PRACTICE OBSERVED

Sex Problems in Practice

Homosexuality

Treating patients in general practice

RICHARD BATH, JOHN SKETCHLEY

We attempted in the last article[1] to outline some of the problems that men and women homosexuals encounter: most problems result directly from society's misconceptions and consequent hostility concerning homosexuals. Most homosexuals can be helped therefore by a well-informed general practitioner or a member of the primary care team.

Doctors, naturally, are not immune to prejudice and rightly hold personal opinions. Homosexuality is an emotive issue, hence the need to emphasise that those who advise on this subject should be satisfied that they can respond to the needs of the patient and are free from personal bias when acting in a professional capacity. For instance, one openly homosexual patient attending a group practice was repeatedly urged by the Christian doctors to renounce his homosexuality and was invited to evening religious meetings run by the partners. Yet when he offered in return to talk about homosexuality in a religious context he was politely refused.

Doctors have a choice when confronted by a homosexual with problems. Help may be offered from in the practice or the help of various agencies may be invoked. Psychiatric referral is rarely indicated unless the doctor considers that he has not the expertise—and many psychiatrists are equally badly informed—if clear symptoms of psychiatric illness are evident, or if the patient wishes to see a psychiatrist. There is little evidence that "treatment" has anything but a temporary influence. The present accepted view is that aversion therapy and psychotherapy have no part to play and should not be attempted unless the patient clearly requests it and the doctor is satisfied that the patient is well informed about the alternatives and the possible drawbacks.[2,3] Homosexual expression can be extinguished but the effects tend to be temporary, and one cannot assume that heterosexual orientation will emerge. The worst result would be to produce a "cured" homosexual and fail to introduce fully functioning heterosexual tendencies. Other methods—such as medical and surgical castration to remove all sexual responses—are for compulsive male sexual offenders only, and are used strictly with the patient's informed consent given without coercion. Such treatment raises moral, legal, and ethical arguments, which are outside the scope of this article.

At the moment few homosexuals choose to take their problems to their general practitioner. A proportion of doctors feel inadequate, others may be openly hostile, and a few may anticipate mutual embarrassment, and homosexuals who are sensitive to these feelings may go to another helping agency with their problems or may seek no help.

Cambridge
RICHARD BATH MB, BCHIR, general practitioner

BLAT Centre for Health and Medical Education, British Medical Association, London
JOHN SKETCHLEY, PHD, assistant director

What the GP can do

As in any consultation, at the first interview the doctor should attempt to discover the real needs of the patient. These will range from a wish merely to talk to needing help with loneliness and isolation or specific sexual problems, and a few will have personality or psychiatric problems along with, and sometimes resulting directly from, their sexual orientation. The general practitioner can benefit if he keeps in mind that the needs of a homosexual are as complex and varied as those of a heterosexual.

Those individuals who carry feelings of guilt and shame may be tempted to represent themselves initially as bisexual. The doctor's response is thereby tested, and if unfavourable the interview can be terminated with little given away. Most homosexuals simply need to talk with an authority figure whom they may regard as an "expert," and in receiving an accepting uncondemning response will obtain all that they require—"permission" to go ahead in following their natural instinctive feelings.

Commonly patients, especially young ones, may be unsure of their true sexual orientation. Professing uncertainty is sometimes another way the patient may test the doctor's attitudes. But in asking about the content of dreams, sexual fantasies, masturbatory fantasy objects, and which sex the patient instinctively responds to in the streets, the doctor will usually get a clear indication of the patient's sexual identity. The apparent presenting problem may not be the real one, and in this context professing uncertainty may conceal a patient's desperate unwillingness to accept his or her homosexuality—with its implications of remaining unmarried, childless, and outside the norms of society. Supportive counselling may be needed over many months.

These are the same people who sometimes marry as a conscious or unconscious ploy to avoid confronting their dilemma. Such ill-advised marriages clearly rest on unsure foundations and are likely to fail. A consultative document commissioned jointly by the Home Office and the Department of Health and Social Security[4] says: ". . . given what is known about such factors as the distribution of homosexuality and chronic ill health . . . it is obvious that the present popularity of marriage must be drawing into the institution large numbers who lack any evident vocation for it." A married homosexual, needless to say, must be encouraged to face and accept his or her sexual orientation. Until recently, the courts and doctors tended to advocate marriage for homosexuals involved in criminal proceedings. For example, one man who had broken the law was exempted from imprisonment on condition that he underwent psychiatric treatment. The psychiatrist encouraged marriage, which took place with disastrous results for both partners and their two children, who were subsequently reared in an atmosphere of hostility and mutual contempt, progressing eventually to marital separation. A return to being single was a great relief for this man.

