and not distended, and there was a large inflamed, tender irreducible umbilical hernia. A diagnosis of strangulated umbilical hernia was made.

At operation a small hernial sac containing gangrenous omentum was found; loops of bowel appeared normal. The omentum and infected skin were resected and the umbilicus reconstructed. The child's recovery was uneventful and he was discharged the following day.

A search of the literature revealed only 11 children with strangulated umbilical hernia in total worldwide,[2-11] despite umbilical hernia being an extremely common condition. Among the 11 reported cases, delay in presentation was common ranging from 21 hours to nine days. In this case, delay while awaiting an urgent clinic appointment was associated with the need to excise infected skin and gangrenous omentum. Unlike inguinal and femoral hernias, the majority of umbilical hernias in children will disappear completely with increasing age. Thus, the present policy of expectant management should continue.

Parents often seek and receive reassurance early on when the large size of the hernia is causing them alarm. One could postulate, however, that the risk of strangulation will occur much later, when the hernial orifice is becoming smaller prior to complete closure. Parents should be instructed that in the unlikely event of the hernia becoming irreducible or painful, they should seek prompt medical attention. Primary care physicians should refer such cases to their surgical colleagues as emergencies, as with incarcerated hernias at any other site.

V RUDRAN

Bushey Health Centre
London Road
Bushey
Middlesex

R JONES

Ealing Hospital
Uxbridge Road
Southall
Middlesex

References

1. Wood GE. Some observations on umbilical hernia in infants. *Arch Dis Child* 1952; **28**: 450-462.
2. Miller RH. Umbilical hernia. *N Engl J Med* 1932; **206**: 389-391.
3. Haworth JC. Strangulation of umbilical hernia in children. *BMJ* 1957; **1**: 869.
4. Vyas ID. Strangulated umbilical hernia in a child. *Postgrad Med J* 1983; **59**: 794-795.
5. Hurlburt HJ, Moseley T. Incarcerated and strangulated umbilical hernia in infants and children. *J Fla Med Assoc* 1966; **53**: 504-506.
6. Chattergee H, Bhat SM. Incarcerated umbilical hernia in children. *J Indian Med Assoc* 1986; **84**: 238-239.
7. Jeans PL, Wright JE. Strangulated umbilical hernia in infancy. *Aust Paediatr J* 1984; **20**: 75.
8. Auldist AW, Lugg P. Strangulation of an umbilical hernia in a child of six months. *Aust Paediatr J* 1982; **18**: 286.
9. Peggs SP. Umbilical hernia: strangulation in a boy aged ten weeks. *Med J Aust* 1971; **1**: 92-93.
10. Mestral AL, Burns H. Incarcerated and strangulated umbilical hernias in infants and children. *Clin Pediatr (Phila)* 1963; **2**: 368-370.
11. Crump EP. Umbilical hernia. *J Pediatr* 1952; **40**: 214-223.

General practice and drug misuse

Sir,

The letter by George and Martin is to be welcomed (July *Journal*, p.302). General practitioners have always been in the front line with regard to the management of drug users and have regularly contributed to the debate on the care of drug abusers in the community.

The progress of the human immunodeficiency virus and the acquired immune deficiency syndrome has seen 'harm minimization' emerge as the primary role of the treatment of intravenous drug abusers.[1] The issue of prescribing for intravenous drug abusers is central to such an approach and has been strongly advocated in the recent Department of Health guidelines for doctors.[2]

We do, however, have some reservations regarding the methodology of George and Martins' survey and of the conclusions they draw from their data. A sample of general practitioners attending a seminar on drug abuse is likely to comprise those who would be more likely to have an interest in drug abusers and would therefore be favourably disposed to them. As a result, the sample may not be representative of all West Sussex general practitioners. We were surprised that injectable methadone seems to have been the focus of the authors' enquiries with regard to prescribing and that general practitioners were not asked about oral methadone. The Department of Health guidelines[2] recommend that 'straightforward elements' of care (an example of which is the prescribing of oral methadone) are to be taken on by 'any doctor', while 'more complicated interventions', such as the prescribing of injectable drugs, should be dealt with by doctors with 'relevant specialized training, expertise and back-up'. If such guidelines were to be followed, most general practitioners would not be expected to prescribe injectable drugs to intravenous drug abusers.

