Post-viral syndrome

Sir,

Dr Archer (May *Journal*, p.212) argues for a balanced view of the post-viral syndrome as a mixture of organic and psychiatric dysfunction. The particular psychiatric dysfunction that he argues for is hysteria, which is a rare disorder if defined accurately. In my 19 years as a general practitioner I have met three such patients, one of whom had a post-viral syndrome. On the other hand, in the past two years, I have personally examined 200 patients with post-viral or myalgic encephalomyelitis syndrome. All of these patients live in the greater Dunedin area and details of the clinical findings have been recently published.[1] The minimum prevalence here (that is assuming I have seen all the local cases) is 127 per 100 000 or about twice the prevalence of multiple sclerosis in Otago/Southland.

From my considerable experience of New Zealand sufferers, I believe this to be an organic disorder and have evidence that it is associated here with chronic Epstein-Barr virus infection in 19% of cases, with a non-specific rise in IgM in 54% of cases, and positive autoantibody in 17% of cases. A subsequent study, as yet unpublished, has shown significantly decreased cell-mediated immunity in 33 patients as compared with age and sex matched controls. This latter study has led me to believe that the syndrome is an acquired immune deficiency syndrome and we are presently searching for evidence of retrovirus infection in our patients.

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Reference

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Cervical screening in general practice

Sir,

We read the paper by Ridsdale on a call and recall system for cervical screening with great interest (June *Journal*, p.257). As trainees in an east Glasgow practice with a population of approximately 9000, we set up a similar system for women aged 35–65 years with a three year recall interval.

However, we also aimed to increase our opportunistic screening in the younger age group. Our results for the first seven months are at variance with the opinion that opportunistic screening tends to reach those at low risk. The total number of smears carried out in the period November 1986 to May 1987 was 289 and of these 147 arose from opportunistic screening. Among 223 women invited to attend for screening 142 smears were carried out. Five out of eight colposcopic referrals were from the opportunistically screened group.

The aim of screening for cervical cancer is to identify and treat preinvasive lesions, thus preventing the progression to invasive cancer.[1] Cervical screening among younger women may be holding in check an increase in the incidence of invasive carcinoma,[2] so it is essential to continue screening younger sexually active women while increasing efforts to improve the uptake in older unscreened women.

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Voluntary organizations: an underused asset

Sir,

It is a pity that in the editorial on voluntary organizations (August *Journal*, p.339) the authors did not consider three fairly obvious sources of information for doctors and their patients.

First, community health councils should have this information to hand. Secondly, many county and municipal libraries keep a list of voluntary organizations of all kinds in their reference rooms. Thirdly, citizens' advice bureaux have been giving out this kind of information for nearly 50 years. Some 90% of the population of the UK lives within five miles of a citizens' advice bureau; the information is locally oriented and up to date.

I should add that if you live in the area of a new town development corporation, that body is likely to duplicate enthusiastically the information held by the other three sources.

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Sir,

I enjoyed reading the editorial on voluntary organizations (August *Journal*, p.339).

The authors referred to the coordinating bodies for other voluntary organizations in the shire counties, the rural community councils. These organizations also have a significant role in raising the concerns of and representing the needs of people living and working in rural areas. Many rural community councils are actively promoting local health initiatives, helping rural groups improve access to health care, supporting local neighbourhood care groups, working with local authorities to develop care in the community in remote rural areas, and helping local people to make the case for locally available primary health care.

The community councils have recently established an independent national charity to represent their interests, and to perform a range of activities supporting them in their local work. Action with Communities in Rural England is based in the heart of rural England in the south Cotswolds at Fairford. I will be pleased to provide any further information (including names and addresses of local contacts).

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Variation in general practitioners' referral rates to consultants

Sir,

The paper by Wilkin and Smith (August *Journal*, p.350) makes exasperating reading. They report a good study of Manchester doctors but then reach unwarranted conclusions. The thesis that you cannot judge a general practitioner by the number of referrals he makes is sound and sensible, but in their concern to use it they miss two important points.

First, if a ceiling is put on our referrals it will not be because the DHSS has missed the point, but because government has exercised its political will. Secondly, the thesis does not depend in any way upon their research findings, that is, a lack of characteristics in doctors that can be associated with high or low referral rates. It would remain as sound and sensible if they had discovered that left-handed extroverts with one tin leg requested the most second opinions; we should still not be able to infer that such doctors were better or worse than their colleagues.

