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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Snowballing hypothermia alert system or rural noseyness?

Sir,
Hypothermia caused 516 deaths in England and Wales in 1985 (OPCS, personal communication). Many deaths occur in people with identifiable risk factors such as chronic illness, immobility, social isolation and drug problems (including alcohol).

In a recent survey, we have investigated the feasibility of introducing an alert system and assessed its appropriateness to a rural general practice of 6000 patients scattered over 300 square miles in central Devon. The system is initiated by a Meteorological Office forecast of particularly inclement weather which is transmitted to a clerical officer who would telephone a small number of volunteers who in turn would contact further volunteers in a 'snowballing' fashion. These volunteers would visit and offer help to those previously identified by the primary health care team as being 'at risk' of hypothermia. Local figures show that 75% of cases of hypothermia are among patients aged 80 years or over (unpublished results).

This age group of patients was identified from the practice age–sex register and of the 225 people 96% were known personally to at least one member of the practice team. Those considered to be potentially at risk and all of the 4% not known personally were visited by a general practitioner and their circumstances reviewed. Only one of the latter group was considered to be 'at risk' and she was one of five who had not seen a doctor in the previous year — the 10 other patients were either well supported (five) or fit and well (five).

In the entire survey group 28 patients were considered to be potentially 'at risk'. Eighteen of these patients had informal support systems, ranging from knocking on walls, a baby alarm connected through to a neighbours' house and arrangements with neighbours to investigate if milk bottles were not taken in by a certain time, to one lady who spends her winters abroad. Ten patients remained at considerable risk. One is about to move into residential care, four have been referred for a community telephone alarm, two have accepted visits from a neighbour or the British Legion during cold weather and three declined all offers of help.

This suggests that in a stable, rural community, current awareness of the need to support older and frailer members of the community is virtually sufficient to produce a spontaneous system of care. It is noteworthy that those individuals who were less well supported all lived in the same locality and such patchy distribution may occur in other practices. It is not known whether such intensive neighbourhood support occurs in urban areas but it seems likely that stability of the population is more important than its density. The survey included only patients aged 80 years and over. Hypothermia is not the exclusive prerogative of this group and the risks for younger age groups need to be remembered. However, awareness of hypothermia risk for the elderly would appear to be good in rural areas and is possibly best supplemented by general practitioners actively considering this aspect of care for particularly vulnerable patients.

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Classification of psychosocial disturbances in general practice

Sir,
The editorial by Sharp and King (September *Journal,* p.356) highlights an important area in the thinking of general practitioners about psychosocial disturbance. I use the word 'thinking' because the editorial also raises the question of the role and value of classifications in the day to day management of patients' problems.

A classification must help doctors to think about these problems and not force their thoughts to conform to the pattern and presuppositions of the classification. It must be flexible and versatile. It must allow, and indeed encourage a process of discovery which enhances knowledge and understanding of the problem and it must allow the practitioner to put together accurately the pieces which compose the jigsaw puzzle of the individual problem. Research and analysis — the definition of common categories of problem with common denominators — can then take place retrospectively, on the basis of what actually happened and was recorded, and formal diagnostic descriptions and management plans can be developed. These in turn can be tested by the collection of new evidence, and modified accordingly.

A distinction must be made between a classification which accommodates information in a non-preemptive way, making it freely available for us to learn from by induction, and one based on a certain doctrine which confines the learning process within the limits of that point of view.

The ideal is to make a classification sufficiently flexible and versatile to avoid the disadvantages of labels that are self-fulfilling, inadequate or inappropriate, while retaining their advantages — the more formal 'scaffolding' of diagnostic terms which we all use to structure, manage and communicate a problem. This is what the Read classification[1,2] sets out to do in the new edition being prepared for publication. Its purpose is to 'emcompass ... the multiaxial classification which is required in psychosocial disorders'. This is made possible largely by the versatility of the new chapter one dealing with case study, history, and symptomatology. It should, for example, be possible to classify and code this statement: 'Mr A has Alzheimers disease and is unable to dress without help. He is violent towards his wife when she helps him to dress, but the community psychiatric nurse observes that this is because she treats him like a baby when doing so'. The nomenclature aims to pro-

vide rubrics that relate appropriately to each component of the statement. The structure of the classification provides access to the various dimensions of the problem for formal analysis. In this example it would permit the collection of data on the effect of negative self-esteem in dementia, the coping behaviour of wives towards demented spouses and the value of domiciliary observations by community psychiatric nurses. The statement also remains available in free text as a poignant observation of a human tragedy.