The authors feel their data present a 'more hopeful view' of shared care as some 60% of their sample were willing to engage in the management of intravenous drug abusers. However, even among this interested group of general practitioners, 40% implied no willingness to be involved, 21% would not accept a new patient with a history of drug abuse and 56% were unaware of any drug abusers on their lists. There is ample evidence that general practitioners find drug abusers a difficult patient group,[3,4] and that general practitioners are wary of prescribing for them.[5] We feel that it is likely that the results would have been less hopeful in a truly representative sample.

Recent work has shown how intravenous drug abusers can be cared for successfully in a general practice setting[5,6] and has highlighted the need for improved liaison between specialist drug treatment agencies and the general practitioner.[5,7] If 'harm minimization' is to become a reality, the general practitioner will have an increasingly important role to play. It is essential that general practitioners have a say in what functions they are prepared to fulfil and what support they will require from specialist agencies. This can only be achieved by canvassing the views of representative samples of general practitioners in different geographical areas.

BRIAN A KIDD
GEORGE E RALSTON

Southern General Hospital Drug Project
1345 Govan Road
Glasgow G51 4TF

References

1. Cooper JR. Methadone treatment and AIDS. *JAMA* 1989; **262**: 1664-1668.
2. Department of Health Medical Working Group on Drug Misuse and Dependence. *Guidelines on clinical management*. London: HMSO, 1991.
3. McKeganey N. Shadowland: general practitioners and the treatment of opiate abusing patients. *Br J Addict* 1988; **83**: 373-386.
4. Greenwood J. Unpopular patients. GPs' attitudes to drug users. *Druglink* 1992; July/August: 8-10.
5. Greenwood J. Persuading general practitioners to prescribe. *Br J Addict* 1992; **87**: 567-575.
6. Cohen J, Schamroth A, Nazareth I, *et al.* Problem drug use in a central London general practice. *BMJ* 1992; **304**: 1158-1160.
7. Rozewicz L, Caan W, Johns A. Managing drug misuse in general practice. *BMJ* 1992; **304**: 1442.

Sir,

I read with great interest the article by Ronald and colleagues on their practice's response to the local problem of drug misuse (June *Journal*, p.232). This is a topical issue, another practice with a large population of drug misusers having also reported its findings recently.[1]

There are interesting differences in the approaches reported by the two practices and my own which, presumably reflect the attitudes of the doctors involved and the

local resources. As a single-handed general practitioner with 2100 patients, of whom at least 100 have serious chemical dependence, I work closely with the local statutory and voluntary drug counselling agencies to provide care for this group. There seems to be little practical information about how general practitioners should manage large numbers of drug addicts coming to their surgery for primary care and for help with their dependence.

Perhaps it would be useful if those practices which have experience of between 50 and 100 chemically dependent patients at any one time on their list could pool their combined experience. With the Royal College of General Practitioners acting as facilitator a forum could be established enabling this information to be available to a wider audience. I would, of course, be pleased to hear directly from any other practices involved in this sort of work.

H M CAMPBELL

Freedom Health Centre
78 Lipson Road
Plymouth PL4 8RH

Reference

1. Cohen J, Schamroth A, Nazareth I, *et al.* Problem of drug use in central London general practice. *BMJ* 1992; **304:** 1158-1160.

Sir,

The article by Ronald and colleagues on the problems of drug abuse, human immunodeficiency virus (HIV) infection and the acquired immune deficiency syndrome (AIDS) (June *Journal,* p.232), highlights that much of the responsibility for therapeutic care and ongoing support for individuals and families with these problems now lies with primary health care facilities and in particular with the general practitioner and the primary health care team.

