With the introduction of newer techniques such as epidurals, fewer patients now fit the category of normal cases as originally laid down by the GP unit's code. There have therefore been fewer cases for which the general practitioner has sole charge.

I also wondered why Dr Bull was so keen on pregnancy tests. He did not explain in his paper what there was to be gained by a pregnancy test at six weeks over a clinical assessment at eight weeks. Doctors have for years been diagnosing pregnancy and I wondered if there was anything to be gained by the high cost of routine pregnancy testing.

However, Dr Bull's essay was worth while in that we may well need more general practitioner obstetricians in the future. With the present rise in the birth rate following the decrease in the 'seventies, we are finding in many cases that Area Health Authorities have failed to re-provide the obstetric beds which were taken away five years ago. In the present economic climate we do not look like getting these beds back. After the end of the recession there may well be a further rise in the birth rate and it could well be that hospital obstetricians will then look very hard to primary health care teams to provide general practitioner accouchers.

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SICK DOCTORS

Sir,

Recent editorials in the *Journal* (December issue) and the *BMJ* (3.1.81) rightly highlight the urgent need for consideration of the problems facing potentially sick doctors and their families in a climate of increasing patient expectations.

The isolated, self-employed general practitioner may be especially vulnerable because of his status in the community.

The College, presently preoccupied with prevention, is perhaps ideally placed to demonstrate its caring nature to its colleagues, by co-ordinating local networks of willing counsellors to whom practitioners felt to be at risk could turn for confidential guidance before their problems got out of hand. This would be in the certain knowledge that they would be received sympathetically by someone independent, but with a good working knowledge of the problems of general practice, and without being formally cast in the role of 'the sick doctor', with all its attendant connotations and implications.

It is perhaps salutary to note that such arrangements have existed successfully for some time amongst our nursing sisters who, whilst acknowledging that there is a counselling function within the nursing process itself, also recognize that counselling forms an important feature of the nurse manager's role. More recently the needs of nurses themselves in their caring roles have also been recognized, and indeed, in some areas, special posts have been created in order to try to meet these, particularly at St Thomas's and Guy's hospitals in London, and also at the Royal College of Nursing, where courses in co-counselling are being promoted.

Perhaps general practitioners could follow this lead, and help each other to put their own houses in order, for it is well known that their record of managing their own psychological problems to date has not been good. Surely there could be no finer role for the College to explore, since patients are likely to benefit considerably from having healthier and happier doctors?

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DIET AND ARTERIAL DISEASE

Sir,

In the Report of our Sub-Committee on the Prevention of Arterial Disease in General Practice (RCGP, 1981) we attempted to be brief. We now consider that our brevity may have caused us to be misleading with regard to our views on the role of blood fats and dietary modification (Ch. 2, p. 5 of the Report).

Abnormalities of lipid metabolism are associated with an increased risk of arterial disease and there is considerable evidence that one or more aspects of the Western diet are important in the aetiology of ischaemic heart disease. Numerous official organizations have recommended dietary change, including an increase in fibre-rich carbohydrate, a decrease in saturated fat and some increase of polyunsaturated fat. The circumstantial evidence in favour of such change is strong. The Sub-Committee did not, however, consider dietary change in great detail as it was felt that the role of general practitioners should in the first instance be in dealing with hypertensives and cigarette smokers. For this reason, our chief recommendation concerning diet is the control of obesity. This is the first dietary goal in the treatment of all hyperlipidaemias, and achieving ideal body weight will also help to achieve lower levels of blood pressure and blood glucose. Failure to offer further advice concerning diet reflects only our view that this would have gone beyond the scope of the present Report rather than disagreement with other recommendations.

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POLYMYALGIA RHEUMATICA

Sir,

The article by Drs J. G. Jones and B. L. Hazleman (May *Journal)* highlights the difficulty in diagnosing polymyalgia rheumatica and giant cell arteritis, but they gave no real answers to the problem. They stressed that these syndromes may present non-specifically with systemic illness, elevated alkaline phosphatase, anaemia, raised immunoglobin level or even occasionally as depression. Surely the key to correct diagnosis must be a high index of suspicion of these diseases in those patients with limb girdle pain and morning stiffness without joint swelling. Those with giant cell arteritis will have cranial artery tenderness, headaches or visual disturbances. Because the diagnosis of these conditions is difficult, it is impossible to give a true incidence of them in the population; however, Ostberg (1973) suggested, on histological evidence, that at least one in 50 of elderly subjects might be affected by some form of the temporal