Those concerned should assess the potential of the new edition of the Read classification before drawing conclusions about the rival virtues of the available classifications. The choice of the Read classification by the Department of Health as the standard in primary care may turn out to be more imaginative than Sharp and King suppose.

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1. Read JD, Benson T. Comprehensive coding. *Br J Healthcare Computing* 1986; **3:** 22-25.
2. Weeks R. Coding colds. *Br J Healthcare Computing* 1989; **6:** 9-10.

Sir,
I read with some dismay the editorial by Drs Sharp and King (September *Journal,* p.356). General practitioners, and doctors in general, appear to be very concerned with classifying everything they come across. In the seven years since I became a principal in practice I have gradually discarded the medical model of psychiatric disease and adopted the counselling model. Using this model one soon realizes that most of the patients one sees are not ill in the medical sense, so it is not surprising that they do not fit into the categories defined for them by doctors. Their illnesses are a product of behaviour patterns learnt during childhood and the stresses experienced during their lives. Helping patients to unravel some of the underlying problems is an exciting challenge with remarkably good results.

It is entirely practical to undertake this kind of work in general practice and in my experience it often saves time in the long run and makes patients feel that they have achieved something. It is not possible without adequate support and in the practice where I work community psychiatric nurses are used to the fullest possible extent and we have direct liaison with counsellors in private practice. We also make full use of other counselling agencies such as 'Cruse'.

It is time that we stopped medicalizing 'behavioural' problems, understood the psychological factors producing them and started to recognize their origin and to treat them appropriately. Patients are individuals. How can they possibly be classified when the influences upon them are so varied and so personal?

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Adverse effects of screening

Sir,
The College does many useful things but perhaps the most useful is to encourage general practitioners to have a scientific approach towards their work. Karl Popper, the philosopher of science, has cogently argued that the basis of the scientific method is the forming of hypotheses and then testing them in a rigorous manner. It was obviously necessary that prior to the accumulation of sufficient well researched data the College's view on what was 'good' general practice was of necessity based on intuitive feeling. I would certainly have agreed that it was right 'to encourage the development of health promotion and preventive services in the practices of its members'[1] and it can be no coincidence that the government is planning to compel all doctors to screen their patients.

However, in my own practice I have become increasingly concerned about the adverse effects that various screening procedures have upon patients' well-being. My unease was strengthened by reading Dr Stoate's article (May *Journal,* p.193) and the harm that screening can do was further emphasized by Marteau in the *British Medical Journal.*[2]

It seems clear that we have underestimated the harm of screening. For some diseases (for example, carcinoma of the cervix) the benefit might outweigh the costs but general screening seems a most dubious activity. It is not yet proven to do harm but it certainly has not been proven to do good.

If we wish to be regarded as a scientific body then surely it is our duty to reject the hypothesis — screening is good for you — when investigative science suggests the contrary. If we do not do so, then we are as locked in our dogma as mediaeval astronomy was.

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2. Marteau TM. Psychological costs of screening. *Br Med J* 1989; **298:** 527.

Treatment of asthma

Sir,
Dr Brogan's letter sows seeds of doubt about the appropriate treatment of asthma (September *Journal,* p.390). However, there are answers to many of the questions he poses. Underdiagnosis does matter since in the absence of a diagnosis of asthma in children, very few will receive specific therapy and it is the use of suppressive treatment in the form of cromoglycate or inhaled steroids which can dramatically reduce time lost from school.[1] Adequate treatment also matters. Published surveys of asthma deaths in the UK invariably comment on the under use of available therapy because both doctor and patient failed to assess the severity of symptoms adequately.

Evidence has now emerged of preventable morbidity as a result of undertreatment of adult asthmatics. After an episode of acute asthma, patients who were treated less intensively in hospital and who were less likely to be sent home on inhaled steroids or reviewed subsequently, reported significantly more symptoms of poorly controlled asthma a fortnight after discharge and were 10 times more likely to be readmitted with acute asthma within a year than those who received more intensive treatment initially.[2] Indeed, in the same survey, a separate analysis of readmitted patients showed that the underuse of oral steroids immediately after discharge from hospital and of inhaled steroids in the medium term were the main predictors of readmission (Bucknall FE, *et al.* Factors predicting hospital readmission with acute asthma. Presented at Scottish Thoracic meeting, summer 1988).

Asthma is probably the most common chronic symptomatic disease in the community with as many as 60% of asthmatics suffering regular daily symptoms.[3,4] Yet perhaps only half of these patients currently receive regular treatment in the absence of a structured management plan within a practice.[4]

There are questions which remain unanswered but the case for treating patients with current symptoms of asthma in a rational manner is proven.

People with symptomatic asthma should be allowed the possibility of safe