

## References

1. Bridges-Webb C. Standard classifications and terminology for general practice. *Med J Aust* 1984; 140: 8.
2. Bridges-Webb C. Codes and classification in general practice computing. *Practice Computing* 1984; 1: 16-17.

## Individual and group cognitive therapy

Sir,

As a non-statistician and somebody with an interest in seeing cognitive therapy evaluated, I was unsure of your rationale in publishing the paper by Ross and Scott (*May Journal*, pp. 239-242).

First, they state 'treatment gains are mainly aimed at follow-up at 12 months', yet out of their invited (small) group of 51 patients, only 20 had been followed-up for 12 months (39% of the initial group), 14 others having 'not yet reached 12 month follow-up', the remaining 17 presumably having dropped out. I am not sure that on this basis their statement is justified. Should not publication have waited for all of the 34 patients to have reached 12 month follow-up?

Secondly, they state 'There is no significant difference between patients treated with group or individual cognitive therapy.' This statement is based, I believe, on Table 2 and some statistical ramifications thereof — but where are the actual figures on which this statement is based so that the reader can verify this important statement?

Thirdly, how are the 20 patients in Table 5 made up? These 20 patients achieve mean scores of 9.4 (Beck) and 7.6 (Montgomery-Asberg) after cognitive therapy but the 'waiting list' group achieved mean scores of only 16.8 (Beck), not even achieving remission, and 12.7 (Montgomery-Asberg) — despite their roughly comparable pre-treatment values. Is this a reflection of the fact that group therapy is predominant for these patients (12 out of 21) or are the patients in Table 5 and the 'waiting list' group really quite distinct?

This paper ends by confusing me — or have I just got the reasoning wrong? Surely a paper should present as complete a set of results as possible so that the reader can verify the conclusions drawn.

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Sir,

To answer Dr Gunstone's queries:

1. The 51 patients who received cognitive therapy in our study represent the largest sample studied in general practice to date. (In fact our study is of a

comparable size to the only published British hospital study of cognitive therapy involving 49 patients by Blackburn.<sup>1</sup>) Seventeen patients dropped out during treatment leaving 34. When we first submitted the paper we had intended only to present data on the completion of cognitive therapy. However, the referees enquired whether some preliminary data might be available for 12-month follow-up. This we provided. As stated, there was no systematic qualitative or psychometric difference between those who completed 12-month follow-up and those who have yet to do so, and so this was an eminently reasonable thing to do. We shall of course eventually publish definitive results for all of the group.

2. Dr Gunstone has concluded that the Beck scores of the waiting list group and those of the immediate cognitive therapy group differed after cognitive therapy treatment. He has concluded this by comparing figures quoted in Tables 3 and 5. These tables, however, are not comparable because Table 3 includes patients who dropped out in the waiting list period and Table 5 is presented for different reasons to look at the prognosis for completers. Because our 'intention to treat' analysis necessitated assuming no further progress since last point of contact, the results are over pessimistic. For the Table 3 patients excluding these drop-outs, the mean Beck score is  $12.7 \pm 8.2$  — 13 out of 21 patients scored 16 or less.

Furthermore, because some patients are present in both tables (as waiting list patients who subsequently had cognitive therapy treatment), and others are not (because they were in the immediate cognitive therapy group) it is not possible to perform a meaningful statistical test between the groups.

We are sorry that Dr Gunstone was confused and hope his points have now been answered. We are sure that the effectiveness and economy of cognitive therapy provision in primary care as demonstrated by the paper, underline the need to disseminate provision of this treatment method without delay. For this reason we fully defend the publication of our paper.

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## Reference

1. Blackburn IM, Bishop S, Glen AIM, *et al.* The efficacy of cognitive therapy in depression: a treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. *Br J Psychiatry* 1981; 139: 181-189.

## Laughter and medicine

Sir,

I would like to challenge Dr C.P. Elliott-Binns (*August Journal*, pp. 364-365) in his assertion that laughter is not generally recognized as a psychiatric technique, and that it is rarely used in that specialty. If one adopts Dr Elliott-Binns' definition of laughter as a state where 'the corners of the mouth are raised and a series of guttural noises issue from the mouth', this indeed may be true. However, laughter, as more usually defined, is much in evidence as a means of communication between patients and staff in everyday contemporary psychiatry. There are, I feel, some good reasons for this, including the informal atmosphere prevalent in the psychiatric setting, the relatively long time available for talking with patients and the considerable intimacy which develops when problems are viewed in depth.

Many of Dr Elliott-Binns' comments hold true for traditional analytical psychotherapy, such as the emphasis on detachment rather than attachment in training and the view that laughter allows patients to escape from sensitive issues. However, analytical psychotherapy is but one small part of current psychiatric practice, being confined to large cities and executed predominantly in the private sector. Although psychotherapy generally has an important place in contemporary psychiatry, it is rarely of the dead-pan analytical variety and is more likely to be supportive in nature and characterized by less emotionally stilted interaction. Many of the new psychotherapies, which are of increasing importance in the National Health Service owing to their cost effectiveness, emphasize humour as part of the genuineness and empathy established between therapist and patient. Cognitive therapy<sup>1</sup> provides a good example of this.

Finally, the author's proposal that doctors need training in humour and wit, with the aid of videotapes only seems to call into question the priorities exercised in medical student selection and training.