The doctor needs to be prepared to answer patients who seek reasons for their homosexuality, the inquiries coming particularly from these same individuals who are having problems of self-acceptance. A professional man in his 30s stated that he was bisexual and with a girlfriend came to ask if he could be referred for psychoanalysis, believing that if he could pinpoint a specific cause he would be helped to decide whether to marry the woman or seek a permanent homosexual relationship. Three salient points should be considered with all such inquiries. Firstly, a wide variety of causes of homosexuality have been suggested: genetic factors; events occurring during intrauterine development; early childhood experiences; parental factors; adolescent seduction; and single-sex environments. There are too many various and unconnected causes to construct a coherent plausible theory. Secondly, if the patient is encouraged to seek reasons then guilt or recrimination may be growing in the family of the homosexual, and attitudes about sickness or deviancy may be reinforced. Thirdly, and perhaps most important, asking why is wasteful and futile and more constructive is to start from where one is in life and to build on that. Nevertheless, we have heard people say that their doctors have suggested that they have become homosexual because of the shape of their hips, the early death of a parent, seduction by an older person, education at a single-sex school, or because the paternal grandmother was living with the family. By contrast, one openly homosexual woman claims that her doctor said she could not possibly be lesbian because "you do not look like one."

Religious support

For patients who may be distressed by religious or moral arguments, referral to a priest may add to their burden. One of us referred a 17-year-old homosexual man to a supposedly sympathetic church official, only to find that the young person's confusion was made considerably worse because he was told that he was too young to know and that the Bible condemned homosexuality. The Quakers, however, have produced a sympathetic booklet,[5] and a prominent Methodist minister has published an excellent book.[6] The Roman Catholic Church seems to be developing a "real" view—that of personal conscience—as distinct from an official view. As theology is a specialty in its own right it is perhaps best left to the clergy who are known to be knowledgable and sympathetic to deal with the religious difficulties surrounding homosexuality. The Gay Christian Movement, founded as an interdenominational organisation a few years ago, has some influence on traditional church thinking and would probably be of most help to the troubled Christian.

Social support

Loneliness can be a major problem. There are many pubs, commercial clubs, and discos that cater specifically for homosexual men and women. These exist mainly in the cities and large towns, so that for those living in rural areas without transport the difficulties remain. The Campaign for Homosexual Equality is, as the name implies, a political organisation, having also a social function through local groups throughout England where homosexual men and women can meet, talk, and obtain mutual support and friendship. *Gay News*, published fortnightly and available in most large towns and cities, contains information of events, venues, and places of entertainment for both sexes. Some local libraries now put *Gay News* on their shelves.

Social support groups specifically for women are not well established and this is indicative, as described in the first article, of the disadvantaged position of women, but what exists is listed in *Gay News*.

Marital disharmony as a result of one or the other partner's homosexuality is commoner than is generally assumed, and sometimes the non-homosexual partner will seek an end to the marriage. Such couples will need encouragement in communication and contact with other married couples who have adjusted. Sigma is an organisation that helps mainly the non-homosexual partner.

Homosexuals may lose their jobs if discovered; the law does not provide reliable protection. Similarly, there is the chance of ostracism from a person's chosen church, workmates, or social groups. One man, known to us, was discovered to be homosexual after many years as a committed, active churchgoer, and now is distressed that his former church friends will not have contact with him except to offer exorcism. Hence the homosexual's reticence in the spheres mentioned, coupled with the awareness of possible physical violence. Understanding support from the general practitioner can be of great value in these circumstances.

FRIEND is an independent national organisation run by specially selected and trained homosexual men and women that aims to help others through counselling and befriending. There are telephone numbers that can be dialled by the patient, or referrals come through the Samaritans, social workers, and others who know of its existence. It is backed up by local psychiatrists and doctors who are consulted when psychiatric or medical problems are thought to be present. Local lawyers and clergy may be called upon for other specialist consultation.

