well by a Scottish assembly to argue for cutting health-care expenditure—on the grounds that greater health gains could be secured by spending more on social services or housing, or to encourage greater NHS productivity—as by advocates of a larger budget for the NHS in England.

We thank Tony Harrison, Nick Mays, Jo Ann Mulligan, Maria Evandrou, staff in the Department of Health and Social Services in Northern Ireland, John Halsall, Richard Hamblin, David Heald, John Wyn Owen, Christine Robson, and an anonymous reviewer for help and advice.

Funding: None.

Competing interest: None.

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(Accepted 23 October 1998)

A memorable patient Repeating the tests

Three months ago my patient had a rash on his right lower leg, which was treated initially as fungal without effect, but cleared rapidly after treatment for allergy. Two months ago, he had severe stabbing pains "like glass digging in" on his left inner arm and right shin. These pains got worse, especially at night, and became agonising. One month ago his hands and feet blew up, became red, and subsided with a scaly rash; there was a preceeding sore throat and a raised antistreptolysin O test. He had seen various doctors over the months and had now come to me.

His medical history included syphilis in the distant past; numerous negative results for VDRL (Venereal Disease Research Laboratories) tests in recent years, in my hands one year ago, and again one month ago abroad (where he now lives) along with a negative test for HIV, which he had done at his own initiative, desperate for a diagnosis; bisexual in the past, but now in a 10 year stable relationship with one woman; a heavy smoker.

Examination of my limping patient revealed only exquisite tenderness along the shins and along the left ulnar border. Bone and chest x ray examinations were negative. Among other tests, I did another VDRL test, which came back positive at a titre of 1 in 64.

At this point there was a review of his history, which led to an ashamed and reluctant admission of one casual relationship four months ago with a man when drunk at a party. Meticulous neurological examination showed nothing. I diagnosed a new secondary syphilis and began treatment. Within one week the bone pain was less; in three weeks it was gone and he was walking normally. He obviously had syphilitic periostitis that was responding to treatment. A repeat test for HIV gave a negative result.

I had many thoughts. What if I had not done another VDRL test? Rather than triumphant, I was pensive because it was not "logic in medicine" which led me to repeat it. So how can I depend on getting the right diagnosis next time in a difficult case? When we hear of doctors missing the diagnosis, don't we all shudder vicariously?

What of the constant criticism nowadays that we overinvestigate? Would a reviewer looking at my laboratory investigations before the result have cried "overinvestigation" since repeated VDRL tests up to one month ago had been negative? Where do we draw the line? How far do we investigate "tired all the time" patients who do not seem depressed? Continuing medical education, textbooks, and audit do not provide answers, though seasoned colleagues may advise through anecdote. And how do we develop the intuition which we all feel that we need?

Guidelines, protocols, algorithms, and evidence based medicine all attempt to spread good medical practice. How do we prevent financial managers and lawyers from using them as rigid criteria and ourselves from being stultified by them?

Edward Lavendar, *general practitioner, Kuwait*

We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.