understood. This would require exactly the wider public role for general practitioners that Dr Tudor Hart advocates. When consumers are knowledgeable advertising becomes impotent.

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Sir,

I do not know of anybody or any organization that is advocating the no holds barred, unrestricted, heavily persuasive advertising by general practitioners which Dr Tudor Hart addressed in his article (December *Journal,* p.559).

In fact it has been a hallmark of this topic that the profession, represented by the General Medical Council and the Royal College of General Practitioners, has never carefully or correctly defined the degree of advertising intended by those in favour of some relaxation of the present GMC guidelines. The word advertising is all too easily connected with rampant commercialism. Therefore it is hard for people to restrict themselves to commenting on just the provision of information and not be diverted into a much easier attack on some imagined exaggerated advocational content.

Dr Tudor Hart follows the pattern and again discusses the hypothetical situation he wants to discuss but ignores the actual proposals being considered. I can understand that politically it may be expedient to fight on a false front so that a loss may be turned into a victorious compromise but this does not facilitate debate or flatter the ability of the writer's mind to define the issues.

I am equally disturbed at Dr Tudor Hart's suggestion that the profession be a force for social change. What public mandate have the GMC or royal colleges obtained to take on this role? I am sure that individual doctors will disagree about the relative merits of different social values, so what social values are the profession to uphold? I am against the private ownership of property but I would not expect the profession as a whole to support me. The purpose of a profession is to serve society not change it.

Dr Tudor Hart does, however, present some of the right evidence in coming to the wrong conclusion. He correctly emphasizes the public's right to care according to need, not ability to pay and he draws our attention to the shortfall in chronic care provision, many patients being without care at all. The importance of a good doctor–patient relationship is also emphasized, one that allows and encourages the patient to accept some responsibility. He reminds us of the mobile nature of society today with the average stay with one doctor being only nine years not for a lifetime. We were not, however, reminded that 25% of the public are dissatisfied with their general practitioner's management[1] or that one in three 35-year-olds use alternative therapies.[2]

Part of the solution for these shortcomings, which will also help facilitate the formation of good doctor–patient relationships, is to increase the public's power and choice of medical care by improving their access to relevant practice information. This means raising the profile of all locally available general medical services, NHS and private, by the use of the newspapers. Notices or announcements of the existence and availability of these services will increase the chance of the public seeking the medical care appropriate for them.

Dr Tudor Hart fails to see the problem from the public point of view. All he can say is: have faith, trust us, it will be alright in the end. But the false promise of perfection delivered tomorrow in five or 10 years time is not good enough. People are suffering today and practice information in local newspapers will benefit them now.

The profession has to adapt to the needs of the people and not vica versa.

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## Community care for the elderly

Sir,

Sharing the rising concern about the increased workload generated by artificial aggregates of elderly patients, as demonstrated in the study carried out by Dr Andrew (December *Journal,* p.546), my partner and I audited demand for the fourth quarter of 1988. The subjects were 23 patients resident in purpose built flats for the elderly with a 24 hour resident warden. There is no domestic or nursing care provided and therefore residents have to be able to care for themselves, although 'meals on wheels' and home help services are available for those who qualify. Twenty three control patients matched for age and sex and not living in special accommodation for the elderly were also studied. The average age in the two groups was 80 years (range 92–65 years) and there were four men and 19 women. The workload generated by the two groups over the three month period is shown in Table 1.

**Table 1.** Workload generated by 23 elderly patients living in special accommodation and 23 age and sex matched controls.

| | Subjects | Controls |
|---|---|---|
| No. of visits (daytime only) | 20 | 1 |
| No. of surgery consultations | 20 | 24[a] |
| Total no. of medications prescribed | 74 | 40 |
| Mean no. of medications prescribed per patient | 3.2 | 1.7 |

[a] 13 generated by two patients.

Even allowing for the small sample size, the potential workload and cost implications of these figures is alarming, with the rising elderly population and the drift into special accommodation. This problem is something to which we, as independent contractors, should address ourselves, and something which our General Medical Services Committee negotiators should have in the forefront of their mind in their current negotiations with the government.

