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.

R WESBY
J EARLE
E BULLMORE
A HEAVEY

The Three Bridges
Regional Secure Unit, St Bernards Wing
Ealing Hospital, Middlesex UB1 3EU

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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.

C A HUGHES

Rivendell
Malthouse Court
Thornham
Norfolk PE36 4NW

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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

health checks, screening for early disease, and unsolicited advice ought to take second place, and only then if underpinned by proper sociological and psychological techniques.

BRUCE CHARLTON

Division of Epidemiology and Public Health
University of Newcastle upon Tyne
Newcastle upon Tyne NE2 4HH

MICHAEL P KELLY

School of Social Sciences
University of Greenwich
London SE18 6PF

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Health care needs assessment

Sir,

I am writing in response to Gillam's thought provoking editorial on the general practitioner's contribution to health care needs assessment (October *Journal*, p.404) and agree that a more coherent approach is needed.

First, a working definition of need must be reached. It seems most useful to define need as a capacity to benefit. Therefore if a person cannot benefit from a treatment or service they do not need it.[1]

Secondly, a distinction has to be drawn between assessing primary and secondary health care needs. District health authorities and purchasing consortia, along with the Department of Health, are attempting to assess needs for secondary health care, mainly by using the approaches outlined in the National Health Service Management Executive's discussion paper on needs assessment.[1] This is involving large amounts of work in determining the incidence and prevalence of disease and the effectiveness of treatment options. The conclusions reached are being used to influence purchasing decisions. However, general practitioner fundholders operate outside this system. If general practitioners are purchasing care without information on incidence and prevalence of disease or effectiveness of treatment options, how can they hope to improve the health of their practice population or use their budgets efficiently? Communication between district health authorities or purchasing consortia and fundholders must ensure the sharing of such information, especially as district health authorities are purchasing for dwindling populations. Fundholders must resist the temptation to purchase services or treatments whose effectiveness has not been adequately evaluated.

Thirdly, there is the issue of primary health care needs assessment. Increasing numbers of district health authorities and family health services authorities are providing information at a practice level for practice based needs assessment. Caution must be exercised in using such information. Even in large practices the number of people dying from common conditions will be small, consequently the confidence intervals around standardized mortality rates will be wide. Seemingly high standardized mortality rates may, in reality, not be statistically significant. If this point is not understood resources may be directed inappropriately.

While I agree with Gillam's assertion that numeracy and awareness of local services, negotiating skills and common sense are important in needs assessment, the most important key to the process, communication, seems to have been overlooked. Excellent communication between district health authorities or purchasing consortia and local practices will be needed regarding incidence and prevalence of disease and effectiveness of services, as well as information on appropriate methods of needs assessment at a practice level and the appropriate interpretation of data.

DENISE KENDRICK

Department of Public Health Medicine and Epidemiology
University of Nottingham
Queen's Medical Centre
Nottingham NG7 2UH

Reference

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X-rays and pregnant women

Sir,

Dr Edoman describes the case of a young pregnant woman sustaining a fracture of the radial head and being denied radiological examination (letters, October *Journal*, p.440).

Dr Edoman's report raises two points. First, since the treatment of a radial head fracture is simply to rest the arm in a sling and gradually mobilize the elbow as symptoms permit, this patient was not managed wholly inappropriately. In the rare event of complications, which would be diagnosed clinically and not radiologically, excision of the radial head is the preferred treatment and this should not be done until two or three months after the original injury because of the risk of myositis ossificans.

Secondly, this patient could have been spared a great deal of unnecessary pain and anxiety if someone had said to her that it was quite likely that she had a fracture of the radial head, it did not need an x-ray but that she would need to be kept under review to make sure no complications arose and that if they did, they would be treated appropriately. This poor woman was clearly the victim of a collusion of anonymity compounded by radiological uncertainty.

P G WEAVING

The Surgery
Brampton
Cumbria CA8 1NL

Flourishing or floundering in the 1990s

Sir,

I read with great interest the stimulating editorial by Geoffrey Marsh.[1] He described the sweeping changes imminent in general practice, and foresaw large community health centres covering the widest aspects of primary health care, in which the general practitioner was the central coordinator. As would be expected, the article was argued persuasively and was well supported by references. I have no doubt it is a reasonable forecast of what our health planners have in mind and Marsh has done a signal service in drawing our attention to this prospect.

One omission seemed strange — the word 'consultation' was mentioned only once and almost incidentally. It is clear that with all the other duties mentioned consultation has been given a low priority in this vision of the future. Perhaps Marsh will recall a famous saying of one of his most distinguished teachers: 'The essential unit of medical practice is the occasion when a patient who is ill or thinks he is ill seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it'.[2] Nor has time altered the truth of this aphorism. In 1984 Pendleton and colleagues stated 'The consultation is the central act of medicine. To doctor and patient alike the general practice consultation is the medium through which medicine is most frequently practised'.[3]

Recently Stuart Carne, lately president of the Royal College of General Practitioners, referred to the 1980s as the golden