The parents of young homosexuals often have feelings of guilt that they may have caused their son or daughter to become homosexual. They can be reassured. Sometimes the homosexual will suffer total parental rejection, but more often the subject will be uneasily avoided by all parties and thus never properly resolved. Occasionally parents resort to hostile action, as in the case of one young policewoman whose parents compelled her to suppress her true instincts by threatening to inform her employers; or the case of a university student writing to tell his parents he was homosexual who received no reply at all. Parents' Enquiry is run by the mother of a homosexual, whose aim is to help parents either directly or through correspondence to come to a better understanding and take a supportive and encouraging role. The doctor, in his often long-standing position of family counsellor, with extensive background knowledge, is in a unique and influential position. His attitude may be crucial in relieving the homosexual of parental disapproval or rejection.

Homosexuality may appear to be a complex and frightening topic. But in the best medical traditions the doctor has at his command all the medical skills (empathy, confidentiality, judgment, authority, and knowledge) to assist the homosexual man or woman to solve many of the problems of life. Perhaps some doctors need change nothing more than the preconceived notions about homosexuals and collect a small amount of updated information to give all the help that is required.

Correspondence should be addressed to Dr R Bath, 20 Cross Street, Cambridge, or Dr J M Sketchley, BLAT Centre, BMA House, Tavistock Square, London WC1 9JP.

Some useful addresses:

Gay Christian Movement, BM Box 6914, London WC1N 3XX; tel 01-283 5165

Campaign for Homosexual Equality (CHE), 42A Formosa Street, London W9 2JP; tel 01-289 9335.

Gay News Ltd, 1A Normand Gardens, Greyhound Road, London W14 9SB; tel 01-381 2161.

Sigma, 33 Springcroft Avenue, East Finchley, London N2 9JH.

FRIEND, c/o CHE.

Parents' Enquiry, 16 Honley Road, Catford, London SE6 2HZ.

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Practice Research

Rubella vaccination: screening all women at risk

SAM ROWLANDS, R G H BETHEL

Congenital rubella is a preventable cause of fetal malformation, and the affected babies who survive have a high incidence of multiple handicaps.[1] When the Department of Health launched a campaign in June 1979 to improve rubella vaccination uptake we decided to undertake a screening programme.

Six studies from general practice have described screening women who attended their general practitioners for contraception or other reasons,[2-7] but in each study very few of the women at risk were reached. Two Canadian practices[8,9] have attempted to screen all the patients on their list, but one practice confined its age range to patients between 8 and 22 years and included males.[8] We attempted to assess the immune status of all fertile women in our practices and tried to answer the following questions:

(1) What is the response of a total population to a screening programme using a postal invitation to attend for a special appointment?

(2) Is such a programme feasible as a routine procedure in general practice?

(3) What are the financial implications for the general practitioner?

Based on a study that was given first prize in the Royal College of General Practitioners Astra Research Award, 1980.

Dorking, Surrey RH4 2BG
SAM ROWLANDS, MRCGP, DCH, trainee general practitioner (present appointment: research assistant, Margaret Pyke Centre, Soho Square, London W1V 5TW)

Englefield Green Health Centre, Surrey TW20 0PF
R G H BETHEL, MA, MRCGP, general practitioner

Methods

Both practices are located about 25 miles from central London in areas whose residents are largely from social classes I and II. Practice 1 was in Dorking and practice 2 in Englefield Green. The study was started in August 1979 and lasted six months in practice 1 and nine months in practice 2. Women aged 15 to 44 years were identified from the age-sex registers and their notes marked with a red "Rubella survey" label. Both the practice and the local authority records for the age group 15 to 23 were searched for evidence that the women were vaccinated as schoolgirls. We excluded women who were previously shown to be seropositive, those who were sterile after gynaecological surgery or were on a waiting list to be sterilised, and those who were pregnant. (Antenatal patients are screened routinely in our local maternity units and offered post-partum vaccination if seronegative.) We included those who had been vaccinated, either as schoolgirls or in the puerperium, to confirm seroconversion, and women whose husbands or partners had had a vasectomy.

Special appointments were arranged for blood to be taken by a nurse. Letters giving specific appointments were sent, enclosing DHSS leaflet RV2 ("Catch German measles before it's too late") and an addressed envelope for reply. A detachable part of the letter gave the choice of acceptance or refusal. If the appointment was inconvenient the women were asked to contact the surgery to alter it. A single reminder was sent to all non-responders and those failing to keep appointments. At these appointments the nurse filled in a questionnaire, information from which is reported separately.[11] Blood samples were sent to the same laboratory, where they were analysed by single radial haemolysis (SRH).[10] Samples with a zone of haemolysis equal to or greater than 15 IU were regarded as immune. Letters were sent to women informing them of the result. Those who were immune had a green "Rubella immune" label placed on their notes. Seronegative women were asked to make an appointment with the doctor.

