transmission has been undertaken for many decades. Fifty years ago Lewis and Keilgren demonstrated that pain associated with autonomic and muscular effects could be created at a distance from nociceptor stimulation in paravertebral tissues.[1] To most clinicians referred pain still equals 'nerve root pressure'. Other work shows the fundamental role of a complex interactive signalling system in the cord in the creation of pain. Of basic importance is proof that pain may arise from a change in balances of signals within that system which is unrelated to stimulation of nociceptors. As long as clinicians continue to ignore this scientific evidence we shall continue to be unhelpful to women with chronic pelvic pain.

Using this available knowledge transforms a frustrating unproductive consultation into an intellectual challenge requiring a truly whole body approach by the clinician. Something from which, by his very calling, the specialist is exempt.

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Reference

1. Lewis T, Keilgren JH. Observations relating to referred pain. *Clin Sci* 1939; **4**: 47.

Caring for the mentally handicapped in the community

Sir,

Dr Payne's timely editorial on the future of community and residential care (December *Journal,* p.536) alongside Dr Andrew's study of a general practitioner's work in a private nursing home for the elderly (December *Journal,* p.546) draws attention to a problem of concern to most general practitioners. The burden of chronic care is exacerbated further by the consequences of the policy of caring for the mentally handicapped in the community.[1]

I practice on the doorstep of two of the country's largest mental institutes and I have just received a report based on a two week visit by the National Development Team for People with a Mental Handicap to the Ribble valley in June 1987.[2] The report correctly highlights the importance of general health care for mentally handicapped patients relocated in the community and recommends that 'health authorities develop ways of monitoring and improving the quality of health care to people with a mental handicap'. In spite of a policy of resettling patients in their original health authorities where possible, general practitioners in the Ribble valley have found themselves looking after many resettled patients. Primary health care needs appear to have a low priority, and registration with a general practitioner is an afterthought.

A representative of the Lancashire family practitioner committee met a member of the visiting team to give evidence but neither the local medical committee nor the local general practitioners were aware of the visit. National hospital advisory teams visiting our district have invited, received, and appreciated a general practitioner input.

There are two types of resettlement: in homes organized, staffed and resourced by hospitals, and in private residential homes with apparently little supervision or control.

I have carried out a brief audit of the effect of one home of the first type, with six young patients and residential staff. The effect on the workload of a group practice in Clitheroe is shown in Table 1.

Table 1. Effect of a residential home on practice workload.

	Mentally handicapped patients ($n = 6$)		All practice patients ($n = 7585$)	
	1986	1987	1986	1987
Number of doctor–patient contacts[a] per patient per year	5.5	4.8	3.6	3.6
Number of visits per patient	0.5	1.3	0.6	0.6
Number of other contacts[b] per patient	18.3	18.2	N/A	
Number of letters written per patient	4.0	4.2	0.2	0.2

[a] Appointments and visits. [b] Telephone communications and new prescriptions. N/A = not applicable.

The reasons for this higher workload from mentally handicapped patients include the associated physical handicaps, for example spina bifida with suprapubic catheter and epilepsy, and the high expectations of the staff who were used to

daily ward visits by general practitioners employed as clinical assistants in the hospital. The patients generate a large amount of correspondence including progress reports to the hospital, but there is as yet no recognition of the additional resources required, not even an elderly patient capitation fee.

General practitioners in Clitheroe are perhaps more able than most to absorb these demands — we have average lists below 2000, with good living conditions and low unemployment among our patients,[3] but we feel the strain. How will other practices, which are already severely stressed, cope? Perhaps by refusing to accept such patients.

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References

1. Department of Health and Social Security. *Better services for the mentally handicapped.* London: HMSO, 1971.
2. National Development Team for People with a Mental Handicap. *The development of a contraction strategy for the Brockhall/Calderstones Unit in Lancashire.* London: DHSS, 1988.
3. Breheny M, Hall P, Hart D. *Northern lights: a development agenda for the north in the 1990s.* University of Reading, 1988.

