I know I am not alone in failing to understand why PPP (and the other private health insurance companies) are unable to conform to the usual ethical conventions when they request medical evidence in respect of potential subscribers. At present, a clerk writes to the patient asking the doctor to furnish written evidence to the company. This is an imposition for the patient and insulting to general practitioners. All life insurance companies manage to write from Chief Medical Officer to general practitioner that the patient has consented to disclosure of information, and offering to pay the normal professional fee.

If the private health insurance organizations would change their practice and comply with this convention, I am sure there would be a much better spirit of co-operation to the benefit of patients, insurance companies and general practitioners.

R. G. CHAPMAN

22 Hockliffe Street
Leighton Buzzard
Beds LU7 8HE

Paediatric surveillance

Sir,

We are sorry that the experience of Dr Moulds and Dr Martin of well-child care (July *Journal,* p.412) is so much less rewarding than our own (March *Journal,* pp.152-154). Did they really, during four years, find no undescended testes or new cases of deafness?

In a health district like ours, committed to universal preschool child surveillance, the issue for a practice is whether to have any part, not whether the service is offered at all. We agree that *appropriately trained* health visitors can do much developmental work, as ours do, but some aspects are surely best performed by doctors. Our sessions together total three-and-one-half hours weekly, and seem to produce useful returns. We also find our meetings with other members of the team helpful in developing a co-ordinated approach to the shared care of patients of all ages.

The immunization figures we reported for 1983, were inexplicably disappointing. In July 1984, rates for completed courses among children born in 1982 were 78 per cent for pertussis, 82 per cent for measles and 95 per cent for diphtheria, tetanus and poliomyelitis (health district means 73 per cent, 71 per cent and 89 per cent respectively).

Your correspondents ask about eventual outcomes, which are difficult to determine for any intervention. For a very partial answer, we have examined records of children referred in the year 1982–3 for ear and hearing problems. Audiologists confirmed a significant hearing loss in 10 out of 15 children referred with suspected deafness, while results were unknown in two. ENT surgeons saw 14 children, seven following audiology. They confirmed defects in nine children and arranged surgery in six cases. Two are still under review, two are unknown and only three were considered normal. We find that ear problems, unlike squints, are often unrecognized by parents. The short-term benefits to hearing from surgery seem to us to enable useful catching-up in speech and language development, although we remain uncertain about ideal management.[1]

Child surveillance, like antenatal care, is only partly a screening process and also offers useful support to mothers.[2] Clearly this important aspect merits further systematic inquiry.

Of course we need research into both basic developmental processes and longer-term outcomes. Much of this work is going on. Our intention was to illustrate how ordinary practices can use intermediate outcome measures[3] to see if they are providing 'good enough' care for their child patients.

JOHN WILMOT
SHARON HANCOCK

16 Clarendon Street
Leamington Spa
Warwickshire CV32 5SS

References

1. Anonymous. Secretary otitis media *Lancet* 1983; **2:** 1344-1345.
2. Williams PR. Does your child health clinic meet the needs of mothers as well as children? *J R Coll Gen Pract* 1983; **33:** 505.
3. Royal College of General Practitioners *Healthier children — thinking prevention. Report from General Practice no. 22.* London: RCGP, 1982.

Primary health care team

Sir,

The proper functioning of a primary health care team can be greatly facilitated by regular team meetings. The value of these meetings may be restricted, however, if they meet the needs of only some team members and not others. In my position as a clinical psychologist regularly attending such meetings in three different practices I have been able to collect data that illustrates the various functions that these meetings serve.

Casual observation suggests that the history of the meeting influences its function. For instance, where the general practitioners established the meeting they tend to be brief, frequent and concerned primarily with the discussion of individual cases. When social services were the prime movers the meetings lasted longer, were less frequent and considerable time was devoted to the discussion of local problems and liaison difficulties, although not exclusively so. In both examples the team members reported that the meetings were useful.

