

Further investigation showed clear cerebrospinal fluid with no evidence of infection, and electrolytes which showed a sodium level of 122, potassium 3.3, bicarbonate 17, urea 3.3 and glucose 7.0 mM. Chloride was not estimated. A computerized tomography scan showed no abnormality and an EEG showed an excess of high voltage slow wave activity, particularly posteriorly (probably post-ictal).

The patient was observed overnight. During the course of the night he had a diuresis (volume unfortunately not measured) and he awoke the next morning fully oriented with only a slight headache. Electrolytes on the following day showed sodium 137, potassium 3.9, bicarbonate 21 and urea 3.2 mM. He has been well since then and a further EEG three weeks later showed considerable improvement with a mild excess of posterior slow wave activity only.

Questioning of the parents did not reveal a family history of migraine or epilepsy. There was no history or evidence of ingestion of other drugs. His parents reported that they supervised his use of Desmospray and gave him one puff (10 µg) in each nostril before bed. On occasion, however, they have given two puffs when they felt that it had not gone in properly. They reported that the boy did not drink at night after taking his desmopressin. He did tend to excessive drinking during the day, however.

Although desmopressin has previously been recorded as safe for use in nocturnal enuresis<sup>3</sup> there is evidently a risk of hyponatraemia, despite its use according to instructions. The pharmacological effects of desmopressin are noted to last more than 12 hours<sup>4</sup> and it is possible that this child was drinking excessively in conjunction with the 'tail' of the effect of desmopressin.

We recommend therefore that desmopressin be used with caution in childhood enuresis. In particular, having ascertained that the child has a normal blood pressure, urine free from infection and no history of renal problems, we would advise that desmopressin is only administered at least one hour after a last drink and that the child takes no drink whatsoever during the night. We feel that if the child drinks excessively during the day the use of desmopressin should be contraindicated.

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## References

1. Fjellestad-Paulsen A, Wille S, Harris AS. Comparison of intranasal and oral desmopressin for nocturnal enuresis. *Arch Dis Child* 1987; **62**: 674-677.
2. Simmonds EJ, Mahony MJ, Littlewood JM. Convulsions and complications after intranasal desmopressin in cystic fibrosis. *Br Med J* 1988; **297**: 1614.
3. Wohl RA, Boichis H, Orda S, et al. Desmopressin in nocturnal enuresis. *Arch Dis Child* 1982; **57**: 137-140.
4. Blackett PR, Seeley JR, Altimiller DH, Males JL. DDAVP in diabetes insipidus. *Clin Pharmacol Ther* 1981; **29**: 793-797.

## Telephone consultations

Sir,

We welcome the comment (February *Journal*, p.79) on our report on telephone consultations in a general practice (December *Journal*, p.566). Dr Halle rightly emphasizes the danger of litigation when managing requests for visits by giving telephone advice alone but, in common with the findings of other surveys, most of our callers sought medical advice not a home visit. Quantitative information on the risks of litigation after telephone consultation compared with face-to-face consultation would be most valuable. In litigation-conscious North America, an estimated 132 million telephone consultations took place in 1975 (15% of 'ambulatory' contacts); clearly the threat of litigation is outweighed by the perceived advantages.<sup>1</sup>

We agree with Dr South that there are many questions to be answered, but we remain unconvinced by his subjective conclusion that the disadvantages of telephone consultation outweigh the advantages. The questions he poses are apt but, in the UK context, answers are not available and conclusions from studies in other countries are equivocal.<sup>2</sup> Dr South perceives the benefits to patients to be 'banal'. Other doctors do not share his opinion, and neither do patients.<sup>2</sup> Through the telephone, patients may gain access to an additional service, not necessarily an alternative one.

