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

and to audit them, to standardize our records, cover for one another out-of-hours and so on.

The College should support the demedicalization (or dehospitalization) of birth when this is in the best interests of our patients.

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New RCGP Classification

Sir,

My partners and I are resolved on two things: we do not wish to pay £7,000–£10,000 for a computer as there is no commercial justification for this, but we do wish to get involved with a computer on a small scale and in a meaningful way.

Training practices in this region are expected to have all the components of notes sorted in chronological order and to have a summary card for each patient.

We have tried and failed in our practice to introduce formal auditing. Suggestions tended to turn into the equivalent of impracticable, time-consuming research projects because we had little idea what was going on in the practice in the absence of rapid access to a disease and treatment register.

May I now integrate the above three paragraphs? It is logical that the requirement that a teaching practice should have sorted notes and summaries should be taken one stage further. At the moment, summaries fulfil an admirable role in allowing rapid access to a patient's past history, but they tell us nothing about the epidemiological processes operating within the practice. We are failing to exploit the capabilities of the summary sheets. The next obvious step is to classify the data and place it on a computer.

To this end I awaited the publication of *Occasional Paper 26,* for it seemed to make sense that all general practitioners should use the same classification. Though it can be faulted, I think it is a good classification and achieves a sensible balance between detail and generalization. At least it has been prepared for general practitioners by general practitioners. I have, however, experienced difficulty in using the classification and I have suggested to Dr Clifford Kay that the book unwisely assumes on the part of the user a knowledge of the historical antecedents in morbidity coding. The 'FNO' system is particularly confusing for a newcomer. In addition I am finding the classification very slow to use because there is no large comprehensive 'jumbo-index' with synonyms. I believe that such an index should be published urgently as a supplement.

After two months of opportunistic work, I have still reached only the notes of names beginning with the letter 'C' and my triumphal arrival at the notes of Mr Zyxowski is at least a year away. It could be argued that the task should be delegated either to a computer or to a nurse. I am, however, finding that my summaries are incomplete and inadequate when subjected to the discipline of a formal classification and I greatly regret that *Occasional Paper 26* was not available when I began summarizing notes in 1981. I think the best way to avoid the 'rubbish in equals rubbish out' syndrome is to continue the coding myself, but a small study is planned to test the inter- and intra-observer error rate when both a doctor and a nurse independently code the same notes and repeat the process after an interval.

No guidance is given in *Occasional Paper 26* on how to classify drugs. I am using the headings of the *British National Formulary* and the editors have assured me that these headings will be retained in continuity in future editions.

What do I do with all the codings when I have finished? At the moment I do not know. I know what I should like to do. I should like to display numerically and graphically, the frequency (I avoid the terms 'incidence' and 'prevalence') of any disorder in the practice, to do retrospective case-controlled studies and comparisons with the computer selecting the controls, to find out what I am prescribing and to whom, and to do basic parametric and non-parametric statistics. I do not see how one can teach in general practice without access to this sort of information and it should surely become the norm for all teaching practices in the future.

The *cognoscenti* of general practice seem to be interested only in large expensive systems for primarily administrative purposes. No advice seems to be readily available for a general practitioner with limited aims and unlimited ignorance. What could I use as inexpensive hardware? Where is the software? Small is beautiful. It is time for a change in attitude to computers in general practice and for new and less ambitious priorities.

I am grateful to Dr Clifford Kay for his helpful advice about the use of the classification.

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Focus on women at 35

Sir,

I am sorry that Dr Schrire (Letters, December *Journal,* p.664) has picked out the last sentence in a short report on a survey we carried out on our patients throughout 1983. To interpret our results as he implies, that we only carry out cervical smears for profit, is very unfortunate and was not mentioned in the letter.

As a practice, we offer all our female patients, on starting oral contraceptives, the opportunity of having a cervical smear. I am not sure what others have experienced but we find it very difficult to convince young ladies that such is both necessary and sensible. In order to get the rate of take-up in our patients as near 100 per cent as possible, we selected an age at which patients would, we felt, be receptive to the idea and also welcome not only a cervical smear but a general check-up and questionnaire on many aspects of their physical and social health.

This questionnaire consisted of 29 questions, and routinely we examined breasts, blood pressure and urine as well as a pelvic examination. The uptake and response from the patients has been very good and for the amount of time and effort put into the exercise it would hardly be cost-effective if we were relying on private fees alone. We are constantly being urged by the College to practise health-care rather than illness-care medicine and this is a small way of starting our contribution within the spirit of the NHS.

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