between subjects with Alzheimer's disease, subjects with multi-infarct dementia, and controls (identified clinically with the criteria of the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association³ and the *Diagnostic and Statistical Manual of Mental Disorders Third Edition, Revised (DSM-III-R)*.⁴ We found that magnetic resonance imaging had a blind agreement with clinical diagnosis in 14 (61%) of 23 cases, and single photon emission tomography in 24 (77%) of 31 cases.⁵ Furthermore, all 22 subjects with dementia tolerated single photon emission tomography whereas six were unable to tolerate magnetic resonance imaging. For single photon emission tomography we used a gammacamera with three detectors with a total acquisition time of only 15 minutes.

It thus seems that single photon emission tomography with hexamethylpropyleneamineaxime labelled with technetium-99m is not only a clinically useful tool separating these disorders but the procedure best tolerated by elderly and demented subjects.

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General practitioners and skin biopsy

SIR,—Several articles in recent issues focus on the performance of skin biopsies by general practitioners.¹⁻⁴ Matters of concern are incomplete clinical information¹; inaccuracy of clinical diagnosis²; incomplete excision³; use of wrong fixative⁴; unnecessary operations on benign lesions²; increased workload generated for pathology departments²; and inadequate management of malignant tumours.⁴ One potential drawback is not addressed by these authors: incorrect interpretation of the histology report by the general physician.

Dermatologists are well aware of the fact that any incongruity between clinical diagnosis and histopathological description and the doctor's conclusion may cause severe harm to the patient. This

especially holds true for false negative reports of skin malignancies. If clinical suspicion of malignancy is not confirmed by the histopathological report then the dermatologist performs another biopsy or keeps the patient under regular control. How many patients with so called "benign" histopathological labels are wrongly reassured by the general physician, causing serious delay or mismanagement?

In this context I have scrutinised my experience over 15 months to the end of December 1991. Out of 278 patients with clinical suspicion of malignancy there were six with benign histopathological diagnoses that had to be challenged on clinical grounds. These patients underwent a second biopsy, either immediately (three within 1-2 weeks) or delayed after unsuccessful treatment attempts with various topical remedies (three after 6-10 weeks). The table shows the clinical and histopathological diagnoses.

An important difference between this series and the quoted reports on general practice skin surgery is the type of biopsy under consideration. Biopsy specimens of suspected skin malignancies in my practice are often partial (punch biopsies), whereas general physicians will usually perform excisional biopsies. The chance of correct histopathological diagnosis increases with completeness of biopsy procedure.

Clinical diagnosis of malignant skin lesions can be difficult even for the experienced dermatologist. In case of doubt, appropriate interpretation of the histopathological findings is crucial. The risk of woeful delay in patient management after incorrect judgment of the histopathological report by the general practitioner cannot be overemphasised.

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Deciding whether to be a doctor

SIR,—Having read J Parker-Williams's comments on selecting and helping potential doctors, I am glad that I did not graduate from St George's Medical School.¹

I agree that secondary schools and medical schools do not provide enough information for a potential doctor to make a properly formulated decision. They cannot convey the significance of sleep interrupted by frequent, sometimes petty, queries and emergencies; of a social life completely disrupted every six months; of stress induced by jobsworth nurses and technicians and overbearing seniors; of scrabbling for precious training posts; or of studying for examinations with very low pass rates while working excessively long hours. The average candidate cannot fully comprehend the

deadly dullness of routine blood drawing; of chasing results and investigations through reluctant pathology departments; and endlessly overbooked outpatient clinics—the normal working day of most junior doctors.

The preregistration year is undoubtedly a shock to most newly qualified doctors, not only because of the excessive demands placed on them but because of the lack of support from colleagues and seniors. Many people have doubts, fears, and uncertainties, which are only natural at the start of a career in medicine. The wise keep their own counsel, as seeking advice often singles out a person, who is then perceived as weak. Parker-Williams labels these people as misfits unworthy of having thousands of pounds spent training them and questions their commitment to medicine. It seems he would rather have medical schools churn out emotionless automatons.

A more professional approach to postgraduate training, education, and counselling would be most welcome, but on the basis of Parker-Williams's opinions I fear that we have a long way to go.

