slight tenderness over the right hip, but no abnormality of the back was detected. Pelvic pathology was suspected and radiology of the pelvis confirmed this, showing a large lytic area extending from the ilium through the acetabulum into the upper posterior part of the ischium. She received palliative radiotherapy to the right acetabulum for pain relief and was discharged home a few days later free of pain and mobile. She died six weeks later at home having had no recurrence of this problem.

In the second case a 70-year-old woman with bronchial carcinoma was referred to the hospice for assessment. Shortly after admission she developed left thigh pain associated with a deterioration in mobility. Pelvic disease was suspected and radiology of the pelvis showed extensive erosion of the medial aspect of the left ilium and a lytic area within the inferior pubic rami, consistent with metastatic disease. She received palliative radiotherapy to the left side of the pelvis with marked symptomatic improvement and was discharged home where she lived independently until shortly before her death one month later.

In the third case a 71-year-old man with bladder carcinoma was admitted to the hospice with rapidly deteriorating mobility owing to pain in his right knee and lower medial thigh. The pain was precipitated by movement. Prior to admission he had been able to walk and dance despite a mild right hemiparesis following a stroke 18 years previously. Examination of the knee, hip and back revealed no obvious abnormality. General examination revealed a mild residual right hemiparesis. Radiology of the knee and femur was normal; however pelvic x-ray showed bony destruction of the right acetabulum consistent with metastatic disease. Palliative radiotherapy to the metastases was planned with the aim of pain relief and restoration of mobility. However, his general condition deteriorated and he died before this could be carried out.

In these cases, pelvic metastatic disease presented as referred pain to the knee in two patients and to the thigh in one patient. Recognition of this promoted palliative radiotherapy which was effective in alleviating pain and restoring mobility to two of the patients, allowing them to return home. This was clearly worthwhile, producing improvement in their quality of life even though their prognosis was limited.

It is essential to consider the possibility of more distant disease and to examine and x-ray the hip and lower spine when patients present with knee or thigh pain, especially if they have no obvious local abnormality. As we have shown, this has important therapeutic implications.

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Reaccreditation

Sir,

Reaccreditation is being considered by general practice leaders at present, but may not be popular among trainees. These motivated young professionals, coming to the end of formative and summative assessment programmes are preparing to enter general practice at a time where change and uncertainty are the only certainties. Could reaccreditation be made more acceptable to them by employing the Leicester assessment package (March *Journal,* p.109), thereby building on their newly acquired (and all too well tested) skills?

Stanley and Al-Shehri highlight the difficulties encountered in the 'how' question of reaccreditation.[1] They are rightly uncertain about measuring competence; measurement of performance against a guideline comprising the 39 separate competences of the Leicester assessment package would be reassuring and would form a suitable benchmark, especially as its face validity has been established. If utilized with video recordings of doctors' consultations in a surgery, such a package would blend seamlessly into Stanley and colleagues' model of experiential learning.[2]

England's chief medical officer is keen for the profession to take responsibility for its self regulation.[3] I hope someone will direct the chief medical officer towards the Leicester assessment package which offers great potential as a tool which will be acceptable to, and feasible for the reaccreditation of, all general practitioners, but especially to the decreasing numbers of trainee general practitioners when upgrading to principal status.

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Counselling in general practice

Sir,

I was interested in the comments expressed in the editorial by Salinsky and Jenkins (May *Journal*, p.194) and in the work of King and colleagues (p.229).

It is good practice to refer to counsellors those patients who may have, for example, marriage difficulties or drug-related problems, because they will receive both specialized and well-informed help and advice. However, my work on the 'heartsink' issue in general practice suggests that general practitioners may often use counsellors for the wrong reasons, and that the issues associated with the difficulties in providing health care have not been confronted. For many reasons heartsink relates to a relationship problem between a general practitioner and a patient, and the patients involved do not necessarily have psychiatric morbidity, social problems or a family or life crisis.[1,2] General practitioners, particularly those new to practice, have accepted that limitations in their medical training, their own stress and tiredness, and clinical uncertainty are an important part of the problem.[3,4]

These findings have important implications for the future of counselling in general practice. First, the problems associated with heartsink cannot be passed to a third party. Balint's concept of the 'collusion of anonymity' would once again raise its ugly head,[5] and furthermore, more questions than answers would arise. Is it correct to assume that counsellors will not face the same problems? What happens when counselling fails? Would some