Only those who had used a reliable method of contraception for the previous month and who undertook to continue this for another

three months were vaccinated. Wistar RA 27 3 vaccine was used in preference to Cendehill.[12] Repeat blood samples were taken eight weeks after vaccination, and the women were again told the result. Those who failed to attend for the second sample were contacted by post or telephone. We kept records of income and expenditure during the study.

Results

In the two practices there were 2588 women aged 15 to 44 years in a total population of 13 300—a proportion (19·5%) similar to the figures of 20·3% for the United Kingdom.[13] Table I shows the number of women who had left the district, the number who were excluded, and the number who attended for a blood test. Details of the response to the letters are given elsewhere.[11]

Of the 1926 women at risk, 886 (46%) attended for a blood test, while 886 (25%) did not wish to attend. Out of the 486 refusals, 133 were women aged 15 to 24, and their records showed that 67 (50%) had been vaccinated before (mainly at school). Sixty-three per cent of the women in the age-group 15 to 19 and 29% in the age-group 40 to 44 attended. Despite this decline in attendance with age, 197 were aged 35 or over. Among the 886 women who attended, venesection failed on one occasion and two specimens were lost en route to the laboratory. Thus 883 samples were tested and of these, 107 (12%) were seronegative (table II).

The surgery notes showed that 191 out of 433 (44%) women aged 15 to 24 who attended had had a rubella vaccination. Local authority data raised this figure by 49, giving 55%, who had definite evidence of previous vaccination. Two of the seronegative women had been vaccinated five years earlier at school with Cendehill vaccine (different batches). We were able to determine from the manufacturers that neither batch was substandard in any way. No antibody was detected in their blood samples. Both were aged 17.

Ninety-seven (91%) seronegative women were subsequently vaccinated. Ten women declined vaccination—three had husbands who had undergone vasectomy (and their marriages were stable), one was psychiatrically ill, one was trying to conceive, and five gave no special reason.

Repeat blood tests were obtained from all but six women who had been vaccinated (94%), and all but two women seroconverted after one immunisation; one of these was from the pair previously vaccinated with Cendehill vaccine. The batch of vaccine used in these two women was effective in other cases. Both women seroconverted after a second immunisation with standard RA 27 3 vaccine (from a different batch).

One 24-year-old single woman who reported current regular menstrual periods was vaccinated after being prescribed the contraceptive pill but failed to attend for the repeat blood test. She came to the surgery four months later complaining of a weight gain of 3 kg and was found to have an advanced pregnancy (34 weeks). She had been vaccinated at 18 weeks' gestation. Antenatal tests showed seroconversion. She was subsequently delivered of a normal baby. Developmental assessment to date has shown no abnormality.

TABLE I—*Breakdown of women aged 15-44 years in the practice population*

	Practice 1				Practice 2				Total			
	No.	%			No.	%			No.	%		
Population at risk	936	76·5			990	72·5			1926	74		
No who attended for a blood test			494	32			692	36			886	34
No who did not attend			542	44·5			496	36·5			1040	40
No not studied	290	23·5			372	27·5			662	26		
Left district			68	5·5			131	10			199	8
Excluded			222	18			241	17·5			463	18
Total No of women aged 15-44	1226	100			1362	100			2588	100		

TABLE II—*Number of women with rubella antibody*

	Age in years						All ages
	15-19	20-24	25-29	30-34	35-39	40-44	
No positive/total No.	251/272	149/161	98/127	108/127	99/113	71/83	776/883
Per cent	92	92·5	77	85	87·6	85·5	88

Discussion

The small proportion of seronegative women in our study—12%,—illustrates the advantage of the more clear-cut result obtained from SRH than from haemagglutination inhibition (HAI). Doubtful seropositive results from HAI (indicating either immunity or the presence of non-specific inhibitors) tend to be reported to clinicians as seronegative. Mountfield[2] had a proportion of seronegative women of 48%, with many unnecessary vaccinations.

Although it appears that the proportion of seropositive women aged 15 to 24 may be higher than in the other age groups (table II) the difference is not statistically significant. Others[14-17] have shown, however, that the programme of vaccinating schoolgirls has had a definite impact on this age group. We proved that over half of the women aged 15 to 24 who attended had been vaccinated—a considerably higher proportion than reported previously.[14]

The pitfall of inadvertent vaccination during pregnancy is illustrated by our unfortunate example. Menstruation during the first months of pregnancy does occur rarely.[18] All programmes have a small risk of this happening.[19-22] None of the women, however, conceived during the three months after vaccination.