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1 Parker-Williams J. Deciding whether to be a doctor. *BMJ* 1992;304:319. (1 February.)

SIR,—M J Kelly has presented the benefits of showing potential medical students what their future may hold,¹ but why is no support system available in the United Kingdom for those highly intelligent, expensively educated young men and women who drop out of the medical profession shortly after qualifying?

I write as a lay person and as the parent of a recently qualified young doctor, who, last summer, after just four months as a preregistration house officer, felt quite unable to continue. This sudden decision came as a shock to all those with whom he worked. He was regarded as hard working and extremely competent.

Should my son choose, of his own volition, to get in touch with his medical school at some stage in the next year he will almost certainly be helped to get back into the system. Unless he makes the first move, however, nobody will communicate with him. He is rapidly, it seems to me, becoming just a statistic.

The last thing I would wish to see is a system that attempts to retain people by force. There will always be those who realise, too late, that they are in the wrong profession. My son may be one of them. I am convinced, however, that among those who drop out there are some who, with extra support—perhaps the chance to work part time for a short period—would go on to make good doctors.

In my own profession, teaching, it is often said that the best practitioners are those who understand at first hand the difficulties experienced by their pupils. Could this not also be true to some extent in medicine?

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Child health surveillance lists

SIR,—In July last year we reported the variability of the criteria used by family health services authorities to admit general practitioners to child health surveillance lists¹ despite the existence of national guidelines.² In the same issue Waine

reported that these guidelines were being updated.³ We hoped that the revised guidelines would address two of the problems that we had highlighted in our report—namely, unfairness in accreditation and general practitioners being required to attend basic courses. Unfortunately, neither of these problems is likely to be resolved by the revised guidelines,⁴ which are virtually unchanged except for a U turn on the status of the MRCGP and DCH examinations. These qualifications are now thought to be evidence of competence in child health surveillance as an alternative to either three or more years' experience or attendance at an approved course. We do not think that family health services authorities are any more likely to follow these guidelines than they did the original ones.

Our survey showed that a greater percentage (71%) of family health services authorities recognised an approved training course than recognised three or more years' experience (56%).¹ As a result many experienced principals were advised to attend courses on basic child surveillance. The suggested content of these courses in the revised guidelines is almost exactly the same as that in the original ones, including undergraduate and trainee material which is not appropriate for established principals in general practice. A danger of the present and proposed system is that general practitioners who are not accepted on to child surveillance lists have no incentive to provide a full service for children. On the other hand, there is also the danger that a basic course of 10 sessions will be considered to be adequate education in child surveillance for the whole of a principal's career.

We believe that every practising general practitioner should be encouraged to provide a full service to the children on his or her list. It would surely make sense to drop the "once and for all" hurdle of accreditation and instead set up a system of continuing education and audit for all those who wish to provide child health surveillance. Such a system would be more likely to ensure that high standards of care were maintained in general practice paediatrics.

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Medical negligence

SIR,—In his editorial Richard Smith calls for a no fault system in cases of medical negligence and criticises voluntary arbitration as proposed by the Department of Health.¹ Additionally, he calls for a strategy to reduce medical accidents. These are both important issues but are not necessarily related or comparable in importance.

The Department of Health's proposals could help greatly in two ways. The panel of arbitrators would be sufficiently small for the experts to be able to meet quickly. The process would therefore be greatly speeded up so that justice would be more prompt. Also, the present system is so costly

that many cannot afford even to start a claim unless they are eligible for legal aid. So these are considerable advances.

For those who are not injured by negligence the issue is to distinguish a medical accident, which implies an avoidable action, from unavoidable complications. The no fault concept would encounter this problem, and what is proposed is really an insurance system. And why only medical accidents and not others—for instance, road accidents—too? If no fault included negligence it would (not might, as Smith says in referring to arbitration) reduce the deterrent effect of litigation.

In order to reduce medical accidents I agree that we have a good lead from the Harvard study of hospital records in the United States, which has been effective.² We too need to audit the incidence of adverse events, especially in hospital practice. As with each of the major audits carried out in this country we would learn a great deal and, more importantly, reduce the problem. A proposal to carry out such an audit is being prepared at present.

