consultation skills, there may well be benefits for the patient both in terms of receiving appropriate treatment and as a result of the therapeutic value of the consultation.

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You can't mishear what is written

Sir,

The article by BH Smith and RJ Taylor (April *Journal*)[1] and the editorial by AF Wright (January *Journal*)[2] emphasize the importance of stories and writing as an integral part of general practice.

In Sheffield there is a continuing medical education course entitled 'Reflections in writing for general practitioners'. As one of the members wrote:

> It is easy for GPs to work in almost total professional isolation, even in a friendly partnership, and it can be hard to admit to mistakes, vulnerability, sadness and even occasionally joy. If you can commit some of these thoughts to paper, then not only can it be personally therapeutic, but by sharing with others you may bring insights that can strike a chord and be of benefit to others.[3]

Also in Sheffield, a pilot project, funded by the Royal College of General Practitioners, centres on therapeutic writing for patients with anxiety/depression. The benefits of such a project are expressed by Purdy:

> 'If only GPs who are so quick to prescribe instant tranquillisers to silence distress would suggest the cleansing therapy of putting pen to paper instead. It's healing in rejection, grief, heartache or despair. It can clear our heads when we're faced with choice and indecision. It doesn't make you fat, sick or wreck your liver. And since nobody can possibly know more about us than we know ourselves, [it's] infinitely superior to any psychiatrist.'[4]

Stories, with their beginning middle and end, and poetry, with its clean spareness, offer a structured form and a secure enough process for exploring and expressing both personal and professional material. Redrafting to hone the image to needle-sharpness can focus the writer's mind — an intensely self-educative process.

All this helps the practitioner 'recognise (and address) internal conflicts, frustrations and stress',[1] joys, laughter, and successes, and to share them with others. Another member of the CME group has said: 'Writing... is a ritual that I know will help me sort out and organize my feelings about the subject. The next stage is to bring the contribution to the group to share... and we have arrived at levels of intimacy that are indeed supportive.'[5]

The two Sheffield projects would be enriched by the experience of others. We are also planning to publish a book of doctor's stories, to inform the Health Service, medical students, and patients about the workings of general practice. Please send us writings, or information about your experiences.

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Predictive value of ultrasound in threatened miscarriage

Sir,

May I answer Dr Lindsay Smith's comments on our article on the above subject (January *Journal,* 1996). First, he complains that we do not quote the gestative age of the pregnancies when bleeding occurred. The data are available but we felt that they were of little practical or statistical importance because the overall loss in the viable pregnancies that looked normal at the first scan was only 2.7% (3/112). Supposing the range of loss was 0–5% depending on the gestational age, it would require a very large survey to show a significant difference at each different week. At the end of the investigation would it be of value (as he suggests) to 'practisicing GPs' if the loss did vary by this small amount?

Secondly, we did not use a Doppler (or a fetal stethoscope) to identify fetal viability as most of the pregnancies were earlier than the twelfth week, when a Doppler is only 73% reliable. A fetal stethoscope is not useful until the sixteenth to the twentieth week. Ultrasound, on the other hand, is dependable by the eighth or ninth week.

Thirdly, when we said that early arrangements could be made for for the care of those women with a non-viable pregnancy, we should have said 'earlier than if no ultrasound had been done'. I have always felt that routine evacuation of the uterus was wrong, and Nielsen's[1] article merely confirmed what most general practitioners know already — that in the absence of heavy bleeding many women do not need to be admitted to hospital with a threatened miscarriage if their general practitioner feels confidents to care for them at home.

Finally, I cannot agree that ultrasound should be delayed for two weeks after the onset of bleeding, as recommended in the otherwise excellent Dutch protocol on this subject.[2] Ultrasound has given us[3] the ability to provide a rapid and reliable answer to every woman's question, 'Is my baby alive?' Women deserve better and more effective care than they are getting at present. Further research in general practice is urgently needed.

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