alents per day. Of the 119 patients, 41 (34%) were receiving additional psychotropic medication.

Depot medication should not be regarded as a fixed prescription for life; patients should be reviewed regularly to ensure that they receive the lowest possible dose to prevent relapse, and to minimize the frequency of side effects, particularly tardive dyskinesia.[2] While regular assessments of mental state and adjustments to dosage can be undertaken in a general practice clinic, more major interventions such as a trial of a recently developed drug, or cessation of depot medication, would usually require advice from a psychiatrist. In this study four of the 14 general practice patients (29%) had not been reviewed by a psychiatrist during the previous two years.

In our study, the results suggest a steadily increasing number of patients have received depot medication since its introduction 20 years ago, and as community psychiatric clinics become overcrowded, more patients may choose, or will be referred back to, their general practitioner. The development of a more organized system of shared care should be encouraged. Ideally such a system would allow patients freedom to choose which clinic to attend, would increase communication between professionals and would ensure that patients are not lost to follow up. A cooperation card as used in antenatal care would be useful for those patients attending several clinics (including accident and emergency departments) and would be particularly helpful with regard to other psychotropic medication that had been prescribed. Regular psychiatric review could be organized by means of confidential local registers of patients receiving depot medication. There remain practical difficulties to be overcome but every effort should be made to optimize the long term care of this vulnerable group of patients.

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Emergency contraception

Sir,

I was interested to read the two letters about emergency contraception (September *Journal,* p.394). In February 1992 a study was carried out to examine how general practices in Norfolk educated their patients about emergency contraception.

A questionnaire containing four questions was sent to all 138 practices in the Norfolk family health services authority area. The questionnaires, containing closed questions and addressed to one partner in each practice, were sent by post and collected via the family health services authority post. The questionnaires were returned anonymously and the data analysed.

Responses were received from 101 practices (73%). All the practices had had patients presenting for emergency contraception. Only 14% of practices displayed a poster about it somewhere in the surgery. Of those practices which did, 10 displayed a poster in the waiting room, six in the nurse's consulting room, three in the doctor's consulting room, three in all toilets, one in the women's toilet and one in the men's toilet.

Thirty eight doctors routinely mentioned emergency contraception when giving contraceptive advice to a patient for the first time.

A study of 88 women attending an abortion service in Tower Hamlets showed that nearly half would have been suitable for emergency contraception, and 80% said that they would have used it if they had known about it.[1]

Accepting that there is a need for emergency contraception, both after unprotected intercourse or contraceptive failure, there are several approaches to improve its uptake. Education, both in schools and the media, is important.[2,3] There should be open access and in rural areas such as Norfolk this may mean the general practitioner playing a major role.

It is disappointing that so few general practitioners in this study had a poster on display. This is even less than the results of the Tower Hamlets study, where one third of general practitioners had information about postcoital contraception available for their patients.[4] Another opportunity to mention emergency contraception is when clients first present for contraceptive advice, but only 38% of general practitioners did so.

Finally, perhaps information should be available to men as well as women, since men are jointly responsible, and may be the partner to identify condom failure.

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Health promotion: time for a new philosophy?

Sir,

We should like to answer Domhnall MacAuley's criticisms (letters, October *Journal,* p.443) of our editorial.[1] MacAuley states that health promotion should be 'integrated into medical care', and 'should remain an important component of the consultation'. We take issue on two grounds: it is our belief that the principal concern of clinical medicine must be the management of illness and disease, not the promotion of health,[2] and the kinds of social–psychological interventions required for behaviour and lifestyle change are fundamentally different to those of medical intervention.[3]

There is little enough time in the average general practitioner consultation to deal adequately with the patient's presenting complaint. To further reduce this time by giving health advice seems reckless, especially if unaccompanied by an appropriate behaviour change technology (the gap between providing information and actual behavioural change must be bridged using appropriate models from social science.[1]) Health promotion as a routine component of the consultation is also likely to prove unpopular with patients, who may (with justification) resent being nagged about their personal habits when they have come to a doctor because they are sick. Furthermore, there is good evidence to suggest that lay people are already aware of the important facts about lifestyle 'risks' to health, and therefore that repeating the same information is unlikely to modify behaviour[4] and potentially produces a population of worried well people.

In contrast to MacAuley, and also to the general philosophy underlying the new general practitioner contact, we anticipate serious problems in integrating health promotion with general practice. The general practice consultation ought, surely, to be oriented towards existing illness, whether presented explicitly or implicitly. The major duty of a general practitioner is thus to react appropriately to a patient's actual problems. Proactive interventions such as