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.

Mental health services — primary concerns for the future

Sir,

As primary care groups (PCGs) take over commissioning the majority of mental health services, they may seek to shift the emphasis of commissioned care to meeting the needs of patients suffering from mild and moderate degrees of mental illnesses, such as anxiety and mild depression, at the expense of those with severe, enduring mental illnesses. We should like to sound a note of caution to PCGs as they assume increasing responsibility for commissioning mental health care services.

There is a general feeling in primary care that there has been little effective help in the past for primary health care teams who have struggled to cope with complex patients;[1] often those with inadequate or psychopathic personalities, chronic neuroses, schizophrenia, manic depressive psychoses, or patients with 'dual' diagnoses. A shift in the focus of services towards primary care would conflict with guidance from the centre to prioritize the needs of the severe and enduring mentally ill and emphasize public safety, above all else.

As PCG commissioning of mental health care services begins, GPs may favour diverting resources to patients with mild to moderate mental illnesses, and the balance in the range and extent of provision could slip too far towards the primary care setting. Over-medicalizing people whose main problem is that they simply cannot cope with life, and for whom it is convenient to categorize as having a mild mental illness instead of a social problem, would be a costly mistake.

Effective commissioning will require a secure evidence base, which does not yet exist. As with so many other aspects of mental health care, there has been a relative neglect of research and development.[2] Many mental health interventions remain untested. Mental health is to be a priority for the National Service Frameworks,[3] and the construction of national standards and performance measures should provide an opportunity for commissioning effective mental health care and be a stimulus for more research where insufficient evidence is found.

The Royal College of General Practitioners is leading the way in educating GPs in mental illnesses by developing a new network of over 60 teachers around Great Britain, who are doing bottom-up, practice-based, learner-friendly multiprofessional skills training. But primary care professionals will not be motivated to take up such training and improve their recognition rates of mental illness unless there are sufficient resources to match needs and manage mental ill-health well in their primary care or community mental health teams. The morale and dynamics of the primary health care team itself will need to be addressed before real progress can be made on increasing skills or implementing change.

Management of severe and enduring mental illness requires that services be commissioned from secondary mental health care. A dialogue between primary and secondary mental health teams, to ensure that local and national evidence is used in the commissioning process, will facilitate this.

MARY BURD
RUTH CHAMBERS
ALAN COHEN
MICHAEL KING
HUW LLOYD
RICHARD MAXWELL
DONALD ROBSON
PETER TUDOR-MILES
ANDRÉ TYLEE
ALASTAIR WRIGHT

Mental Health Task Force of the Royal College of General Practitioners
14 Princes Gate
London SW7 1PU

References

1. Mental Health Task Group. *Minutes of March 1998 meeting of Mental Health Task Group.* London: Royal College of General Practitioners, 1998.
2. King M. Mental health research in general practice: from head counts to outcomes. *Br J Gen Pract* 1998; **48:** 1295-1296.
3. National Health Service Executive. *National Service Frameworks. Health Service Circular.* [HSC 1998/074.] London: NHSE, 1998.

Management of painful joints

Sir,

Jones and Chattopadhyay (January *Journal*)[1] show good results from a simple and inexpensive intervention in an often indolent condition. Their success begs a question regarding the management of other painful joints.

Have we all been too intimidated by the textbook images of Charcot joints to consider the potential benefits of denervation, by local block or other destructive modality, of major joints such as hips, knees, ankles, elbows, as well as shoulders? I am thinking particularly of the debilitated elderly in whom arthroplasty might be thought imprudent.

Though I have never seen one, nor heard any colleague describe having seen one, I had been under the impression that a true Charcot joint took years to develop. In the debilitated elderly, with limited life expectancy, perhaps intolerant of NSAIDs and conventional analgesics, would some additional structural damage to a joint be acceptable in exchange for freedom from pain and some restoration of mobility?

STEVEN FORD

Five Stones
Heugh House Lane
Haydon Bridge NE47 6HJ

Reference

1. Jones DS, Chattopadhyay C. Suprascapular nerve block for the treatment of frozen shoulder in primary care: a randomized trial. *Br J Gen Pract* 1999; **49:** 39-41.

