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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References

1. O'Dowd TC. Five years of heartsink patients in general practice. *BMJ* 1988; **297:** 528-530.
2. McDonald PS, O'Dowd TC. The heartsink patient: a preliminary study. *Fam Pract* 1991; **8:** 112-116.
3. McDonald PS. *The heartsink problem in general practice (PhD thesis).* Nottingham: Department of General Practice, University of Nottingham, 1993.
4. McDonald PS. Stress and doctors [letter]. *Br J Gen Pract* 1993; **43:** 263.
5. Balint M. *The doctor, his patient and the illness.* 2nd edition. Bath: Pitman, 1964.

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