Our vaccination rate is the highest obtained in general practice except for the reported 100%, rate in American women attending for "check-ups."[8] Although we did not document side effects, there were several cases of arthralgia. One of the two women who failed to show seroconversion using SRH had arthralgia. It may be that side effects do not necessarily imply seroconversion, but it is also possible that a more specific test might have detected an antibody response.

We are convinced that serotesting must be performed in a screening programme and are opposed to "blind" vaccination.[3] Considerable quantities of vaccine would be wasted when 88% of women are immune. Even more important, however, is the wasted time and energy spent to ensure adequate contraception for this 88%, for three months after vaccination.

Our seroconversion rate was similar to that in another study using RA 27/3[14] (about 98%) and confirms experience outside general practice.[14,15] Long-term duration of immunity is still unknown but is at least 10 years in most people.[18-20] Our two seronegative 17-year-olds who were previously vaccinated either failed to seroconvert or the immunity waned. Unless they are subsequently exposed to natural infection they might become pregnant later in life with a false sense of security. We therefore think that it is ideal to include those who have been vaccinated in a screening programme.

We are not alone in thinking that for the same reason a repeat blood test to prove seroconversion is desirable.[3,8,17,18,20-22]

Had we not carried this out, two of the 97 vaccinated women would not have benefited from the programme. RA 27/3 vaccine has the advantage of producing a more rapid immune response,[8 11] so that reliable results may be obtained as soon as eight weeks after vaccination. Retesting too soon after vaccination can be misleading.[1 2]

Our comprehensive programme is not feasible as a routine procedure. We describe elsewhere[11] the considerable amount of extra work and expense, and suggest a simpler programme, spread over a longer period of time, where neither an age-sex register nor much extra work is required.

We are convinced that rubella screening is a vital aspect of preventive medicine. It needs to be continued for at least two more decades, and general practice is the best setting for it.

Conclusions

Forty-six per cent of all women at risk (totalling 1926) in two group practices were screened for immunity to rubella. The single radial haemolysis technique showed 12% to be seronegative. Ninety-one per cent of the women were vaccinated with RA 27/3 vaccine. Seroconversion was ascertained by repeat blood tests. A simplified version of this screening programme could be used in general practice as a routine procedure.

We thank the partners and staff of both practices for their co-operation. Sisters Barbara Beadle and Helen Elliott in particular made major contributions to the study. Dr D R Gamble, Public Health Laboratory, Epsom, gave invaluable guidance. Helpful advice was given by Smith, Kline & French Laboratories. Data analysis was performed by Miss J A Bertram at the Wellcome Foundation. Financial assistance was received from: Searle Laboratories, Smith Kline & French Laboratories, Syntex Pharmaceuticals, Wellcome Scientific Services Division, and Wyeth Laboratories.

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Report of a Joint Working Party on Radiological Services for General Practitioners

The Royal College of General Practitioners and the Royal College of Radiologists have published this report in the September issue of the *Journal of the Royal College of General Practitioners* pp 528-30. The following information has been taken from a press release.

Direct access to radiological services is essential to general practitioners, and they should have a similar right of access to consultants for their patients.

Clinical priorities should determine the use of services if resources are short. Priority should normally be given to hospital inpatients, but if constraints have to be applied they should fall equally on referrals from general practice and from hospital outpatient departments, subject to the radiologist's decision on medical priority.

X-ray facilities should be provided in properly staffed departments. The working party was not generally in favour of the further provision of x-ray equipment in health centres or other small units, except where geographical considerations determine otherwise. More complex examinations require adequate supervision and should be restricted to departments where there is a radiologist. The specialist radiologists assume clinical responsibility for patients while in x-ray departments.

When possible, general practitioners should be able to visit x-ray departments to view the films of their patients. In the interests of reducing radiation exposure as well as economy films should be transferred with the patient when the patient moves to the care of another hospital.

There is a need for better education of medical students and trainee general practitioners in the use of radiological services.

Correction

Diabetes mellitus: I: Diagnosis and initial management

An error occurred in this article by Dr John Jarrett *et al.* (5 September, p 648). The last sentence on page 649 should have read "... a fasting plasma glucose concentration above 7·8 mmol·l (140 mg/100 ml), or a whole blood glucose concentration greater than 7 mmol·l (126 mg/100 ml)."

