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.

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Reference

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Diastasis of the pubic symphysis

Sir,

In 1991, Scriven and colleagues noted that diastasis of the pubic symphysis was a 'serious and underdiagnosed obstetric problem'.[1] Over the past four years the Royal Berkshire Hospital in Reading has seen a marked increase in the incidence of diastasis of the pubic symphysis, both antenatally and postnatally. Over the period 1989–91 15 severe, postnatal, previously undiagnosed cases were seen. In 1993 51 cases were referred antenatally with symptoms of varying severity. As a result, my colleagues and I are carrying out a retrospective study of all cases seen at the Royal Berkshire Hospital since 1989.

Women present with inability to weight bear owing to severe supra-pubic and groin pain. They complain of inability to turn in bed or to perform any movement which involves hip abduction, and there is marked tenderness on palpation over the pubic symphysis.

Following a recent article on the health page of a women's magazine, in which my name was quoted, I have received over 100 letters and telephone calls from women all over the country, who are either currently suffering from this excruciatingly painful condition or have done so in the past. All told the same story: having met with a lack of sympathy, a lack of understanding and a lack of knowledge by the medical profession. Many women spoke of long-term morbidity — months even years of pain, the inability to walk any distance, and/or monthly premenstrual recurrence of symptoms.

At present there is debate whether multiparity increases the likelihood of this condition; it has been noted that gross pelvic instability may be more likely to occur in the second pregnancy.[2] There appears to be no correlation with excessive birthweight, or overexercise. One women who contacted me was nulliparous, the symptoms occurring after miscarriage.

At the Royal Berkshire Hospital we recommend complete bed rest, minimal mobility with the use of elbow crutches if necessary, and avoidance of stairs until asymptomatic. It is worth noting that even with severe symptoms x-ray investigations taken immediately postnatally may show nothing of clinical significance.

Until we find the reason for the unexplained increase in this previously largely unrecognized condition, early diagnosis by general practitioners and midwives is essential. Referral to an obstetric physiotherapist for advice can be of great benefit. Highlighting the problem by good communication heightens the awareness of the obstetric team, thus leading to appropriate management at delivery (the left lateral position appears to be the optimum delivery position in severe cases) and long term morbidity may be avoided. Indeed, in our experience, with increased awareness by general practitioners (through correspondence and education of midwives) and consequent appropriate antenatal referrals to physiotherapy, then sympathetic management of labour, the incidence of diastasis of the pubic symphysis postpartum has decreased markedly.

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Reference

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Health checks for GPs

Sir,

There has been much recent concern about the health of doctors. Many are under stress.[1,2] All too few have had even the simplest of health checks, such as blood pressure measurement. Indeed, of all occupational groups, doctors may be the least well served. However, the solution is partly in our own hands. Some months ago my general practitioner wrote to me. 'Dear David', he wrote, 'I have been reading about the problem of stress and ill health in doctors, and have decided to write to all doctors registered with me to invite you to come for a health check.' I went along, had my hepatitis B immunity checked, and my blood pressure measured, and we discussed matters that can remain confidential to the doctor–patient relationship, for that is precisely what it was.

Subsequently I wrote to all the doctors registered with me. I made the same offer. Several came in. One turned out to be in real need of medical help, and said 'I just swallowed more and more self prescribed tablets and put up with it. If it hadn't been for your letter I wouldn't have come'. All replied, and all were grateful.

Why not make this into the most benign form of medical chain letter? Each of us should be registered with a general practitioner. I believe that we owe it to each other to offer this service. It takes little time, and even those who choose not to attend appreciate being asked. I would encourage every general practitioner to join this initiative today.

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Failed emergency contraception

Sir,

The clinical and scientific committee of the Faculty of Family Planning and Reproductive Health Care is compiling a register of infants born after failed postcoital hormones given as emergency contraception. We already have data on over 70 cases and would like more to compile a significant number. The object is to find out whether the hormones have any effect on the fetus.

I would be most grateful if doctors could let us know of any cases, past or present, and report them to the medical secretary at the address below.

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