and recording symptoms but difficulties were reported in: assessing indrawing of the ribs (14 of the 34 mothers had difficulty); noting the colour of the nails (nine mothers); recognizing an inguinal hernia (17); and measuring rectal temperature (11). Although Thornton and colleagues reported that familiarity with the check improved performance[3] this trend was not confirmed in our sample. Despite this, all mothers reported that the information booklet was easy to read, that the check was worthwhile and only four said they would not like to continue doing it.

There is little doubt that general practitioners and mothers alike would welcome the advent of a tool to grade the severity of a baby's illness. However, on the basis of our work, parents of low socioeconomic status would require further education in assessing physical signs in infants. Although the revised version of 'baby check' contains a photograph showing indrawing of the ribs, we agree with Kai that there is a need for explanation regarding recognition and significance of certain physical signs.[4] Kai also observed mothers' concerns about measurement of rectal temperature and, as found in our study, observed that many mothers substituted axillary temperature measurement despite its reported low sensitivity.[5] We conclude that 'baby check' was acceptable to a disadvantaged population but question whether the educational input required to achieve parental proficiency in its use would be feasible on a large scale.

Differentiation between minor and serious conditions in infants remains a worry for parents and general practitioners.

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Drug abuse and homelessness

Sir,

Patients with problems of drug abuse or homelessness are an everyday part of urban primary care but little has been written in the United Kingdom about the association between the two.

In the United States of America Herman and colleagues found that 46% of substance-addicted patients with mental illness in New York were homeless,[1] and Spinner and Leaf found that 45% of a sample of homeless people in Connecticut were abusing drugs.[2] In my practice in East London I have been treating 44 patients, mostly heroin users, on a long-term drug abuse management programme over the last four years. Of these patients, 17 (39%) are or have been homeless, which is in line with the work from the USA.[1,2] Social chaos, that is, the presence of two or more out of the following three factors: long-term unemployment, lack of a relationship with a non drug abusing person or erratic outbursts towards self or others, is a marker of problems relating to other people. Social chaos was present in 26 of the 44 drug abuse patients in my practice (59%).

It was considered that a clinical outcome had been reached where a patient had stopped using opiate drugs completely, had reached a maintenance dose of methadone with no further reductions in a 12-month period, or had left the prescribing programme before reaching one of these points. Patients were not included in the outcome data when, for example, they had only attended one appointment in the drug abuse management programme.

Thirty five patients have reached an outcome, 23 using the programme for positive change and 12 being unable to use the programme for positive change. There was a significant association between presence of social chaos and outcome. Of the 23 patients with a positive outcome, social chaos was present in eight, and of the 12 patients with a negative outcome, social chaos was present in 11 (Yates variant of the chi square test, $P<0.01$). No trend or association was found between homelessness and outcome. This runs counter to the conclusions of McCarthy and colleagues who consider housing provision to be essential in order to support and maintain recovery.[3]

Outcomes are hard to interpret, and the numbers reported here are small. However, these data may suggest that for drug abusers who are socially and psychologically damaged the need to form meaningful human interactions is even more fundamental than the need for a permanent address. If this is so, primary care methadone programmes should focus on the doctor–patient relationship as a key therapeutic tool.

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GPs and anaesthetists: do we 'gas' enough?

Sir,

I was a general practitioner before I became an anaesthetist. The jobs are not too different. In the community, general practitioners are the first to be contacted when there is a crisis. In the hospital this is the anaesthetist's role and not just when there is airway compromise or respiratory failure but whenever a patient is critically ill. We both put the presenting complaint into context and take account of all contributing factors. We both are required to make prompt diagnoses, to start immediate treatment and then to arrange definitive management and care. Our knowledge and expertise extends into the medical, surgical, paediatric and obstetric fields.

It is often said that doctors who dislike talking to their patients and colleagues train to be anaesthetists, but I write because I am concerned that we do not 'gas' (talk to each other) enough. Patients with anaesthetic risk factors known to their general practitioners sometimes present for anaesthesia and surgery without this information being communicated to the anaesthetist. During the six years that I have been a full-time anaesthetist I can recall only one occasion when I received a letter for a general practitioner; he warned me that his patient had developed hyperpyrexia following a previous anaesthetic, and I was grateful to have this information. Conversely, patients may be discharged from hospital with no mention in the discharge letter of an anaesthetic complication. This is probably because these letters are written by non-anaesthetists. Some of my anaesthetist colleagues have written to general practitioners when there have been specific problems (for example, hypersensitivity reactions, malignant