Conference Report

Psychological problems in general practice: Oxford conference on a "grey area"

RICHARD SMITH

A great many unhappy, disturbed, anxious, fed-up, and depressed people walk into general practitioners' surgeries hoping for some help. All of the 200 delegates to the Mental Health Foundation Conference on psychiatric disorders in general practice were agreed on that, but they were not able to agree on much more. They disagreed on the size of the problem; how to recognise, define, treat, and study the patients' problems; and how to organise treatment and preventive services.

Pertinently, in a conference bedevilled by generalities, platitudes, jargon, uncritical statement, and "broad strategic discussions," the confusion and disagreement were best illustrated by discussions about a particular patient. Dr Anthony Clare of the Institute of Psychiatry and Karl Sabbagh, director of the MSD Foundation, showed a video recording that the Foundation had made of a 10-minute consultation between a general practitioner and a woman who said she was depressed. After watching the recording the conference delegates (about 60 general practitioners; 36 psychiatrists; 12 psychologists; 12 social workers; and others) were asked to write down how they would describe the woman's problem, what they would do for her, and what they thought of the general practitioner's performance.

Later in the day a recording was shown of the woman being interviewed a year after the original consultation. The woman had been pleased with her two short consultations with the general practitioner: she was now feeling much stronger and better able to cope; and she thought that the doctor had helped her. Some of the conference delegates, however, had not been impressed by the doctor's consultation: and proportionately twice as many psychiatrists as general practitioners thought that he had performed badly. There were wide differences, too, in the way that the doctors described the problem; and a sixth of the general practitioners and psychiatrists attached a formal psychiatric label to the woman, although the interview of a year later seemed to confirm that this was quite inappropriate.

One of the most interesting points to emerge from this practical act in a weekend of theory was that each of the various professional groups tended to suggest that this woman would benefit from the treatment that they could offer: family therapists would have given her family therapy; counsellors would have counselled her; marriage guidance workers would have guided her marriage; psychiatrists would have offered her a long interview; and general practitioners would have offered a series of shorter consultations. Yet the woman after being given a few simple insights by her general practitioner had solved her own problems with her own resources.

What should be the priorities of those who offer and organise treatment services, Dr Clare asked. What was the natural course of patients' psychological problems? What were the forces that people used to deal with their own problems? How many of these patients really stood to benefit from expensive and intensive treatments? These were questions raised also by others; Dr John Fry, a general practitioner, pointed out that there was no good evidence that one form of managing these patients was better than another. He called, too, for longitudinal studies of the natural course of these disorders. Dr Jack Ingham of the Medical Research Council epidemiological research unit in Edinburgh suggested that before hordes of enthusiasts were financed and unleashed on those many patients seen in general practice with psychological problems better evidence was needed of who was likely to benefit and who would recover regardless of treatment.

Back to theory

The theory of the meeting fleshed out the issues raised by the videos. The prevalence of any problem in a population depends critically on how that problem is defined. For some 30 years epidemiologists have been playing the game of trying to put a prevalence figure on psychiatric problems in patients in general practice; they have used a bewildering variety of standard interviews and questionnaires and have employed many different definitions of what is a psychological problem. Consequently, they have come up with wide variations in prevalence—from about 3% to 65%. Standardisation of techniques and increasing consensus on definitions have meant, as Dr Ingham explained, that these figures have come closer together. Most would now agree that about 10-20% of the people in Western communities have psychological problems.

But is this figure worth having? A much more crucial task for epidemiologists is to "sort out this grey area" and decide how many of these problems are overcome by individuals themselves, how many present to general practitioners, how many need treatment, and how many benefit from treatment.

Epidemiological confusion exists alongside diagnostic confusion: while epidemiologists have played with their numbers nosologists have tinkered with their classifications. The latest chimera to appear is "triaxial diagnosis" in which "a statement (rather than a diagnosis) is made" about the patient's problem in biological, psychological, and social terms. But while the nosologists fiddle, general practice burns: individual general practitioners recognise widely differing incidences of psychological problems in their patients. Some see virtually no patients whose problem they diagnose as psychological while others think that half of their patients have problems that are primarily psychological. Professor David Goldberg from Manchester has studied the factors that influence how many psychiatric diagnoses a general practitioner makes. Attitudes, personality, and interview techniques have all proved to be important, and by an intensive three-week training using videos of consultations Professor Goldberg has been able to increase the ability of some general practitioners to recognise psychological problems.