Fortress general practice

Sir,

I am a British doctor, general practice trained but working for the past 15 years in tropical Africa, mostly in ophthalmology. As doctors, we are all encouraged to register with a GP in order to avoid neglecting our health or the dangers of self-prescribing, but many of us hesitate to do so because we feel self conscious and awkward with our status as fellow members of the medical profession:

'I'd like to make an appointment to see

the doctor tomorrow.' I spoke to a young receptionist; she consulted her screen.

'Who is your doctor?' There are six in the practice I attend. I named mine.

'There is no free appointment,' came back the reply.

'Well, I don't mind waiting, or being slipped between others,' I suggested hopefully.

'No, I'm sorry, the doctor can only see real emergencies as extra appointments.'

'Can one of the other doctors see me?' Another shake of her head.

I began to get irritated. What did I have to have to be considered an emergency? Should I drop in a faint in front of the reception desk and froth at the mouth? I left the building.

It had started inauspiciously too:

'Good morning! I'd like to register with the practice.'

'Fill in this form please.' I was handed an A4 questionnaire and a biro.

All the usual personal details were asked for: name, age, sex, marital status, address, phone number, occupation, pre-vious GP, past medical history, hospital admission, and present medication. I noted down my current illness and drug treatment. I was then handed the practice leaflet with details of each of the six doctors and was asked to choose one. I chose and was promptly informed that this doctor's list was full and that I would therefore be assigned to the junior partner's list. I was then told that I would have to make an appointment with the practice nurse for my registration medical. So, a couple of days later, I met the very pleasant practice nurse who weighed and measured me, took my blood pressure and asked about my smoking habits, alcohol intake, and whether I tool any exercise. What was my job? I said, 'Ophthalmologist.' She looked at her screen to find the appropriate code, and that was it; all very efficient. No doubt the practice statistics would benefit from this new set of figures, but it did little for me. No notice had been taken of my present metabolic disorder, not of the medication, and there was no suggestion made about seeing a doctor.

I needed to update my immunization for returning overseas. As this service was offered in a travel clinic within the practice, I walked to the surgery and was told, 'You must fill in this form so that the nurse can decide what injections and advice you need.' Once again, it seemed that the answer to any enquiry at this reception desk was yet another form to complete. I knew exactly what I needed to have, for I have been travelling to the tropics for over 27 years. Nonetheless, I sat down with the form and filled it in.

At the same surgery I have also had my ears syringed twice over the years, but I have never actually met one of the doctors. What, I wonder, does it take to pen-etrate the system and have a few minutes of a GP's time? Questionnaires, receptionists, clinics for ears or travel, well-men medical measurements by the practice nurse, etc. are all designed to keep the patient away from the doctor. So what do the doctors actually do? Who do they see? How does one crack the system?

We, as doctors, are strongly advised by the General Medical Council to register with our own local GPs and to submit out health needs to their care, rather than prescribe for ourselves or, worse, ignore our symptoms completely. Many of us, no doubt, feel slightly uncomfortable with this. We are no longer used to being treated as a patient and find it somewhat demeaning. I certainly feel awkward sitting in a waiting room, trying to look inconspicuous, for I can hardly enter into a conversation and admit to being a doctor in front of the others waiting their turn. And there is the suspicion that your examining doctor also senses the anomaly. Consulting a colleague is different and perhaps not the forte of the junior partner. Part of me wants to be treated as an ordinary citizen, but another part yearns to be treated otherwise.

I too see patients in my eye clinic. We have no appointment system; I see everyone who comes, whether they are attending for a follow-up consultation or are newly registered. Noone is turned away. There are no forms to fill out, access is direct, and I work until all the patients are seen. If such open access can be achieved in the very unsophisticated setting of rural west Africa, why can't a more patient-friendly system be devised for genteel areas of the United Kingdom? General practice is nothing if not accessible to the patients on its list.

I do not suppose that I am different from anybody else. I want easy access to a doctor I know and trust, at unpredictable times, and usually at short notice. That is the nature of illness. But GPs today are hidden behind an impressive array of receptionists, nurses, other health technicians, practice managers, secretaries, rows of computers, and rigid appointment systems: fortress general practice. The doctor has become a manager, a planner, and a commissioner of hospital services: a nameplate at the surgery door who we should no more expect to meet inside than Lord Sainsbury in a store bearing his name. That is not what I, as a patient, want. And it won't encourage us doctors to register with a local general practice if we only ever get to see the subalterns.

I wrote a letter expressing my dissatisfaction to the partnership. I received a reply from the surgery, written by the practice manager: the doctors don't even answer their own mail!

