LETTERS

The role of the College Tutor

Sir,

I was interested to read the article by Dr S.J. Waldman on 'The role of the College Tutor' (March *Journal,* p.180) as I have just completed my first 12 months as GP College Tutor in Brighton. The following comments on postgraduate activities may be of interest.

During the year several extended courses have been held. Each course consists of a series of weekly lectures, each following a sponsored lunch. One course was based on the presentation of symptoms in general practice, and each session was presented by a general practitioner with comments from a consultant and emphasis on the subsequent discussion.

A GP Workshop is held twice monthly at the postgraduate centre. Topics covered include discussing video consultations, preparing audits, meeting new consultants and discussion with other primary health care team members. Three sessions in addition have been held at practice premises.

A Brighton Study Week was held during the year with emphasis on group work and sharing of experience and expertise. The course was planned by the GP tutor and three other local general practitioners, who also served as course tutors during the week. Other more traditional study weeks are held during the year and arranged by the Clinical Tutor.

A group of general practitioners has just completed a counselling course co-ordinated by a local practice counsellor. Group members have learnt and practised various counselling techniques appropriate to general practice consultations. The group has continued meeting over the summer, and a residential weekend is being held in September.

A research group has also been meeting every two months. Each member has committed him/herself to completing a simple research project and presenting the results to the remainder of the group within a specified time. Dr Ken Dawes (Associate Regional Adviser) is acting as expert source to the group.

In conjunction with the South East Thames Faculty, nine general practitioners were involved in the 'What sort of doctor' practice visits. The experience was found by all to be constructive, particularly by the visiting doctors.

Meetings are held every six months for all College Tutors in the South East Thames Faculty and co-ordinated by Dr John Woodward (GP Tutor Sidcup) and myself. Common problems and successful postgraduate ideas are discussed.

Future ideas include:

1. The use of Quality Initiative and 'Prompt Cards' in the GP Workshop.
2. The enlargement of both the counselling and research groups.

The main problem extending into next year is how to attract the large group of general practitioners who, at present, do not attend the meetings.

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Childhood urinary tract infection

Sir,

I read with interest the excellent paper by A.M. Dighe and J.F. Grace (June *Journal,* p.324). It is perhaps unfortunate that no mention was made of the use of ultrasound, plain abdominal x-ray and scintigrams in the management of children presenting with urinary tract infection. Two recent papers in the *British Medical Journal* from Professor T. Sherwood and Mr R.H. Whitaker[1,2] have described diagnostic pathways for different age groups of children with urinary tract infection.

For children aged over six months, plain abdominal examination and ultrasound will reveal radio-opaque stones, enlarged bladder, abnormality in size or shape of kidneys and bladder; also dilated pelvicalyceal system or ureter. If these investigations are normal, then it is likely that all that will be missed are Grade I and probably Grade II primary reflux. The management of minor degrees of reflux is still open to debate, and it has been demonstrated that renal scarring is usually present when children first present.[3] If abnormalities are found by these non-invasive procedures, or if further urinary tract infection is demonstrated, then investigation can proceed on more conventional lines by the use of intravenous urogram (IVU), micturating cystourethrogram and scintigrams. (Scintigrams can either be with labelled dimercaptosuccinate, which gives an indication of renal tubular cell mass, or labelled diethylenetriamine pentaacetic acid, which is filtered by the glomerulus and gives similar information to the IVU.

In children up to six months old Sherwood and Whitaker suggest a micturating cystourethrogram as a first investigation to diagnose serious degrees of obstruction. This can be followed by a relevant scintigram or ultrasound and only then, if there are still diagnostic difficulties, would an IVU be necessary.

Intravenous urography in a child may be a frightening and potentially dangerous procedure. Although it is appreciated that many general practitioners will not have direct access to ultrasound and scintigrams, for those that do, is it not reasonable to reconsider conventional investigative pathways, as detailed by Dighe and Grace?

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References

1. Sherwood T, Whitaker RH. Initial screening of children with urinary tract infections: is plain film radiography and ultrasonography enough? *Br Med J* 1984; **288:** 827.
2. Whitaker RH, Sherwood T. Another look at diagnostic pathways in children with urinary tract infection. *Br Med J* 1984; **288:** 839-841.
3. Hodson J. Reflux nephropathy: a personal historial review. *Am J Radio* 1981; **137:** 451-462.

The clinical psychologist in general practice

Sir,

Dr Freeman and Dr Button (July *Journal,* p.377) are to be congratulated for drawing attention to the need to compare the outcome of 'psychosocial' problems after intervention with their natural history. This type of comparison should be made, but rarely is, for all aspects of care when a new modality of intervention is proselytized by its enthusiasts. Especially when the demand is potentially large (38 per cent of the practice under study) and the service labour intensive.

I disagree with their statement that no benefit has been demonstrated for the clinical psychology service. The study was simply not designed for that purpose. The referred and non-referred groups were not comparable. The former were selected by their general practitioners, and although there were no strict criteria for referral, there are several possible reasons that might make the two groups different. For example, the referred group may have had more severe symptoms or their social network of support may have been more limited. Either of these features would make attention by an individual, whether doctor of psychologist, more valuable. This value is not diminished by the fact that the long-term outcome as measured by consultation and prescription rates is not influenced, (a proposition this study raises but cannot prove).

Further research is needed, particularly as the authors suggest, for the minority of chronic attenders; however, more elaborate tools will need to be developed. No one would dream of investigating the benefits of physiotherapy by conflating heterogeneous disorders of varying severity into one 'musculoskeletal' category. Furthermore, the findings of this study cannot automatically be applied to the other disciplines mentioned in the report, namely counsellors, social workers and psychotherapists.

While fully supporting the authors' healthy scepticism, I believe the paper has more to say about the natural history of 'psychosocial' problems than the clinical psychology service.

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Night calls — an emotional issue

Sir,

As a partner in an urban group practice which does the great majority of its own out-of-hours work, I read your leading article on night calls (July *Journal,* p.362) with a sense of disbelief.

Your anonymous contributor, while freely admitting the effects of tiredness and frustration upon the visiting practitioners — and by implication the adverse effects on the patient concerned, not to mention the patients seen the following day — suggests that the emotional aspects of the consultation should have a high priority and urges us to consider the opportunities for psychotherapeutic intervention.

In the rough world of general practice where an evening and night on call means not only oneself but entire family being tied to the telephone or 'bleep' *any out of hours call is an intrusion.* The urgent call to the seriously ill patient can be tolerated but to extend this to visiting the 'dis-ease' from which many of our patients suffer is to inculcate an attitude of doctor dependence which does the patient little good and the doctor none.

Surely the only practical and educative way to manage out-of-hours calls is to offer appropriate telephone advice (with the attendant guilt feelings and worries about Service Committees) and see the patient, preferably in surgery, at a more convenient time saving the visit only for those patients whose clinical condition appears to warrant it and *actively discouraging* all others. To suggest, as your author seems to, that patients are entitled to have the attention of a familiar practitioner at any time they are anxious about their health and that we should make ourselves more available seems to me to be an invitation to 24-hour 'on demand' general medical services. This could never, surely, be justified on medical, social