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RICHARD SMITH, MB, BCHIR, assistant editor

Unfortunately, he has not shown either that this improvement is maintained over years or that it has any effect on eventual outcome.

Many of the general practitioners and other therapists at the conference were not too much worried by this epidemiological, nosological, and diagnostic confusion because they were primarily interested in management. And, as Dr Clare said, in this "grey area" diagnosis and management do not seem to be much related: doctors treat without diagnosing. And for those primarily interested in management a wide range of therapeutic wares were displayed at the conference.

At one end of the range were psychotropic drugs. These are unfashionable at the moment among the "forward-thinking" groups represented at the conference, and Professor Peter Parish fought a rearguard action in saying that they were powerful removers of symptoms and that "they were not prescribed any more inappropriately than any other group of drugs." Whether this was because most drugs were prescribed inappropriately he did not elaborate, but he was worried about "medical imperialism"—doctors going out looking for patients and playing at politics in the name of prevention.

Other speakers discussed counselling, team approaches, community psychiatry, alternative medicine, and support groups. All sounded marvellous but few have been proved to be of benefit in vigorous, well-controlled trials. Curiously, however, prevention was almost ignored. The Mental Health Foundation had paid for the publication of the Royal College of General Practitioners' report on prevention of psychiatric disorder in general practice and every delegate was given a copy, but there was little detailed discussion of its proposals. The implicit thinking seemed to be that when description, diagnosis, organisation, and management were so inadequate to think about prevention was premature.

All in all, a general practitioner who had given up his weekend to attend this conference would not have come away richly rewarded. As he sat in his surgery on the next Monday morning facing his first patient of the day with a "psychological problem" little would be changed from the previous Friday.

Medical Records

A framework for establishing a record system

L I ZANDER

The inadequacies of our record keeping are well recognised.[1 2] If general practice is to expand and develop into activities such as monitoring chronic disease, prevention, and audit, an adequate information system will be essential. This concluding contribution to the series on medical records attempts to provide a framework for those wishing to improve their records.

Function of records

SERVICE

Consulting patient—Records must allow optimal care.

Non-consulting patient—Information on the characteristics of the practice population such as age and sex structure, morbidity patterns, etc, is essential if the practitioner is to initiate care for all his patients.

MEDICAL CARE PLANNING

Information about clinical and administrative aspects of the practice is necessary to provide optimal care and to make the best use of resources.

SELF LEARNING AND AUDIT

A regular review of clinical records will improve clinical care. Internal audit is generally considered more acceptable and effective than imposed audit, and the presence of vocational trainees may provide a stimulus.

General Practice Teaching and Research Unit, St Thomas's Hospital Medical School, London SE11 4TH
L I ZANDER, MCH, MB, general practitioner

Record design

When designing a clinical record the following criteria should be borne in mind.

Ease and speed of recording is essential if the records are to be completed.

Important items of data should be made to "stand out" by underlining or boxing-in, use of capitals, or placing special items in separate columns.

Information must be easily retrievable so records should be well organised, with letters filed in chronological order.

Data of which the doctor is unaware should be so placed that they will be brought to his attention.

A good record should not just record care that has been provided but should stimulate the doctor to undertake new inquiries or procedures. A problem-oriented format and flow charts for monitoring chronic diseases could be helpful.

Introducing, maintaining, and using better records

Before changing records the implications should be discussed with medical, paramedical, clerical, and reception staff, and the part that each can play in the procedure should be carefully considered.

Unless carefully maintained records will become inaccurate and unreliable. Clerical staff can check recording.

Great efforts are often made to establish age sex and morbidity registers only to find that they are rarely used. How they will be used should be considered before they are produced.

DATA IN THE SYSTEM

The following data should be included: (*i*) information necessary for clinical care; (*ii*) information for establishing a data base, including relevant family and social history; (*iii*) specific "at-risk" factors—for

example, smoking, alcohol consumption, obesity, etc; (*iv*) information for administrative and legal purposes.

Data will usually be obtained during consultations but other methods such as patient self-administered questionnaires should also be considered.[3 4] If information is obtained by the clerical staff the need to maintain confidentiality should be considered.

A mechanism should be devised to remove unnecessary items regularly.