ANDREW R POTTER

BP 924, Parakou,
Republic of Benin, West Africa

Reducing antibiotics for respiratory tract symptoms in primary care: 'why' only sore throat, 'how' about coughing?

Sir,

Despite the promising title, Butler and coworkers' paper (December *Journal*)[1] answered the question 'why' for only one respiratory tract symptom; i.e. sore throat. The other conditions discussed are clinical diagnoses: common cold, bronchitis, otitis media, and sinusitis.

General practitioners (GPs) especially have to deal with reasonable diagnostic uncertainty. Furthermore, it seems that diagnoses are often given to justify antibiotic treatment, rather than the other way around,[2] and that such treatment choices can be better explained by the signs and symptoms than by diagnosis in general practice.[3] Therefore, evidence 'why' to reduce antibiotics for coughing might be more desirable than for bronchitis; i.e. the way Fahey[4] presented the results of his meta-analysis. Likewise, searching for clinically useful predictors to identify patients who will clearly (not) benefit from antibiotics, should start with coughing patients, not patients labelled as having bronchitis.

When considering 'how' to change present practice, an understanding of the prescribing culture is essential. Butler provided this for sore throat,[5] but how about other respiratory tract symptoms?

To explore current medical decision-making with coughing patients, we conducted focus group research with GPs. On suspecting a respiratory tract infection (RTI), the participants attempted to differentiate between viral versus bacterial, upper versus lower RTIs, and between clinical diagnoses; e.g. bronchitis versus pneumonia. This was not possible on clinical grounds alone, according to the GPs. Because of this diagnostic uncertainty, GPs decided on antibiotic therapy, mainly influenced by factors such as patients' expectations and defensive medicine. Feinstein's 'chagrin factor'[6] explained the trend in favour of antibiotics: not having prescribed antibiotics when necessary caused more 'chagrin' than an unnecessary prescription. Particularly in a fee-for-service model of health care delivery, necessary could mean

necessary for the patient's health as well as necessary to preserve the physician–patient relationship or because of time constraints.

Consequently, GPs need guidelines or new diagnostic labels for coughing patients. This means clinically useful predictors for (no) benefit of (non-)antibiotic treatment for coughing patients are required. And GPs also need consultation skills that make 'chagrin' explicit. These might reduce antibiotic use even more.

SAMUEL COENEN
PAUL VAN ROYEN
JOKE DENEKENS

Centre for General Practice Antwerp
University of Antwerp - UIA
Universiteitsplein 1
B - 2610 Antwerpen, Belgium

References

1. Butler C, Rollnick S, Kinnersley P, *et al*. Reducing antibiotics for respiratory tract symptoms in primary care: consolidating 'why' and considering 'how'. *Br J Gen Pract* 1998; **48:** 1865-1870.
2. Cars H, Hakansson A. To prescribe — or not to prescribe — antibiotics. District physicians' habits vary greatly, and are difficult to change. *Scand J Prim Health Care* 1995; **13(1):** 3-7.
3. Howie J. Diagnosis, the Achilles heel? *J R Coll Gen Pract* 1972; **22:** 310-315.
4. Fahey T, Stocks N, Thomas T. Quantitative systematic review of randomised controlled trials comparing antibiotic with placebo for acute cough in adults. *BMJ* 1998; **316:** 906-910.
5. Butler CC, Rollnick S, Pill R, *et al*. Understanding the culture of prescribing: qualitative study of general practitioners' and patients' perceptions of antibiotics for sore throats. *BMJ* 1998; **317:** 637-642.
6. Feinstein A. The 'Chagrin Factor' and Qualitative Decision Analysis. *Arch Intern Med* 1985; **145:** 1257-1259.

Chickenpox in pregnancy

Sir,

Chickenpox in pregnancy can cause congenital embryopathic infection or severe maternal disease.[1,2] After contact with infectious chickenpox or shingles, hyperimmune serum (VZIG) may prevent infection or attenuate disease if given within 10 days.[1,3] VZIG is indicated in the first half of pregnancy as foetal abnormalities only occur after infection in the first 20 weeks of pregnancy, and VZIG is in short supply.[1,2] Severe maternal disease is more likely near term, so VZIG should be offered to susceptible contacts within 21 days of the estimated date of delivery.[1] As the majority of pregnant women have had chickenpox, only those without detectable varicella IgG should be offered VZIG.[4]