The team with its individual skills is potentially ideally suited for this work, but recognition of the need for increased resources for primary care is vital if an already stretched workforce is not to become overwhelmed. It seems to us that it is often small inner city practices with limited resources and personnel who are struggling to cope with the highest workload. The potential not only for therapeutic input but for health promotion and harm minimization is great, in liaison with other community agencies, but this will not be achieved without additional help. Essential to the general practitioner is the provision of adequate back-up specialist secondary care agencies for referral, advice and support. The provision in some areas is still patchy and variable.[1]

General practitioners often feel they have inadequate knowledge to cope confidently with the problems associated with addictive behaviour.[2] The subject is noticeably underrepresented in most undergraduate curricula. Recognizing this, the department of addictive behaviour at St George's Hospital Medical School in London has for the past eight years given priority to a comprehensive training package for general practitioners. The one year diploma course covers the range of substances and behaviours involved in addictions, including gambling, eating disorders and smoking cessation. The course offers theoretical training and education in clinical management skills and basic audit and research skills. Emphasis is placed on strategies for use within general practice by regular discussion of cases from the participants' own practices. The course is now linked to a new multidisciplinary diploma course for other professionals working in the field, thus providing an opportunity to explore and develop wider perspectives on primary health care strategies.

In addition, a special interest group for general practitioners, the SIGMA group, has recently been established at the medical school. The group meets quarterly and provides a forum for information, discussion, research and support, and any general practitioner with an interest in addictive behaviour is welcome to join.

MARGARET BIRTWISTLE
MARI OTTRIDGE

Department of Mental Health Sciences
St George's Hospital Medical School
Jenner Wing, Cranmer Terrace
London SW17 0RE

References

1. Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation.* London: HMSO, 1982.
2. Ghodse AH. *Drugs and addictive behaviour: a guide to treatment.* Oxford: Blackwell Scientific, 1989.

Patient-centred doctors

Sir,

I was interested to read the article by Howie and colleagues relating doctors' attitudes about patient care to their levels of stress (May *Journal,* p.181). I am concerned, however, about the use of the term 'patient-centred doctors'.

The description 'patient-centred' is generally assumed to apply to consulting styles or clinical methods in which the doctor pays particular attention to understanding the patient's expectations, feelings and fears.[1,2] Operational definitions have been described and used, enabling consultations to be classified as patient- or doctor-centred.[1,3,4] Of particular interest is the positive association between patient-centred consultations and their outcomes.[5]

Howie's team used the instrument designed by Cockburn and colleagues[6] to classify doctors as patient-centred or not. As far as I am aware, the scale has not been validated in terms of showing that those with patient-centred attitudes also perform in a patient-centred manner. The difference between what doctors say they would do and what they actually do has already been described.[7] It seems that there is not yet sufficient evidence to describe those with patient-centred attitudes as 'patient-centred doctors' and the implications in terms of outcomes are important to our discipline.

P KINNERSLEY

Department of General Practice
University of Wales College of Medicine
Health Centre
Maelfa
Llanedeyrn
Cardiff CF3 7PN

References

1. Byrne PS, Long BEL. *Doctors talking to patients.* London: HMSO, 1976.
2. McWhinney IR. *A textbook of family medicine.* Oxford University Press, 1989.
3. Brown J, Stewart M, McCracken E, *et al.* The patient-centred clinical method. 2: Definition and application. *Fam Pract* 1986; **3:** 75-79.
4. Henbest RJ, Stewart MA. Patient-centredness in the consultation. 1: A method for measurement. *Fam Pract* 1989; **6:** 249-254.
5. Henbest RJ, Stewart MA. Patient-centredness in the consultation. 2: Does it really make a difference? *Fam Pract* 1990; **7:** 28-33.
6. Cockburn J, Killer D, Campbell E, Sanson-Fisher RW. Measuring general practitioners' attitudes towards medical care. *Fam Pract* 1987; **4:** 192-199.
7. Rethans JJE, van Boven CPA. Simulated patients in general practice: a different look at the consultation. *BMJ* 1987; **294:** 809-812.

The importance of the generalist

Sir,

The editorial (June *Journal,* p.222) by His Royal Highness The Prince of Wales, president of the Royal College of General Practitioners, provides excellent advice to members of the College, reminding us to be generalists not multi-specialists.

Much of the message of the editorial resembles the important lessons which medical practitioners have derived from Balint groups.[1-3] The Balint movement, which originated in the United Kingdom and is devoted to patient-centred