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

patients be affronted and surprised by such a referral?

Secondly, if the current levels of general practitioner stress, tiredness, uncertainty and workload were genuinely reduced then counselling could be performed by those who would be best suited to carry it out. General practitioners should vigorously defend their traditional and unique position as family friend and adviser.

Thirdly, it is encouraging to find practitioners acknowledging their weaknesses.[3] But these self-perceptions are often guarded observations and the resulting desire to increase the emphasis on counselling is too apologetic. This only serves to deflect attention away from the deficiencies of a budget-based health system and the shortcomings in medical training, and fails to question whether current clinical methods are appropriate in the health care of the 1990s.

Salinsky and Jenkins and King and colleagues once again open the debate that Balint introduced nearly 40 years ago.[5] Since then, general practice has discussed such diverse concepts as hypochondriasis, somatization, various illness and health behaviour models, heartsink, and now counselling. However, I am not sure whether general practice has ever been willing to discuss those aspects of these issues that are most pertinent and most uncomfortable.

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Sir,
The editorial by Salinsky and Jenkins (May *Journal,* p.194) provides an upbeat positive message: 'the future for counselling in general practice looks bright'. However, the paper by King and colleagues (p.229) ends: 'Within the limitations of our current knowledge, only controlled evaluations will provide the unbiased assessment needed for the evaluation of counselling.'

The flavour of the editorial is that of the biased believer and the message is delivered with broad generalizations: 'there will always be a considerable number of patients for whom this [a sensitive doctor with communication skills] will not be enough' and 'the demand for counselling and the appreciation of its presence by the consumer is such that patients and practices are not content to wait for a definitive answer as to whether it works.' Unfortunately, this consumer-led approach to treatment reflects poorly on the credibility of academic general practice.

King and colleagues conclude that a controlled trial is feasible. Their article represents the more enduring and appealing approach to the subject of counselling. The editorial is an example of a worrying trend whereby research-led policy is regarded with suspicion if it runs counter to popular opinion. The political and financial implications of this attitude are profound.

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Sir,
King and colleagues are to be congratulated on their paper on counselling (May *Journal,* p.229) despite the small number of patients involved in the study, difficulties in randomization and a negative result. The authors make several valid points about the importance of such trials, and how they could be improved. However, the editorial by Salinsky and Jenkins (May *Journal,* p.194), did not show the same balance. It glossed over the issue of cost, not only the direct cost of counsellors, but also the cost of the supervision they are expected to have, plus the opportunity costs of employing a counsellor instead of offering other services.

A more fundamental problem, mentioned in the editorial, only to be dismissed, is the evidence for the effectiveness of counselling. King and colleagues referred to 10 published research papers all of which had serious methodological flaws or a negative result. If their paper is added to this list, it is clear that counselling is, at best, unproven. Much of the benefit accrues to the general practitioner, in helping with the burden of the stressed, and stressful, patient. This must be acknowledged, because use of a counsellor may not be the best solution to this problem.

Nor is counselling without its hazards. Two of the 24 patients in King and colleagues' study wished they had never started therapy, and a third had difficulty in cessation. If counselling were a drug, of unproven efficacy, with almost 10% of patients suffering side effects, some becoming addicted, and costing over £100 for a course (6.6 hours of counsellor time), the Committee for Safety of Medicines would be unlikely to give a licence. We should not passively accept that the growth of counselling must continue. Our *caritas* must be *cum scientia.*

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Referral for x-ray

Sir,
When a patient presents with a perceived physical complaint and feels that radiography will help to allay his or her fears regarding this complaint, I am sometimes tempted to request radiography, knowing full well that the likely result is going to be negative. However, this may well be of considerable benefit in terms of reduced anxiety, improved perception of health and fewer consultations on the part of the patient, and less prescribing by the doctor. Indeed, the financial benefits may well outweigh the costs of an x-ray.

While accepting the detrimental aspects of such behaviour, especially reinforcing the inappropriate use of investigations and the danger from unnecessary radiation, the balance still may swing in favour of requesting the x-ray. Hence, on rare occasions I believe there is a strong case for 'therapeutic' x-rays.

Referrals for such x-rays, which I suspect occur far more frequently than most doctors would care to admit, quite clearly fall outside the Royal College of Radiologists' guidelines,[1] and therefore will also fall outside any way of examining the impact of these guidelines on general practitioners, as described by Oakeshott and colleagues (May *Journal,* p.197).

This is an issue which both the Royal College of Radiologists and the Royal College of General Practitioners may care to look at in more detail.

R D NEAL