A retrospective review of requests for varicella serology testing of pregnant women was performed. The quality of supplied clinical information needed to identify women eligible for VZIG was assessed. Information required was date of contact and gestational age. The test result was also noted. In one year, 180 requests were received both from GPs and the antenatal clinic, of which 171 (95%) were IgG positive. Forty per cent of requests did not note contact date or gestational age. Of the requests with a specified contact date, 38/120 (31.7%) presented more than 10 days after contact. Of the requests that noted gestational age, 115/155 (74.2%), if seronegative, would have been eligible for VZIG and, of these, 28 (24.3%) had a contact more than 10 days previously. As not all of the eligible group had a date of contact noted, this may be an underestimate.

Owing to its scarcity, VZIG must be accurately targeted. VZIG should be given as soon as possible after contact.[1] It is noteworthy that nearly one-quarter of women that, if seronegative, were eligible for VZIG presented after 10 days, they would have not benefited from VZIG. Pregnant women who do not have an unequivocal history of prior chickenpox should be encouraged to avoid exposure to chicken pox and shingles and be reminded that, in the event, to present promptly for investigation. In an emergency, most UK laboratories can provide a varicella-zoster virus IgG result within 24 hours.[1] The provision of complete clinical details with requests is a prerequisite if those who will benefit from VZIG are to be promptly identified and chickenpox-associated morbidity and mortality is to be reduced.

J R GREIG

St George's Hospital
Blackshaw Road
London SW17 0QT

References

1. Salisbury DM, Begg NT. Varicella/herpes Zoster. In: Salisbury DM, Begg NT (eds). *Immunisation against infectious disease.* [Edward Jenner Bicentenary Edition.] London: HMSO, 1996.
2. Birthistle K, Carrington D. Fetal varicella syndrome – a reappraisal of the literature. *J Infect* 1998; **36(1):** 525-529.
3. Nathwani D, Maclean A, Conway S, Carrington D. Varicella infections in pregnancy and the newborn. *J Infect* 1998; **36(1):** 559-571.
4. Arvin AM. Varicella-zoster virus. *Clin Micro Rev* 1996; **9:** 361-381.

Fatigue

Sir,

I read with interest Heather Elliott's article on fatigue (February *Journal*),[1] in particular her assertions that chronic fatigue syndrome is not a psychiatric illness and that 'research has highlighted important differences between chronic fatigue syndrome and psychiatric disorders'.

These statements assume that there are clear boundaries between psychiatric (mental) and organic disorders. The Oxford English Dictionary suggests that mental illness is 'Of or pertaining to a disorder of the mind.' Its most relevant definition of the mind is 'The seat of awareness, thought, volition and feeling; cognitive and emotional phenomena and powers constituting a controlling system. The spiritual as distinguished from the bodily part of a human being.' It seems to me that the first sentence is a good description of the brain, and that the second relates to religious/philosophical concepts.

The ICD-10 classification system, inconveniently, does not define 'mental and behavioural disorders' in its chapter devoted to them. It includes conditions associated with structural abnormalities of the brain, such as Alzheimer's and schizophrenia (but not others such as paralysis or pain owing to lesions in the primary motor cortex or thalamus); conditions associated with neurochemical/electrical abnormalities such as depression and obsessive compulsive disorder (but not others such as epilepsy or Parkinson's); and some conditions affecting perception or movement or mood or behaviour, but without significant abnormalities that can be detected with our current instruments, such as Tourette's syndrome, somatoform pain disorder, and post traumatic stress disorder (but not others such as phantom limb pain). It currently includes chronic fatigue – under neurasthenia – but excludes post viral fatigue.

There seems to me to be little logic to these inclusions and exclusions. I suspect they are as a result of historical accidents relating to which patients were willing to consult psychiatrists and which conditions they seemed able to help people with. If, as a rule, patients with chronic fatigue syndrome consult clinicians from other disciplines, then I suspect it will become classified as an organic disorder. We must not delude ourselves however, that this mental/organic distinction has any basis in logic or indeed should be of any importance except to scholars of religion or philosophy.

OLIVER ROOKE

Brookdale Adolescent Service
30 Brookdale Road, Portswood
Southampton SO17 1QR

Reference

1. Use of formal and informal care among people with prolonged fatigue: a review of the literature. *Br J Gen Pract* 1999; **49:** 131-134.