LETTERS TO THE EDITOR

PREVENTION

Sir,

The juxtaposition of a leading article on general practitioner obstetrics with one on prevention (February *Journal)* took me back to the late 1950s and early 1960s, when I found my obstetric equipment gradually declining into desuetude. But during that period I was developing more and more a scientific approach to antenatal and postnatal care in co-operation with midwife, obstetrician and paediatrician. This, together with the infant welfare clinic, I came to regard as the most important form of preventive procedure in family practice. I regretted that I was debarred from the logical follow-up of school children. A national *health* service should be, in any case, what it calls itself, as well as a disease and injury service.

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THE SEARCH FOR AN IDENTITY

Sir,

In your editorial (December *Journal)* it was suggested that the last decade had witnessed the attempt to establish general practice as a "major clinical discipline". Paradoxically, the same editorial also asks whether the dearth of high quality clinical articles from general practice is in some way indicative of low clinical standards. Perhaps the editorial board is wrongly over-influenced by the medical ideology of the hospitals and is wrongly applying it and its emphasis on pathology to general practice. The essence of general practice may not be 'clinical' at all, if clinical is taken to mean a purely scientific and impersonal approach to the treatment and observation of patients. On one level the data doctors are presented with may well fall within the normal definition of 'clinical', but how doctors handle those data and synthesize them in their relationship with the patient is, I think, the real task of general practice.

We cannot deny that a knowledge of methodology is the basis for successful research, and that if instruction in epidemiology is included in vocational training then it may become easier for general practitioners to do effective research. The present lack of good quality clinical articles probably reflects this gap in medical training. However, although epidemiology is useful for determining the prevalence of morbidity in the community and the causes of ill-health, the real identity of general practice is surely to be found in the doctor-patient relationship and in the consultation. The quality of general practitioner care will be determined not just by the professional but by the personal attributes of the individual doctor, including his or her emotional warmth, empathy and sensitivity. The ultimate quality of a consultation will depend on the doctor's ability to use these professional skills in such a way that a relationship of trust and confidence is built up.

Thus it would seem that the basis for clinical research into general practice should be firmly grounded within the doctor-patient relationship. Abstracting data from its framework has a certain sterility and is really epidemiology and not 'clinical' general practice.

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PROBLEM-ORIENTED APPROACH TO MENTAL ILLNESS IN DEVELOPING COUNTRIES

Sir,

Dr Essex (November *Journal,* 648-655) has put a great deal of work into developing his protocol. As a general practitioner in a developing country, who has recently completed a study of morbidity, prescribing and referrals in our practice in rural Saudia Arabia, I wonder if I might be allowed to comment.

His work seems to have been based on hospital experience of mental illness, and to a large extent does not include sensitive enough criteria for the much more common emotional or neurotic disease seen here just as I saw it in practice in Canada.

For example, if 'anxiety' were to include irritability, 'nervousness', overreaction with anger to small irritations and insomnia, his net would be spread much more broadly, and would be of much more practical help.

Fatigue, tiredness, feelings of sadness and awakening during sleep are much more sensitive measurements of depression than waiting for the later classical symptoms of depression. Enough work has been done in general practice research to demonstrate that if we pick up such problems, and act upon them, we will be of much greater help in our goal of a healthy community than waiting until they produce mental illness.

If, on the other hand, this protocol is only looking for the one per cent of our work concerning psychotic problems, he may find his yield rather sparse. In my one year's experience here, the little mental illness I have seen, only a handful of people at best, was only found encased under layers of somatic symptoms. I got at it after several visits by persisting with my more sensitive criteria. It takes some time to gain enough trust for people to feel able to tell you what is really going on inside. Helping to relieve the superficial symptoms gains some of this trust, and over a few consultations the yield is much greater.

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SORE THROATS

Sir,

Whitfield and Hughes *(Practitioner,* **225,** 234-239) conclude from their study that antibiotics have a very small part to play in the treatment of sore throats of adults in general practice. While there is some truth in this statement, I think their recommendation is based on a false premise and could be dangerous unless qualified.

Any modern study in this field should recognize that sore throat is not a disease entity as the authors imply, but a symptom, occurring as one feature of many different viral infections recognizable clinically as colds, flu-like illnesses, pyrexial illnesses, etc, and that in some of these illnesses the throat will be inflamed (tonsillitis and/or pharyngitis) and in others it will be not (un-inflamed sore throats).

Immediately, therefore, there is uncertainty as to exactly what the authors studied. By inference, many of the cases could have been un-inflamed sore throats, because (1) the incidence of this type of sore throat is considerable in the adult age range, (2), by definition, the cases included were those presenting with sore throat, and (3) the 7.5 per cent streptococcal incidence of those swabbed is much lower than would be