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,

behaviour therapy and also working with ancillary staff, such as receptionists.

Robson and colleagues' study of a behavioural orientated clinical psychology service[2] used different criteria to assess outcome, that is, psychosocial and economic measures which may be more valid. Both papers indicate areas where further research is needed and I personally would not wish to see the unwarranted conclusions drawn in the summary of Freeman and Button's paper inhibit clinical psychologists from working closely with general practitioners and so prevent useful research in an important area.

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Sir,

Freeman and Button's conclusion (July *Journal,* p 377) 'That no benefit has been demonstrated from individual therapy by clinical psychologists' is not and cannot be justified by their results. This is because of: (1) the non-random nature of referral, and (2) the outcome measures employed.

The lack of random referral within the relevant patient group prevents the possibility of drawing any firm conclusions. It is entirely possible that the very worst patients were referred to the psychologist and that the most successful intervention would have had the effect of keeping them within the trend observed.

The outcome criteria are inadequate because they are too generalized, too distant from the focus intervention, and may often be irrelevant. 'Psychosocial encounters' represent too wide a range of consultations to be expected to reflect treatment success and prescriptions for psychotropic medication represent not only the patients' behaviour but also other factors such as doctors' prescribing habits (which changed dramatically over the six years studied). Reductions in these may be token improvements in some problem areas, such as stopping taking hypnotics — a problem for which psychological intervention has been shown to be of value.[1] For many other problems referred to psychologists (such as enuresis, sexual dysfunction, obesity), a successful outcome would not be expected to produce a reduction in prescriptions for psychotropic medication. The two-dimensional view of outcome embodied in the study does not reflect the diversity and complexity of problems referred to psychologists in general practice. Other studies are similarly flawed.[2,3]

It is time to go beyond studies which ask 'Are clinical psychologists (or social workers, or general practitioners) effective?' to those which are more specific, questioning the effectiveness of particular remedies for particular problems, and answering them through experimental studies with relevant outcome criteria (whether these are dry nights, depressed mood, or frequency of orgasms). Lumping together disparate problems and applying generalized outcome criteria is not a helpful strategy. Freeman and Button's study is interesting, but does not support their conclusions: descriptive studies are no substitute for controlled trials.

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Night calls: an emotional issue

Sir,

The unsigned leader in the July issue of the *Journal* (p. 362) may well reinforce the view of many Members and non-Members that the College is out of touch with reality. It is suggested that general practitioners are opting out of night work because of the emotional and physical demands it makes upon them and that the doctors concerned should be more aware of the psychotherapeutic benefits which may accrue. The writer should reflect that a large part of the population in this country lives in inner city areas. Doctors in these areas wish to avoid night calls because they are afraid. They dread visits to high rise flats, climbing up dark staircases, where they know that 20 per cent of the population is unemployed, many drug dependent, and in due time depending on violence and robbery to provide for their needs. In my own area, in the last six months at least two young doctors have been attacked. We have enough problems in providing primary care for inner city populations, without having to bear unctuous statements about the well known potential benefits of night calls. The writer might consider the mental and at times physical damage to doctors working in these areas in calculating his