puzzled that it should have been thought worthwhile to set up a trial for yet another benzodiazepine, and then compare it with the popular diazepam.

We feel that the comparison is deeply flawed in that the response of patients with anxiety to simply attending sympathetic (and perhaps prolonged) consultation without any therapy at all is frequently very good. The efforts by general practitioners to reduce the amount of benzodiazepines prescribed and the conscious attempt to wean the too many addicted patients off it, may well have been helped if Dr Kay's trial had included a group of patients who received no other treatment than the therapeutic support of seeing the doctor and psychologist or counsellor. Frankly, does it matter very much whether one benzodiazepine is more or less potent than another?

It is difficult to avoid a feeling that the manufacturers were anxious and willing to promote this research for a 'new drug' whose patent may not yet have expired. We wonder whether time and effort should be spent on trials of this sort, particularly when there is bound to be a very considerable interest in the outcome by the Head of Medical Affairs, Roche Products Limited.

The trial was only for two weeks and there must be many general practitioners who would not be inclined to place patients with acute or moderate anxiety of short duration on any medication at all. In fact many of them might regard it as bad practice to do so.

A dose of 15mg a day would seem to us a large dose for mild anxiety and perhaps the withdrawal of five patients for adverse reactions on this dose would not be surprising.

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## The College and the pharmaceutical industry

Sir,

Over the last three years, I have been fortunate to have the opportunity to start a new general practice from scratch. I came to this challenge from full-time employment with a research based British multinational pharmaceutical company. My list size has now grown to over 1,600 patients and I continue to work as a consultant to that pharmaceutical company. I feel that this experience puts me in a special position to comment upon the editorial 'Preventing promotion' (September *Journal,* p.473).

My own feeling is that the issues of the relationship between the *Journal* and the pharmaceutical industry are wider than this simple matter of advertising space. In particular I am interested in drug trials carried out by general practitioners and the subsequent publication of the results of this work. I believe that we should all like to see the *Journal* publish quality work carried out by general practitioners to evaluate drugs.

Unfortunately, it is my general experience that many general practitioners are not interested in undertaking this sort of work. It is very exacting work and requires skill and diligence. It is unfortunately true that general practitioners are also suspicious of covert drug promotion dressed up as clinical research. Sometimes this is a genuine fear, but also sometimes simply an excuse. Fortunately, it is possible to carry out good quality drug evaluation in this country in general practice. The information derived is of great value both to the pharmaceutical industry and to prescribing doctors.

What is the relationship of the *Journal* of the College to all this? Surely the College and the *Journal* have a responsibility to take an active interest in this area of general practice. Unfortunately a journal made up of even the highest quality drug trials would make fairly dry reading. I would therefore propose that this *Journal* seriously considers setting up a supplement to publish this work. Such a supplement need not be circulated to all College members, but would form a body of data available to doctors and may be reported in the *Journal.* This would fulfil the obligation which I believe rests with the College to be seen to be actively involved in this area of research.

I would ask my clinicians frustrated in trying to have their work published, or any member of the pharmaceutical industry interested in supporting this idea to write to me and I will pass on these letters to the College.

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## Fifth disease

Sir,

I was interested to read the short report about fifth disease in Brechin (October *Journal,* p.573). Our rural area based on Stalham, Norfolk, had a similar outbreak of fifth disease which started in November 1983 and was centred on the local middle school. No records are available but between 30–60 children were probably affected.

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## Premenstrual syndrome

Sir,

The recent editorial about the premenstrual syndrome (October *Journal,* p.533) serves only to confuse general practitioners further in the diagnosis and treatment of what is in effect a straightforward progesterone deficiency disease. Straightforward, that is, if one keeps to the correct definition of the syndrome which is: 'the recurrence of symptoms in the pre-menstruum with the absence of symptoms in the post-menstruum.' (Dalton K.) The diagnosis is made very simply by recording the timing of symptoms in relation to menstruation. This is far easier and more accurate than a diary recording day-to-day experiences over a period of a few months.

If the symptoms are only present in the luteal phase then they will be relieved by progesterone supplements. By using this definition and simple charts it offers general practitioners the opportunity of relieving very real, distressing cyclical symptoms that affect not only the patient but her family. It may or may not be that 95 per cent of women experience premenstrual symptoms, but it does not take much discrimination on the part of the patient and her doctor to decide whether an individual needs treating. What is more worrying is that about 95 per cent of general practitioners appear to have little knowledge of this essentially general practice illness and this includes women doctors. 'Pull yourself together woman!' still seems to be the rather depressing advice that continues to be given. General practitioners can easily opt out of their responsibilities and refer such patients to a wide variety of specialists, including psychiatrists, according to the presenting symptoms.

