equality in access to primary care'. What knowledge can we be talking about when we are back to square one? The only certain 'knowledge' at this point in time can be summarized as 'There is no evidence now and there never has been of social inequality in *opportunities* for *access* to primary care' other than that previously mentioned.

I was accused of being extremely selective in my review of literature. On the contrary, it seems to me that this largely spurious debate about social class inequalities has only been kept going by the selective use of convenient statistics and the ignoring of the inconvenient facts.

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New RCGP classification

Sir,
The British, especially British general practitioners, often overlook the extent of their influence in the world of ideas. I recall a sign displayed in an important North American teaching institution. 'We have a choice. We can either do this work, or try to keep up with how far the British are ahead of us'.

The presentation of a new British *Classification of diseases, problems and procedures* in general practice[1,2] is an event of supreme importance and interest to the primary care taxonomers of the world. I have no doubt that the concepts embodied in the work will prove to be very influential on the international scene.

What is mystifying to the friends and admirers of the Royal College is why such worthy work should be conducted in such Byzantine secrecy. The Classification Committee of WONCA was founded by your Robin Pinsent; Donald Crombie, the chairman of the Committee reponsible for the 1984 RCGP Classification was for many years a member of the WONCA Committee, and Clifford Kay has corresponded often with them. Foreign taxonomers were never told about the developing ideas of Great Britain. Apparently even the RCGP representative to the International Committee was not told about the classification work taking place in Manchester!

Openess and internationality are two important features of science; I wish the 'caring scientists' of the RCGP would try to bear this in mind as they push forward with their great works.

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Sir,
The advent of a new RCGP classification of morbidity (which does not yet appear to have a name)[1,2] rouses mixed feelings in many who are interested in general practice morbidity recording at an international level. I would not presume to comment on the need or otherwise for a special RCGP classification, but a number of related issues need discussion.

Dr Kay's statement 'there is never any difficulty in accommodating long lists in shorter lists'[1] is surely an excellent argument for using ICD itself in general practice, since it is apparently essential to be entirely compatible with it. Why have a short list of any sort if 'longer lists and more specific terms are much easier to use than short lists'? We have wrestled with this problem long enough in the International Classification Committee of WONCA to know that this statement does not stand up to scrutiny. The question is, easier for what?

Classifications need to be used for both the input and output phases of data management. Unfortunately a classification which allows automatic coding so that there

is 'minimal restriction on the use of diagnostic terms by the clinician'[2] does also, as Dr Kay says, 'dramatically reduce the need for clinical judgement when coding'[1]. The value of morbidity information surely depends entirely on the validity of the diagnostic terms used by clinicians, and that means that coding requires considerable clinical judgement. It is this issue that has been addressed, albeit no doubt very imperfectly, in the coding criteria developed and extensively field tested for ICHPPC-2-Defined. It is unfortunate that the new classification perpetuates the misunderstanding that classifications need only to be understood by the end user, whereas, as all computer users should know, 'garbage in equals garbage out'.

The good news that comes with the new classification is that it is 'the first of a comprehensive set of recommendations . . . to generate morbidity statistics in a standardized form'.[2] Classifications alone do little to achieve such ends, because the methods by which they are used to collect and analyse morbidity data are so important. The news would be even better if there were some indication that the RCGP wished to co-operate with WONCA to achieve maximum possible standardization for the benefit of the international discipline of general practice. We will all be the losers if this does not happen.

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The clinical psychologist in general practice

Sir,
The summary of Freeman and Button's Paper[1] (July *Journal*) on the work of the clinical psychologist in general practice concludes that the natural history of most psychological disorders is one of crisis and remission and that no benefit has been demonstrated from individual therapy by clinical psychologists.

It is not clear from the report how many psychologists were working in the psychology service, what type of treatment was offered, what training for work in a general practice the clinical psychologists had been given, if indeed any is needed, nor how good the psychologists were!

Outcome of referral was considered good if there was a reduction in consulting rates or a reduction in psychotropic drug records. (There is no information about actual drug prescribing — the amounts of drugs that were given and the repeat prescriptions were not recorded.) In the summary we are told that three-quarters of the patients in a group practice referred to a clinical psychologist during a three-year period showed a marked reduction in the consulting and 'psychotropic drug prescription rates' (despite knowing nothing about repeat prescriptions) in the six months after treatment compared with the six months leading up to treatment. Nowhere in the results can I find any table or information to confirm this.

What we are told is that 3,613 patients were in the practice continuously for six years and that 1,377 of these had at least one doctor contact for psychosocial reasons during that period and these patients formed the 'six-year cohort'.

This cohort were shown to have a 'falling trend' in the number of consultations and 'psychotropic drug records' over the period (and were compared with the whole practice and not the remaining 2,236 patients who had also been in the practice six years which would have made a more sensible comparison). The assumption one is expected to make is that as the whole cohort's consultation rate had fallen there was little point in the psychologist seeing any of these people whose problems were thought to be likely to resolve. In fact 81 of the six-year cohort (5.8 per cent) were referred to the psychologist and presumably these 81 took up the referral. (It would have been interesting to know the numbers offered referral who declined.)

If in general practice we are treating patients and not cohorts then these 81 patients may have had an important and helpful experience in their lives which might help them to deal with any future psychosocial problems in a more constructive way.

There are reasons why only a small percentage were referred to the psychologist. Some of them could be that the doctors concerned had little faith in the service, failed to persuade their patients to take up the offer of psychological help (the process of making a referral to a psychologist, psychiatrist or counsellor can be time-consuming and is an interesting study in itself) or rapidly learnt from the psychologists — either intuitively or following discussion — how to cope with their patients who have psychosocial problems. This latter rather far-fetched theory could indeed account for the fall in consultation rate of the 'six-year cohort' over the period. There is some evidence to support this when the authors discuss the educational role of clinical psychologists and it would certainly seem preferable for doctors to learn more about simple problem-orientated psychotherapeutic skills. There are of course many other ways in which psychologists can help in a practice in addition to individual psychotherapy or counselling, that is,