The telephone consultation is here to stay and should be taken as seriously as the face-to-face one. Presently, there is no clear evidence that the quality of telephone care is inferior.<sup>2</sup> Protocols and manuals for telephone work have been developed in North America and the issues of communication skills, sensitivity to patients' needs, decision making and documentation are being grappled with.<sup>1</sup> Should general practitioners in Britain not be following suit? Data from the 1985 general household survey showed that 7% of general practitioner-patient contacts took place over the telephone (about one half of the North American figure) which is not insignificant.<sup>2</sup>

If our small surveys<sup>3,4</sup> stimulate further debate, research or developments in this neglected area, our aims will have been accomplished.

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## References

1. Curtis P, Evens S. Doctor-patient communication on the telephone. *Can Fam Physician* 1989; **36**: 123-128.
2. Hallam L. You've got a lot to answer for, Mr Bell. A review of the use of the telephone in primary care. *Fam Pract* 1989; **6**: 47-57.
3. Bhopal JS, Bhopal RS. Outcome and duration of telephone consultations in a general practice. *J R Coll Gen Pract* 1988; **38**: 566.
4. Bhopal JS, Bhopal RS, Gilmour WH, Fallon CW. An audit of incoming telephone calls to a practice. *Update* 1988; **37**: 848-851.

## GPs' advice to travellers

Sir,

The interesting article on general practitioners' advice for travellers to Turkey (April *Journal*, p.148) supports a report in the spring edition of the *Journal of the Medical Defence Union*.<sup>1</sup> This gave the results of a postal survey of general practitioners concerning their vaccination programmes and advice for foreign travel. The results of this questionnaire suggested that nearly two-thirds of general practitioners do not routinely follow strictly the recommended immunization schedules for travel abroad. In 1987 a survey of general practitioners' attitudes to malaria prophylaxis found that a substantial proportion modified the specialist advice they received.<sup>2</sup> In 1987 a further study demonstrated that 98% of 'at-risk' travellers receiving advice from their general practitioner subsequently carried anti-malarial tablets. However, only 46% of those receiving advice could name any other method of personal protection against malaria.<sup>3</sup> Is the general practitioner (in addition to the traveller) at risk if the information he supplies is inadequate or out of date? One must now be aware of the prevalence of meningococcal infection, Japanese encephalitis and other exotic diseases. Is the whole range of problems associated with overseas travel now such a dynamic and specialized area that it should be left to specialized clinics?

British Airways medical services for travellers abroad (BAMSTRA) has been formed by British Airways and the medical advisory service for travellers

abroad (MASIA) with the object of establishing a national network of British Airways travel clinics. Each clinic is able to offer a full range of advice. There is also a retail service for medical accessories for the travellers. The clinics are directly linked by computer to the London School of Hygiene and Tropical Medicine and up to the minute information is therefore available concerning vaccinations and health information in all parts of the world.

Patients may obtain the address and telephone number of the nearest clinic by ringing 01-831 5333. Telephone advice is not available and patients should make an appointment at their nearest clinic.

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#### References

1. Holden JD. General practitioners and vaccination for foreign travel. *Journal of the Medical Defence Union* 1989; 5: 6-7.
2. Williams A, Lewis DJM. Malaria prophylaxis. *Br Med J* 1987; 295: 1449-1452.
3. Campbell H. Imported malaria in the UK. *J R Coll Gen Pract* 1987; 37: 70-72.

## Palliative care: home or hospice?

Sir,

In her editorial (January *Journal*, p.2) Finlay looked at the emergence of palliative medicine as a specialty and how best the profession should prepare doctors entering the field. She placed the emphasis on experience in general practice, where the hospice is seen to provide 'a bridge between community and hospital'. I would like to comment not on the training, but on the general issues concerning the evolution of a specialty which should enable multidisciplinary care in the community to be led by the doctor who is in an ideal situation to do so — the general practitioner.

