helped individuals within the apartheid system to bring about change within their organizations as well as raising the awareness of the inequities of the apartheid system overseas.

The National Medical and Dental Association was formed in 1982 by 1000 progressive doctors in South Africa and represents an alternative to the establishment Medical Association of South Africa. These progressive doctors affirm that you cannot divorce health in South Africa from the apartheid system and they deserve our full support.

I would like to draw readers' attention to the Health Workers Against Apartheid organization which was formed in London in September 1988. Membership is open to all health workers and at present comprises doctors, physiotherapists, psychologists, speech therapists, medical students, nurses, dieticians and health visitors. The organization aims to provide information, act as a pressure group on health related issues in South Africa, support people and groups who oppose the oppressive system, and to raise funds for the victims of apartheid.

The Health and Refugee Trust of South Africa is one of the charities supported by Health Workers Against Apartheid. The aims of the charity are 'to provide relief of poverty, homelessness and other forms of distress, the protection and preservation of mental and physical health and the advancement of education' among refugees and their families from South Africa. The charity is currently raising money to fund three major projects:

1. The children's project will help to rehabilitate refugee children who have been brutalized by detention and torture in South Africa by providing psychological support and treatment by appropriately qualified South African psychologists familiar with the cultural and social backgrounds of these children.

2. A workshop on the management of common diseases in refugees in southern Africa has the aim of developing a common approach to their prevention and treatment and compiling an essential drugs list and a rational policy for their use.

3. An on-going project provides education about the nature of the acquired immune deficiency syndrome and human immunodeficiency virus infection, its manner of spread and modes of prevention.

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For further information please write to: Health and Refugee Trust (HEART), 23 Bevenden Street, London N1 6BH; Health Workers Against Apartheid (HWAA), 13 Mandela Street, London NW1 0DW.

Breast self examination

Sir,

I was disturbed to see another call for general practitioners to teach the technique of breast self examination on an opportunistic basis (Letters, October *Journal,* p.470). The benefits of this technique are, despite an extensive literature, as yet unproven, and little has been said of its costs.

The most recent meta-analysis of the studies of breast self examination[1] relates to 12 trials, half of which purport to show some benefit from the technique. The endpoint taken was stage of disease at diagnosis. A small effect on the size of tumour (smaller) and presence of nodes (less likely) at diagnosis was reported in women who had ever practised breast self examination. Interestingly, there was no difference between stage of tumour diagnosed according to whether it was first detected by breast self examination or by accident. The authors conclude that breast self examination 'increased awareness' of changes in the breast, and therefore that the actual method of disclosure is irrelevant. This conclusion is not supported by evidence. The technique of meta-analysis suffers from the fact that 'positive' studies are more likely to be published than negative ones. All the studies analysed were retrospective, and recall bias is therefore a major confounding factor.

It is obvious that survival of women with breast cancer is longer if the diagnosis is earlier, but it does not necessarily follow that earlier diagnosis alters the course of the disease or decreases mortality. An equally plausible hypothesis is that earlier diagnosis simply makes the patient feel miserable for longer since the course of the illness may be little altered by treatment. The continuing uncertainty over the efficacy of mammography, which detects much smaller tumours than those found by breast self examination, highlights this point.[2,3]

What of other disadvantages of breast self examination? First, it takes time and causes some discomfort if correctly performed. Some women find it embarrassing.[4] For every case of breast cancer diagnosed and treated, a number of false positives are generated, with all the anxiety, pain and financial cost that this entails. Finally, what of the guilt of women who have breast cancer diagnosed and who have never practised breast self examination? The more this technique is promoted, the bigger this problem will become. We would do better, pending good research data, to work on persuading people to stop smoking, and to offer breast examination only to women requesting it, rather than trying to deal with our own anxieties by promoting a technique of dubious merit.

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Clinical psychologists in general practice

Sir,

The paper by Drs Milne and Souter (October *Journal,* p.457) does indeed paint a different picture of the role of the clinical psychologist in general practice from other recent papers and editorials on the subject.

It is hard to explain why the experience of clinical psychologists in health maintenance organizations in the USA is not mirrored here in the UK. A 50% reduction in subsequent consultations for any reason is not infrequently recorded in some American studies where outcome has important financial implications.[1,2] In addition, costs of prescriptions fall and patients as well as therapists report satisfaction with outcome. I suspect that the differences are due in part to the doctors' cultural expectations of the psychotherapists and the expectations of the patients who expect something to be done to them. Unless the referring doctors can accept the need for additional training to enable them to make appropriate referrals and to accept their responsibility for ensuring regular contact with therapists and counsellors little will change. Therapists too need additional expertise in managing what is often a new style of brief intervention work which needs to concentrate on limited goals, transference both negative and positive, and the planning of the therapeutic process to encompass beginning, middle and ending of the therapy.

We have a lot to learn in this country from the experience in the USA where the third party carriers (insurance companies) long ago put a stop to indefinite and