Safest place of birth

Sir,

Marjorie Tew's letter (November *Journal,* p.521) repeats her well known position that it is safest to give birth away from consultant obstetric units, with their increased likelihood of obstetric intervention. This position has been thoroughly argued,[1] but her method has been shown to contain important methodological and logical flaws.[2]

Mrs Tew quite rightly states that the hypothesis that 'obstetric management is especially valuable to babies who are at risk because their mothers have certain characteristics or obstetric experiences' has never been tested. However, her challenge to use the Oxford obstetric data system for this purpose is misconceived; observational data sets of this type cannot be used for this task. In clinical practice women are not assigned randomly to their treatment (or place of booking or place of delivery), and statistical analysis, however ingenious, can never make up for this deficiency. In our hospital all women with risk characteristics will have received consultant care, making a comparison with general practitioner care impossible.

Indeed, it is partly because both Mrs Tew and her critics have had to rely on observational data, that there has been such confusion and controversy surrounding the issue of the safest place of birth.

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References

1. Tew M. Do obstetric intranatal interventions make birth safer? *Br J Obstet Gynaecol* 1986; **93:** 659-674.
2. Campbell C, Macfarlane A. Place of delivery: a review. *Br J Obstet Gynaecol* 1986; **93:** 675-683.

Training for hospice care

Sir,

I would like to support the views expressed by Dr Finlay in her editorial 'Training for hospice care' (January *Journal,* p.2). However many hospice beds there are, only a small proportion of patients will spend a small proportion of their illness in them. It is well recognized that hospitals are not an ideal place to care for dying patients from the medical, social and emotional points of view. The majority of patients are going to spend most of their time at home and it is the doctor's ability to liaise closely and sympathetically with the patient's general practitioner and the whole primary care support system, and to appreciate and respond to the pressures of the home environment as well as its opportunities, which are adequately prepared for by experience in general practice. I would like to see this go beyond completing a trainee course to the inclusion of at least two or three years of active practice, with final responsibility for patients.

Dr Finlay's suggestion of a diploma in palliative medicine, well balanced between clinical, communication and management skills seems to be well worth considering.

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Timing and purpose of the MRCGP examination

Sir,

I would like to respond to Dr Robert's paper on the timing of the MRCGP examination (January *Journal,* p.30). I sat the examination two months after completing my vocational training and I learned a lot from this. The emphasis on reading current medical literature including that on non-clinical subjects such as politics, computers and screening is relevant not just to general practice but to medicine as a whole. Trainee day release courses and trainers are not necessarily examination oriented and may teach other equally, or even more valuable approaches, such as Balint type group meetings. For me, the examination was complementary to the trainee year in many respects.

I am currently a senior house officer in psychiatry and intend to make psychiatry, and not general practice, my career. If I had to gain years of further experience in general practice I would not have sat the examination. Many doctors now have more than one postgraduate membership, and it would be a pity if interested non-general practitioners were to be prevented from broadening their knowledge of general practice in this way. A hospital patient has many of the same needs as a general practice patient. Doctors in different hospital specialties may not need to talk to each other, but they all need to communicate with general practitioners and have some understanding of their work.

I hope this viewpoint will be taken into account in debating the re-scheduling of the examination.

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Sir,

It seems almost impossible to open a general practice journal or newspaper without seeing something about the MRCGP examination. Unfortunately, most articles appear to cover the same ground. The latest offering in the *Journal* (January, p.30) is no exception. However, there were one or two points on which comment should be made. The fact that many candidates devote time to modified essay questions and attempt to increase their factual knowledge appears to be anything but reprehensible, especially if you bear in mind that you cannot develop a questioning approach to general practice without first having a sound basis of factual knowledge.

The article also implied that the good practice allowance/postgraduate education allowance, should become tied to the