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.

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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.

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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?

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