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