Snowballing hypothermia alert system or rural noseyness?
S.G. Barber and A. Brown 518

Classification of psychosocial disturbances in general practice
Jeremy M.D. Swayne; G.A. Rutt 518

Adverse effects of screening
James A.D. Finlayson 519

Treatment of asthma
Christine E. Bucknall 519

The exceptional potential of the consultation revisited
Nigel Stott 520

Audit projects for medical students
John Spencer, et al. 520

Core data for practice annual reports
M.G. Dornan 520

Continuing medical education
Alan Searle 520

Torture of prisoners
Norman Levy 521

New contract
T. Richardson 521

Future of the College
John Fry 522

What happens in hospices
Peter Barlow 522

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Snowballing hypothermia alert system or rural noseyness?

Sir,
Hypothermia caused 516 deaths in England and Wales in 1985 (OPCS, personal communication). Many deaths occur in people with identifiable risk factors such as chronic illness, immobility, social isolation and drug problems (including alcohol).

In a recent survey, we have investigated the feasibility of introducing an alert system and assessed its appropriateness to a rural general practice of 6000 patients scattered over 300 square miles in central Devon. The system is initiated by a Meteorological Office forecast of particularly inclement weather which is transmitted to a clerical officer who would telephone a small number of volunteers who in turn would contact further volunteers in a 'snowballing' fashion. These volunteers would visit and offer help to those previously identified by the primary health care team as being 'at risk' of hypothermia. Local figures show that 75% of cases of hypothermia are among patients aged 80 years or over (unpublished results).

This age group of patients was identified from the practice age–sex register and of the 225 people 96% were known personally to at least one member of the practice team. Those considered to be potentially at risk and all of the 4% not known personally were visited by a general practitioner and their circumstances reviewed. Only one of the latter group was considered to be 'at risk' and she was one of five who had not seen a doctor in the previous year — the 10 other patients were either well supported (five) or fit and well (five).

In the entire survey group 28 patients were considered to be potentially 'at risk'. Eighteen of these patients had informal support systems, ranging from knocking on walls, a baby alarm connected through to a neighbours' house and arrangements with neighbours to investigate if milk bottles were not taken in by a certain time, to one lady who spends her winters abroad. Ten patients remained at considerable risk. One is about to move into residential care, four have been referred for a community telephone alarm, two have accepted visits from a neighbour or the British Legion during cold weather and three declined all offers of help.

This suggests that in a stable, rural community, current awareness of the need to support older and frailer members of the community is virtually sufficient to produce a spontaneous system of care. It is noteworthy that those individuals who were less well supported all lived in the same locality and such patchy distribution may occur in other practices. It is not known whether such intensive neighbourhood support occurs in urban areas but it seems likely that stability of the population is more important than its density. The survey included only patients aged 80 years and over. Hypothermia is not the exclusive prerogative of this group and the risks for younger age groups need to be remembered. However, awareness of hypothermia risk for the elderly would appear to be good in rural areas and is possibly best supplemented by general practitioners actively considering this aspect of care for particularly vulnerable patients.

S.G. Barber
A. Brown

North Devon District Hospital
Raleigh Park
Barnstaple
Devon EX31 4JB

Classification of psychosocial disturbances in general practice

Sir,
The editorial by Sharp and King (September *Journal,* p.356) highlights an important area in the thinking of general practitioners about psychosocial disturbance. I use the word 'thinking' because the editorial also raises the question of the role and value of classifications in the day to day management of patients' problems. A classification must help doctors to think about these problems and not force their thoughts to conform to the pattern and presuppositions of the classification. It must be flexible and versatile. It must allow, and indeed encourage a process of discovery which enhances knowledge and understanding of the problem and it must allow the practitioner to put together accurately the pieces which compose the jigsaw puzzle of the individual problem. Research and analysis — the definition of common categories of problem with common denominators — can then take place retrospectively, on the basis of what actually happened and was recorded, and formal diagnostic descriptions and management plans can be developed. These in turn can be tested by the collection of new evidence, and modified accordingly.

A distinction must be made between a classification which accommodates information in a non-preemptive way, making it freely available for us to learn from by induction, and one based on a certain doctrine which confines the learning process within the limits of that point of view.

The ideal is to make a classification sufficiently flexible and versatile to avoid the disadvantages of labels that are self-fulfilling, inadequate or inappropriate, while retaining their advantages — the more formal 'scaffolding' of diagnostic terms which we all use to structure, manage and communicate a problem. This is what the Read classification[1,2] sets out to do in the new edition being prepared for publication. Its purpose is to 'emcompass ... the multiaxial classification which is required in psychosocial disorders'. This is made possible largely by the versatility of the new chapter one dealing with case study, history, and symptomatology. It should, for example, be possible to classify and code this statement: 'Mr A has Alzheimers disease and is unable to dress without help. He is violent towards his wife when she helps him to dress, but the community psychiatric nurse observes that this is because she treats him like a baby when doing so'. The nomenclature aims to pro-