For too long death has been 'medicalized', doctors having taken over what was the job of clergymen in Victorian times, thus largely protecting the public from death. When caring for the dying we can become engrossed in the science of symptom control, neglecting the other essential factors necessary for good care, particularly communication. Failure here reveals our inadequacy in the face of death and without an open and honest approach the patient is sent away from home where he may prefer to be if he knew what was wrong and what prognosis he had. Unnecessary hospital admissions, which drain hospital beds, could be avoided with benefit to the patients and to their quality of life. It is the general practitioner who

usually knows the patient and his family best and therefore is likely to have the best rapport with them. He should use this to his advantage, reversing the trend for death to be hidden in hospitals, and helping death to be once again a 'family affair'.

General practitioners should not be perturbed by the evolution of this new specialty, but stimulated to fulfil their role as family doctors from birth to death, allowing their patients to die peacefully and with dignity, without hospice care unless it is required.

The aim of developing palliative care then should be not so much to encourage an increase in the number of hospices, as to promote a specialty enabling community care by the general practitioner at home. The essence of the problem is not so much the need for a specialist with a place where he can care for the dying but coordination of a multidisciplinary team<sup>2</sup> with the general practitioner as leader.

It is important that the new specialty aims to improve general practitioner care for dying patients at home through research and education, thus attempting to avoid care in an institution. This does not mean that there needs to be evidence of certified experience for general practitioners in the field or the gaining of yet another diploma; but recognition that, as Pugsley describes,<sup>3</sup> there are many who can advise the general practitioner in this role, but none who can perform the task better or with a greater insight into the patient and his family.

The hospice movement is of course essential and to be highly commended. Its main role should be advisory, for education and research and to help in the management of difficult cases.

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#### References

1. Bowling A. The hospitalisation of death: should more people die at home? *J Med Ethics* 1983; 9: 158-161.
2. Wilkes E. Terminal care: how can we do better? *J R Coll Physicians Lond* 1986; 20: 216-218.
3. Pugsley R, Pardoe J. The specialist contribution to the care of the terminally ill patient: support or substitution? *J R Coll Gen Pract* 1986; 36: 347-348.

## GPs should not counsel long-term

Sir,

As a general practitioner who is also a trained counsellor, I was most interested by Rowland and colleagues' discussion paper (March *Journal*, p.118).

I have recently been reviewing my work as a general practitioner in the context of the doctor-patient relationship and the client-counsellor relationship and have concluded that it is both difficult and inappropriate for a general practitioner to have a long-term counselling relationship with a patient. Seeing someone for more than one or two counselling sessions outside normal surgery hours fundamentally alters the doctor-patient relationship and it may not be possible for the patient to allow the general practitioner counsellor to continue in the general practitioner role. This conclusion is supported by Kelleher<sup>1</sup> who feels that the general practitioner counsellor may overstep the boundaries of the doctor-patient relationship and confuse the patient.

My answer to the question 'Can general practitioners counsel?' is in two parts. First, counselling skills are an essential tool in the repertoire of all general practitioners for routine work and for short term counselling interventions. These skills need to be taught to doctors at all levels in their training, particularly in the light of the suggestion that 'prescribing anxiolytic drugs (is) no more effective than brief counselling by the general practitioner in treating new episodes of minor affective disorder'.<sup>2</sup> Secondly, longer term counselling is best undertaken with clear personal boundaries in a confidential and anonymous relationship by a 'secure frame'<sup>1</sup> counsellor who lives away from the locality, is not involved in a long term (often literally a lifetime) relationship with the client and who does not allow the counselling process to be compromised by any other relationship.

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#### References

1. Kelleher D. The GP as counsellor: an examination of counselling by general practitioners. In: British Psychological Society. *Counselling psychology section review* (volume 4). 1989; 7-13.
2. Catalan J, Gath DH. Benzodiazepines in general practice: time for a decision. *Br Med J* 1985; 290: 1374-1376.

## Importance of legible prescriptions

Sir,

The serious consequences of negligently writing medical prescriptions have been re-emphasized by the court of appeal in the recent case of Prendergast versus Sam and Dee Limited and others. Dr Stuart Miller had written a prescription for Mr