

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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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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References

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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 historical 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 or 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).

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