Many chronic illnesses are exacerbated cyclically in patients with true premenstrual syndrome. Some of these illnesses will include psychiatric illness. As for disturbance of 'marital function', let doctors know very clearly that prolonged severe cyclical personality changes in an otherwise sane and sensible woman will inevitably lead to changes in 'marital function'.

It is not that uncommon for an otherwise normal women to leave her husband rather than continue to inflict uncontrollable violence and abuse upon him.

I wonder if when investigating hormone status, Professor Clare did actually measure progestogen levels or is this another careless misprint for progesterone levels. They are two quite different substances and neither the words, nor their actions, are interchangeable in this context.

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Sir,

It is obvious why Dr Nigel Oswald, editorial writer on premenstrual syndrome (PMS) (October *Journal,* p.533) finds attempts to define PMS fraught with methodological problems,[1] for he is looking for symptoms and is unaware that the diagnosis depends on timing. The definition of PMS is the recurrence of symptoms in the premenstruum, or luteal phase, with complete *absence of symptoms in the postmenstruum.* It is important to remember that this definition also includes somatic symptoms such as asthma, sinusitus, sore throats, skin lesions, styes, and urethritis. Diagnosis is by daily recording of symptoms and menstruation over at least two, and preferably three, menstrual cycles. The diagnosis and many helpful diagnostic pointers was covered in one of your editorials two years ago.[3] Clare[4] found that when 25 women kept a two-month symptom diary only four had the same premenstrual symptoms in both cycles. One woman had no premenstrual symptoms in either cycle and a further five had no symptoms in the premenstruum of one cycle. Surely this study adequately demonstrates the failing of diagnosis by menstrual distress questionnaires.

The high incidence of marital disharmony in couples where the wife suffers from PMS is to be expected. It is indeed difficult to live with a wife subject to unexpected mood swings, irrational temper tantrums and unforgivable memories. It is a chicken and egg situation, which, as many general practitioners are finding, is quicker to remedy by correct hormonal treatment[2] than by endless sessions with a marriage guidance counsellor.

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## Reactions of patients to a video camera in the consulting room

Sir,

Dr Martin and his colleague are to be congratulated on their interesting paper concerning the reactions of patients to a video camera in the consulting room (November *Journal,* p.607). There is no doubt that a proportion of patients prefer not to have their consultations recorded, and I suspect that many who dislike the practice are unwilling to verbalize their disapproval for fear of jeopardizing their relationship with their general practitioner. The strength of general practice lies in trust between doctor and patient in the consulting room. Personally, if I discovered that my general practitioner was using a video to record consultations, I would cancel my appointment and seek advice elsewhere.

There is another objection, more subtle and more powerful than that of confidentiality. When a video is used, both doctor and patient are play-acting. Instead of honest question and answer, straightforward clinical examination restricted to essentials, and business-like management of treatment, issues tend to be fudged by consideration of what the transaction will look like to those viewing it later. The patient may disguise his real objective in seeking the consultation, and the doctor may become more concerned by what his peers will think of his practice than what is most necessary and effective in the management of his patient's problem. An element of artificiality, often amounting to humbug, is injected into the whole affair.

There are, undoubtedly occasions when a doctor's personal ambitions are allowed to take precedence over his prime duty to protect and foster the interests of his patient. I suggest that all too often the use of video camera in the consulting room aids and abets such undesirable objectives.

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## Home births

Sir,

I was pleased to see the letter from Franklin and Iliffe in the College Journal (October *Journal,* p.566)

There is now little to support the notion that carefully planned home birth for properly selected women is riskier than hospital confinement. An increasing number of us believe the converse to be true. Even if this were not so, we have a duty to support the woman who makes a rational and informed decision to have her baby at home.

Now that the Maternity Services Advisory Committee has given official credence to the importance of the mother's role in the decision-making around her own confinement, seeing her relationship with professionals as an equal partnership,[1] the College has an opportunity to support more actively both those women who choose home birth and the doctors who care for them, in the same way as we are committed to the partnership of a patient with his/her doctor in general primary medical care.

It is hard enough to provide a caring, safe and efficient service to those women who request home confinement, in the context of an ever-increasing workload and in the face of continuing eroding cutbacks in the NHS. We should be aiming to develop our domiciliary maternity services so that we can offer actively the advantages of home birth to those women for whom it may be appropriate.

In Sheffield, those of us committed to this have begun to meet in an effort to co-ordinate and improve our obstetric services