Record content

The NHS envelope is unlikely to be replaced. Portability is its principal advantage, and many have shown that its size is no handicap to good recording.[5] The advantage of the A4 folder is increased space for clinical recording and letters. Replacing the paper record altogether by computer is, I believe, not worth considering at present.

The record design should ensure adequate entry of relevant information and easy extraction of important data. The possibility of all members of the team making entries should be considered.

PROBLEM LIST

There is general agreement about the value of having a problem list but not about what it should contain. I suggest the following classification.[2]

Conditions important for clinical assessment—Conditions liable to remission or recurrence—for example, peptic ulcer, multiple sclerosis; conditions liable to complications; malignancy; major operations; conditions patients are reluctant to mention—for example, venereal disease, attempted suicide, alcoholism.

Conditions requiring continuing medical care—Long-term management—for example, hypertension, pernicious anaemia; long-term follow-up—for example, renal insufficiency, after a gastrectomy.

Conditions affecting choice of drugs—For example, allergies and sensitivities, peptic ulcer, valvular heart disease.

Long-term severe handicaps—For example, blindness, phobic anxiety state.

Social factors—Abnormal family structure—for example, one parent family, family violence—for example, battered baby; long-standing disturbed relationships—for example, chronic marital disharmony; sociopathic behaviour—for example, chronic truancy, prison record, compulsive gambling; severe social handicap—for example, illiteracy, chronic unemployment.

Flow charts for monitoring chronic diseases may improve the care provided by encouraging the doctor to undertake certain agreed clinical actions.[6]

Hospital letters occupy much space and need continual pruning. Time will be saved if essential details are highlighted.

Although called family doctors, our knowledge of our patients' family and social history is often inadequate. The use of a family tree for recording has several advantages[7 8] as does the use of family folders.[9]

By including entries of the health visitor, district nurse, etc, the value of the record is greatly increased. This may be made easier but is not dependent on the use of A4 records.

Computers

The rapid developments in microprocessing has meant that using microcomputers in group practices is becoming feasible. Those contemplating their introduction should consider the following questions:

(1) What aspects of clinical care and practice management can be done more easily, completely, and economically by a microcomputer?

(2) What useful data can be obtained that are otherwise difficult to acquire?

(3) What will be the negative effect on other aspects of practice activity?

(4) What will be the likely demands on personnel and finance?

Personnel

The implementation of a record system concerns many individuals with differing needs and contributions to make.

As the main users of the system there should be general agreement between the members of the health care team about its design and utilisation.

Much effort is required to maintain the accuracy of records and their maximal use, and this may be better undertaken by a clerical worker than by a doctor. Individuals with no medical training can undertake the maintenance of the record system: processing all the records from the family practitioner committee; discarding unnecessary contents; drawing up the patient's summary problem list and family chart; maintaining an age and sex and associated morbidity register; reminding doctors of inaccuracies in their records; and extracting data necessary for clinical studies.[7]

Patients may contribute directly to data collection through self-administered questionnaires. Should patients have access to their own records?[10] We found that when patients were allowed to retain their "official" obstetric record throughout pregnancy the results were good.[11] The implications of such an approach to doctor-patient communication are worth considering.

Conclusion

The provision of medical care is being reappraised and evidence suggests a shift of emphasis towards primary care. General practice must show itself able to rise to the challenge. If, as in Lord Taylor's words, "a doctor's practice is only as good as his records"[12] we should ensure that this central aspect of our work receives the attention it deserves.

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ONE HUNDRED YEARS AGO Thomas Carlyle and Edinburgh University. The late Thomas Carlyle has shown the interest he felt in the university, of which he had been Lord Rector, by bequeathing to it the estate of Craigenputtock, in the county of Dumfries. The estate is about eight hundred acres in extent, and of the annual value of £300. Ten bursaries are to be founded, and are to be in custody of the Senatus Academicus; they are to be called the "John Welsh Bursaries." They are to be given to students the "worthiest" after competitive examination, five on the subject of classics, and five on mathematics. We could have wished that some of them had come to the medical faculty, but we trust they may help to give a thorough arts training to some who will afterwards enter the profession. The bequest is thoroughly Carlyle-like in its wording, and finishes thus "and so may a little trace of help to the young heroic soul struggling for what is highest, spring from this poor arrangement and bequest; may it run for ever if it can, as a thread of pure water from the Scottish rocks, trickling into its little basin by the thirsty wayside, for those who it veritably belongs to. Amen." (*British Medical Journal*, 1881.)