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## Crohn's disease

Brown and colleagues (December *Journal,* p.549) set out to 'aid general practitioners in the earlier diagnosis of Crohn's disease'. In reality there is nothing in their paper to help a general practitioner evaluate lower bowel symptoms, but this is not surprising given the study design. It is difficult to imagine how the authors could have expected to provide guidance for general practitioners from a retrospective survey of hospital records. There is no information in this paper about the consultation frequency or pattern of the patients studied before they were seen in hospital and nothing about the severity of their symptoms or the effect of the symptoms on function.

Symptoms referrable to the gastro-

intestinal tract are common in the community. Symptoms compatible with the diagnosis of irritable bowel syndrome, for example, are experienced by at least one fifth of the general population.[1,2] Not surprisingly, gastrointestinal complaints are common reasons for consultation with general practitioners and the difficulties of making clinical diagnoses in upper and lower abdominal disorders are well documented.[3] The diagnostic delay reported in this study is hardly surprising, particularly in view of the rarity of Crohn's disease. Although the authors comment on the changing pattern of this disease, three quarters of the patients, as expected, had colicky abdominal pain or a change in bowel pattern, although it is interesting to note that only about 40% had rectal bleeding. Before suggesting that diagnostic delay could be reduced it would be necessary to know something about the frequency and severity of symptoms during the period between symptom onset and final diagnosis. It may be, for example, that those patients in whom diagnostic delay appears excessive had relatively mild and infrequent symptoms during this period. It is perhaps also worth pointing out that a small proportion of patients confidently diagnosed as having irritable bowel syndrome after exclusion of organic disease by extensive investigation subsequently turn out to have inflammatory bowel disease.[4]

For these clinical observations to be of value in making a diagnosis, some measure of the predictive value of symptoms, either in isolation or in combination, needs to be determined. Otherwise, one logical conclusion which could be drawn from the study is that more investigations should be performed at an earlier stage in more patients, leading to unnecessary use of investigations and to wasted resources.

Perhaps most importantly, we need more information about how far general practitioners are able to investigate patients with persistent lower bowel symptoms in the surgery. Access to radiological and pathological tests is now fairly widespread, but only a minority of general practitioners have the expertise and facilities to perform sigmoidoscopies, for example, in their surgeries. Given that two thirds of the patients in this study had large bowel involvement with Crohn's disease, the use of sigmoidoscopy is of particular diagnostic relevance.

What would be of great interest would be a review of the general practice records of these patients. It might then be possible to describe thresholds of symptom frequency or severity leading to investigation or to determine the diagnostic weight of individual symptoms or symptom complexes.

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## Chronic pelvic pain

Sir,

Dr Guirgis reports a personal study of 200 women years of pelvic pain (December *Journal,* p.567). In no less than three teaching hospitals gynaecological assessment failed to reach a diagnosis in the majority despite laparoscopy in 174 cases and only 26 improved with gynaecological treatment. As a result of this study he suggests that 'chronic pelvic pain has a psychological rather than an organic basis in the vast majority of cases'. He then makes a series of recommendations to general practitioners.

His suggestions and recommendations reflect the confidence of the well trained. The less well trained could be forgiven for having doubts about their validity. Doubts about the infallability of collecting evidence and about its interpretation, both so dependent on personal experience, learning and preconceptions. Doubts too about the completeness of our present taxonomy of diseases.

While certainty dispenses with questions, doubts should generate questions and these may lead to the discovery of new symptom complexes, unrecorded physical signs or even a revision of the current conceptual models used in diagnosis.

Dr Guirgis offers the standard dualism of psyche and soma for the origin of pain. The one accessible to exploration, experiment and laboratory testing, the other far less so. Little account has apparently been taken of the processes going on in that almost totally inaccessible area that links the two together — the spinal cord.

Research into the mechanisms of pain