The authors were justifiably proud of having studied so many general practitioners, but a paper published earlier this year, surveying the work of 21 London principals and their trainees over 12

months, reached very different conclusions about associated characteristics.[1] Perhaps caution should have been displayed in discussing the Manchester results.

Although routine referral data provide no basis for an outsider to make judgements, there is no reason why every practice interested in this aspect of its work should have to collect the data for itself. Although we do not know why one doctor differs from another, there is no reason why a concerned practitioner should not be informed about how much he differs from the local average. Although Wilkin and Smith find it hard to think of ways in which the information could be used, this does not mean that others are not more imaginative.

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Reference

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Sir,

In the recent article on referral rates (August *Journal*, p.350) the authors found it difficult to come to any clear conclusion. I would suggest that one of the mistakes made was to measure referrals per 100 consultations. A general practitioner with a referral rate of 5% who sees 40 patients in a surgery would generate as many referrals as a doctor with a rate of 10% who sees 20 patients. It might be more appropriate to analyse referrals by list size.

In our first annual practice report I have given individual and total referrals per 100 patient years. This removes variations owing to individual consulting methods and it is a simple matter to divide the number of referrals per year by your list size and multiply by 100, although it would be difficult to measure variations between partners in a practice which does not have a strict personal list system. This system would however give a much clearer picture of trends, for example whether psychiatric referral rates were going up or down, as defined against a measured population rather than by the number of patients consulting.

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Sabbatical leave

Sir,

Dr O'Dowd's editorial (July *Journal*, p.290) will have stimulated many established family doctors to see which stage of burn out they have reached, and they may be wondering what they are going to do about it. Having identified and highlighted the problem, Dr O'Dowd did not go on to suggest options for resolving the problem. Entering the medico-political field, becoming a trainer or becoming involved in research are all feasible activities but the answer for many general practitioners is to take sabbatical leave from the practice for three to six months in order to undertake some different type of work or study.

Having recently enjoyed sabbatical leave myself, with the assistance of a Claire Wand Fellowship, I can thoroughly recommend the experience. However, it would be useful if the College had a package of information available to members who are considering sabbatical leave. At present the College library only has one article available (*Update* 1983; **27**: 795-797). The British Medical Association are only able to provide a copy of their *Notes on contracts for appointments overseas*, a list of overseas BMA branches and affiliated medical associations and some advice about work in South Africa, Zimbabwe and Saudi Arabia. While this information is useful, it does not help a doctor to plan sabbatical leave, with all its implications for his practice and family. Help is also required with contracts, references, employment agencies, work permits, and application for an educational allowance and a contribution towards the employment of a locum if prolonged study leave is being sought from the family practitioner committee.

Perhaps the accumulated experience of members who have taken sabbatical leave could be collated by the College for the benefit of those who are planning it.

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Health questionnaire

Sir,

The paper by Wallace and colleagues (August *Journal*, p.354) on health questionnaires in general practice prompts me to report our experience with a similar questionnaire designed by Anderson.[1] In January and February 1987, questionnaires were distributed in the waiting room of our urban practice in West Cumbria by our receptionists and 195 completed forms were collected; only one patient refused to answer the questions.

The practice has approximately 10 500 patients, mainly from social classes 4 and 5. There is a high proportion of council housing in the area and the unemployment rate is 18%. Ten patients failed to reveal their sex and among the remaining 185 respondents there were 67 men with a mean age of 47 years and 118 women with a mean age of 36 years.

Forty men (60%) and 47 women (40%) admitted to smoking; 19 men (28%) said that they had not taken alcohol in the previous month compared with 36 women (31%); 45 men (67%) had not been dieting compared with 74 women (63%); and 22 men (33%) and 40 women (34%) reported taking some exercise in the previous month. Although this was not a controlled study, several useful points can be raised. First, the smoking prevalence found is higher than class specific figures[2] especially among men, although men who smoke are probably over-represented in our waiting room. Secondly, there were more non-drinkers than expected.

Patients were interested in being asked about their health and lifestyle and were happy to answer questions. However, some elements of the questionnaire proved too complicated and to be useful as a health screening tool rather than a research device, a simpler section on drinking is needed. One approach would be to combine the CAGE questionnaire[3] with three additional questions: (1) On how many days a week do you take an alcoholic drink? (2) What sort of alcoholic drink do you usually take? (3) If beer, how many pints do you drink in an average session?

Despite some difficulties the questionnaire has given us a useful insight into our patients' habits and encourages us to include such enquiries in our consultations as opportunistic health screening.

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