and counselling techniques by general practitioners is haphazard and reflects the wide range of possible responses to large numbers of patients with problems which are loosely defined as psychosocial. The management of these problems over years rather than months renders assessment difficult, as Anderson points out in his study.[1]

A general practitioner is the only member of the primary health care team with legal responsibility for the patient. Therefore, the medicolegal consequences of any breakdown in communication or confidentiality between general practitioner, patient and counsellor is borne by the general practitioner.[2] The status of the counsellor as therapist within the context of general practice raises serious ethical problems. The harmful or negative effects of counselling are perhaps recognized more reluctantly by patients and counsellors than by general practitioners who are responsible for the continuity of care.

The cost-effectiveness of counselling is not mentioned by the authors in their discussion paper even though they are all affiliated to the Centre for Health Economics, University of York. The cost of counselling to the patient in the open market is £25.00 (1985 price) per session — the minimum rate for an accredited counsellor.[3] Despite the lack of evidence of long-term benefits to the patient, the decision to reimburse general practitioners for attached counsellors is taken exclusively by individual family practitioner committees.

It is also relevant to reaffirm that counselling, or the use of counselling skills, occurs in the course of consultation between patients and all members of the primary health care team, including health visitors, community psychiatric nurses, social workers, practice nurses, district nurses and receptionists. The assessment of the need for the addition of a professional counsellor or a clinical psychologist acting as counsellor for specific management problems would vary according to the approach and attitudes of the individual general practitioner. The use of marriage guidance counsellors and psychosexual counsellors is very different from the help demanded by those 'help-seeking and vulnerable' patients whose demands for support are often life-long.

Finally, I would disagree with the underlying assumption of the authors, one of whom is writing from the standpoint of a counsellor in general practice, that 'counsellor attachment schemes' are self-evidently beneficial. The question whether general practitioners themselves can act as counsellors remains undecided and rooted in the definition and qualification of the term 'counsel'. As Roslyn Corney concludes from her own study 'Promoting a large counselling service in general practice before establishing what benefit occurs from this service is unwise.'[4]

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Management of benzodiazepine withdrawal

Sir,
I read with interest Mr Onyett's comprehensive review article on the management of the benzodiazepine withdrawal syndrome (April *Journal,* p.160) in which he concludes that supplementary effort from other primary care staff or agencies with specific psychological expertise may be necessary in the management of benzodiazepine withdrawal. In a recent survey of patients in my own practice,[1] however,

I was able to demonstrate that there was a significant proportion of benzodiazepine users who would have great difficulty in discontinuing their tablets. This tends to support the view that careful assessment, perhaps in conjunction with a psychiatrist,[2] rather than psychological counselling in a general practice setting would be a more appropriate way of dealing with these patients.

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Stationery for medical records: 1912–21

Sir,
In his letter (March *Journal,* p.127) Dr Kopelowitz states that as far as he can ascertain, the state made no arrangements whatsoever for providing stationery for recording medical notes before 1921.

In fact a form was agreed in 1912 'following the model of an ordinary day book "such as doctors keep in connection with their private patients" '.[1] These forms were found to be unsatisfactory and in 1913 card forms were introduced — in two parts. At the end of each year the part with the name of the patient and details of attendances was sent to the insurance committee (forerunner of the family practitioner committee or health board), while the other part, containing particulars of illnesses and summary of attendances (unidentified, to preserve confidentiality) was sent to the insurance commissioners. These forms remained in use until the beginning of 1917 when 'because of pressure on practitioners consequent on the withdrawal of so many of their number on military service'[2] the insurance commissioners decided as a temporary measure to suspend the obligation to keep records.

Medical record envelopes, as Dr Kopelowitz states, were introduced in 1921, following the report of the Rolleston committee: 'The envelopes should be of practically the same form and size as the old record cards, so that the cabinets which have been in use for keeping these may continue to be so utilized.'

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Secrecy and the College

Sir,
Much though I respect the achievements of Keith Thompson and Bashir Qureshi in advancing the cause of general practice, I think that their attack on Dr Julian Tudor Hart is seriously mistaken (May *Journal,* p.218). I cannot agree with their contention that the proceedings of the General Purposes Committee must remain 'confidential'. I believe that far too much of what doctors do is kept secret, not only in relation to their patients, but also professionally in the name of those who elect them, pay for their meetings and bear the consequences of what they decide — in other words those who underwrite the democratic process. Why should there be the automatic assumption that unless important matters are discussed secretly, those at the meeting will be inhibited from saying what they really think? There is a well researched comparison with doctors showing their patients what is in their medical records; most doctors are afraid of doing it, but those who do, find that the openness brings almost nothing but benefits to their patients and themselves.

It is unfortunate that it has been traditional for prominent members and officers to avoid replying in public to criticism of the College. 'No comment', as Donald Irvine was reported in *General Practitioner* as saying in connection with Dr Hart's letter in the *British Medical Journal,* really will not do. Marshall Marinker was honest enough to say that he felt very sore about the revelations, but why, until Thompson and Qureshi's letter, has nobody else joined in the debate? To paraphrase Dr Hart on another cat-among-the-pigeons sort of occasion,[1] it is as though a claxon had been let off in a string orchestra: everyone winces, but pretends they have heard nothing. Yet if we do not know what is being said, we can scarcely heed the words of the chairman of council, to 'listen sensitively to all the advice we are receiving'.

In the *Journal* and its *RCGP News* supplement we have an excellent medium through which to communicate with each other, and as the *RCGP News* is almost bang up to date, it is possible to get reports into print very rapidly. May I suggest that this supplement should be developed so that it includes many more reports, with much more detail, of what is going on in Princes Gate. If members use their own publications for discussing College issues there will be much less need to rely on the weeklies and the College could become a living reality to those many members who seldom or never take a direct part in its affairs.

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Small practices and the new contract

Sir,
Now that a compromise has been agreed between the Health Secretary and the British Medical Association on the new contract I would be interested to know the College's stance on the adjusted contract in view of the disadvantageous financial implications of many new proposals for small practices. This is likely to prove very divisive for general practice.

Presumably those members of the council who have advised and influenced the government considered the effect of their actions. Does this mean that the College regards doctors in small practices, particularly in inner city areas, as the second XI members? I am sure that they are aware of the danger of confusing the pursuit of excellence with elitism.

Perhaps the time has come for the College to clarify their position on small practices and reassure these members that their interests are being represented. I understand that some inner city practices, large and small, may be treated as special cases in the new contract because of their special problems often related to the social and ethnic mix of their patients.

It would be nice if, rather than again waiting for overwhelming pressure from the grassroots, the College were seen to be leading from the front in support of this and loudly acknowledging the difficulties experienced by these practices in achieving certain standards.

Meanwhile my membership renewal is still on hold.

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Carcinoma of the testes: help wanted

Sir,
I would be very grateful if any readers could look up the notes of their patients with any kind of carcinoma of the testes and let me know what the smoking habits of their mothers were during the time that the mothers were pregnant with the offspring that developed carcinoma. Please write to me direct.

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