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## Reference

1. Beck AT, Rush AJ, Shaw BF, *et al.* *Cognitive therapy of depression*. New York: John Wiley, 1979.

Sir,

I read with interest Dr Elliott-Binns' thoughtful leading article on laughter and medicine (*August Journal*, pp. 364-365). Dr Elliott-Binns draws our attention to the

association of some jokes with groups or races and I am moved to wonder if, in some circumstances, the underlying insights possessed by these people may be more profound than the author has recognized. The wry humour of the Jews can be traced almost to the earliest days of the tribe with the arrival of the patriarch Isaac. His very name is derived from the Hebrew word for laughter. Abraham's wife Sarah had been barren until, in her old age, she conceived her child and Abraham recorded his fierce joy at the birth of his son by naming him in the likeness of mirth. Perhaps the underlying psychology of this story is an intuitive recognition of the value of laughter in human relationships — a recorded discovery in Semitic tribal folklore several thousand years prior to the advent of the Royal College of General Practitioners and Elliott-Binns' timely reminders on the subject.

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## Variations in the night visiting rate

Sir,

We read with interest the paper by Dr Usherwood and colleagues on variations in the night visiting rate (*August Journal*, p.395). Going out at 03.00 hours on a cold and rainy night is an unpleasant experience; hence, we suspect, the repeated studies undertaken on night visiting.

Dr Usherwood's conclusion that variations in night visiting rates between the practices that he studied were due to doctor/patient factors is probably correct, and it would be churlish to criticize the various assumptions made in reaching that conclusion. Variations in the patients' and the doctors' perceived need for a night visit ultimately determine that event.

We conducted an analysis of night contacts (that is to say, telephone calls and/or night visits) over a 12-month period in our practice of approximately 16 000 patients, seven partners and two trainees, and several interesting points emerged.

1. As our practice offers obstetric care, the number of night contacts is higher than in other practices — this is not surprising.
2. The percentage of night contacts dealt with by telephone alone varied enormously between doctors — the lowest was 9% and the highest was 75%.
3. Doctors were asked whether they felt that the contact was justified (the doctors' perceived need?). One doctor

considered that 92% of the contacts were justified (the highest) and another considered that 15% were justified (the lowest).

4. About 15% of the contacts were admitted to hospital, were requested to reattend surgery or were told that they would be visited again at home at some later stage. This may be an indication of the actual need in strictly medical terms.
5. The further the practitioner lived from the contact, the more likely it was that the contact would be dealt with by telephone alone.
6. The younger the practitioner, the fewer were the contacts that he considered to be justified.

In conclusion, we feel that to be meaningful, all night contacts (telephone calls and visits) must be studied. There are wide variations between doctors in visiting rates and for a variety of reasons (age, travelling time and so on). The patients' perceived need and the doctors' perceived need are often widely disparate and measurements, where possible, of actual need tend to suggest that many contacts do not need a visit in strictly medical terms.

Although not conclusive, our study seems to indicate that the considerable differences in doctors' attitudes and habits are probably more important than the patients' expectations. In studying night visits, it is therefore important that all telephone contacts should also be considered. In addition it is important that the role of the general practitioner in general practice obstetrics is clearly stated.

Finally, as in the paper by Dr Usherwood and colleagues where different practices on a shared rota system were studied, it is important that the individual practitioner's contribution to that rota is taken into account when considering differences between practices.

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Sir,

Dr Usherwood and colleagues conclude in their paper on night visiting rate variations between practices (*August Journal*, p.395), that some facet of the doctor-patient relationship may be the key. I would suggest that it is more likely to be some facet of the receptionist-patient relationship that matters most. While the individual practice's policy for

appointments and visits may appear to reflect the wishes of the doctors concerned, the patient's first contact with the doctor is through a receptionist and the importance of her manner and approach to patients should not be underestimated.

My own impression is that the single most important factor is likely to be the flexibility of an appointment system which, of course, is largely governed by the receptionists.

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Sir,

I was interested to read the article by Dr Usherwood and colleagues (*August Journal*, p.395). Our study considered the apparent differences in visiting rate between two practices operating from the same health centre in London.<sup>1</sup> On the basis of analysis of individual doctors' responses to requests for night calls, we concluded that the difference in visiting rates is related to the difference in the doctor's attitude and response towards minor symptoms. Both practices in our study had a similar number of calls for serious symptoms but the practice which responded to apparently minor symptoms with a visit and which considered that minor symptoms were due to non-specific organic disease rather than to over-reaction or over-anxiety or unreasonable demands, had a higher rate of demand.

Although our conclusions were suggestive rather than definitive, we believe that they are part of the answer to Dr Usherwood's question.

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## Reference

1. Cubitt T, Tobias G. Out of hours calls in general practice: does the doctor's attitude alter patient demands? *Br Med J* 1983; **287**: 28-30.

Sir,

The article by Dr Usherwood and colleagues on the wide variation in night visiting rates (*August Journal*, p.395) concludes that further research into this subject would be fruitful. One of the aims of setting up a doctors cooperative, such as ours in Leeds, was to encourage such research. As all the clinical work is carried out by general practitioner principals covering each others' practices it is an ideal arrangement for studying comparative visiting rates and patient