Detailed analysis of the meetings was possible by systematically recording the direction and content of interactions that occurred using a simple category system adapted from social psychological studies of group behaviour. The system was piloted at two meetings to establish its reliability in this setting and observations were made at five consecutive weekly meetings of one practice team. These meetings were attended by four doctors, the district nurse, health visitor, social worker, assistant social worker and myself.

Although the content of the discussions were evenly distributed across all 13 of the separately coded categories it was evident that over 80 per cent of the interactions were related to individual case work and that 60 per cent involved a referral to social services for help. Approximately 17 per cent of the discussions utilized the specialist skills of the non-medical staff attending the meeting and approximately 13 per cent of the discussion was devoted to general non-case related matters. The majority of the interactions were initiated by the social workers who passed information on to the doctor. Detailed examinations of the three- and four-way interactions that occurred showed that the meetings not only fulfilled the primary aim of providing a forum for the exchange of information, but also facilitated a team work approach to problem solving.

No doubt primary care teams will vary in their approach. Team meetings, however, would seem to have the potential for broadening their scope and improving the overall care of the patients.

STUART LINKE
Senior Clinical Psychologist
Pontefract General Infirmary
Friarwood Lane
Pontefract
West Yorkshire WF8 1PL

Hospital statutory holidays following bank holidays

Sir,

Yet again following the bank holiday the problem of hospital departments taking an extra day's holiday has caused great inconvenience to my patients. It would seem to me that it is particularly important that, after sometime four days of emergency-only functioning, hospitals further disrupt their regime with this obnoxious practice. I have no wish that they should not get all the holidays that they deserve, but surely this could be taken at different times so that no individual department would be closed for normal duties on days following bank holidays.

As a general practitioner I feel that the disruption of bank holidays is explicable to our patients but the extra day is unreasonable by any standards. I hope that as general practitioners and Members of the Royal College we can put some pressure on so that this practice can cease as soon as possible. I should be interested to hear what other members of the College feel about this.

D. A. GREGORY
Cartington Terrace Medical Group
1 Cartington Terrace
Heaton
Newcastle upon Tyne NE6 5RS

Intrauterine devices

Sir,

Dr Peek's letter about items of service payments for IUCD fitting (August *Journal,* p.468) misses several points.

Contraceptive choice is a real and sometimes unresolvable dilemma, for there is no completely safe *and* effective contraceptive method. All involve risks of adverse effects and/or unplanned pregnancy, and therefore final judgements about contraceptive methods are often determined by psychosocial factors as much as by technical considerations. A highly mobile inner-city population with changing social relationships is not a suitable target for fixed rules and plans. While IUCDs are not to be recommended to nulliparous women, they may well be chosen by them as a useful form of contraception that is worth trying, others having been rejected.

In those circumstances our ability to deal with the issue of informed consent is tested. We do not know why some women find IUCDs suitable and others do not beyond simple indicators like menorrhagia, dysmenorrhoea and parity, and therefore cannot always predict outcomes for individuals with workable accuracy. The risks of salpingitis rise following IUCD fittings, but they exist for all sexually active women regardless of contraceptive method. The risk of accidental pregnancy may be greater without the IUCD than with it, in a subgroup of nulliparous women uncomfortable with the range of alternatives. Given our limited understanding of these issues, how do we gain the informed consent of our patients? The easy way is to make the judgement for them; the harder route is to inform them of the risks, as far as we understand them, and tolerate the trials of IUCD that may follow.

If item of service payments distort practice, as both Dr Peek and I think they do, why have them at all? Paying fees for fitting diaphragms solves nothing, for diaphragms are unpopular, and inefficient as contraceptives, although they are certainly safer for doctors. If we are concerned with advising about appropriate contraception, why bother with such incentives? Are fees for items of service rewards for honest toil, or just the products of a pay bargaining system reflecting low standards and low commitment in general practice?

STEVE ILIFFE
97 Brondesbury Road
London NW16 6RY