The government's proposals are a positive step forward. If they were accompanied by an audit of medical accidents considerable progress would be possible in dealing with the basis of the problem. The subtitle of Smith's editorial could then be transposed to read "Forget no fault and go for arbitration and audit."

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Patients' views of the patient's charter

SIR,—Much is said about the patient's charter, which is portrayed by politicians as defining the inalienable rights of patients. But how and why did the charter emerge in this form, when for the most part it sets out so called rights that have been normal practice in health care for many years? Is the government being overly paternalistic or does the charter indeed reflect what patients find important in the health service today?

In the third week of November last year we interviewed 25 consecutive patients in the waiting rooms of each of eight general practices in south London. Our aim was to determine (a) whether patients had heard of the patient's charter; (b) how important they thought the rights were; and (c) whether they thought that each right was being fulfilled. The responses to the second and third questions were scored on a scale of 0-4. Finally, patients were asked if they would change the way that they used the NHS in view of their new rights. We had to paraphrase each of the 10 rights in the charter as we considered the wording to be too complex for easy digestion in a questionnaire.

Of 200 questionnaires returned, 167 had been fully completed and were included in our study (82 from men, 85 from women; mean age 40). Given that every household in Britain should have received a summary copy of the patient's charter by mid-November last year, we found that 91 patients were still ignorant of its existence at the time of our survey.

The table shows the degree of importance attached to each right and the degree to which the patients thought that each right was being fulfilled, expressed as the sum of the scores as a percentage of the maximum possible score of 668. Notably, the degree to which each right was fulfilled was, without exception, lower than the degree of importance. The patients gave highest priority

Importance of each right to patients and degree to which patients thought each right was being fulfilled

Right	% Importance* (total score)	% Fulfilled* (total score)
To receive free health care	97 (648)	82 (547)
To receive emergency health care	97 (648)	77 (514)
To register with general practitioner	95 (635)	93 (620)
To be referred to specialist	93 (621)	70 (468)
To have treatment explained	93 (621)	65 (434)
Guaranteed maximum 2 year waiting list	93 (621)	61 (408)
Investigation of complaints	91 (608)	51 (341)
Information on local health services	86 (574)	56 (374)
Non-participation in medical education	80 (534)	54 (423)
Access to medical records	73 (488)	36 (240)

*Total score as percentage of maximum possible score (668).

to receiving free health care and emergency treatment. Of least importance were the non-clinical aspects of health care, such as access to medical records, non-participation in medical training, and information on local health care services and waiting times. The less important rights were perceived to be less fulfilled than those traditionally considered to be the basis of the NHS. Perhaps the neglected aspects of the health service merit future attention in these competitive times.

Will the government achieve the charter's standards by April, as promised, or will increased accessibility to redress lead to a torrent of complaints? Either the government has given us a stick with which to beat it or this represents a commitment to realistic change. Change, however, requires resources directed at the problems, and that may be the sticking point, regardless of all good intentions.

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Doctors and Desert Storm

SIR,—Judging by his comments about Desert Storm, the war in Iraq, David Widgery is a caring doctor.¹ He is probably distressed when he thinks about the millions of Chinese killed by the old warlords, the occupying Japanese, and the communists; images of the millions of Russians murdered by Stalin and by the Nazi death squads would trouble him, as would the memory of his compatriots wiped out by the Luftwaffe and the Germans destroyed by Bomber Command. He may shed a tear for the six million victims of the Holocaust, though, in Stalin's view, such a figure is not so much a tragedy as a statistic.

Widgery and similar propagandists never offer a better line of action than leaders of the Western democracies might have taken. How would he have dealt with Nazi Germany? Even Lord Russell thought that the Allies fought a just and righteous war between 1939 and 1945. The United Nations having decided that Saddam Hussein should be removed from Kuwait, how would Widgery have achieved this end? Would he have tried the Chamberlain method? Churchill pointed out that the two main tasks of any government are to prevent war and to be prepared for it if it comes. Widgery has grasped the first point but not the second. A third world war was prevented not by the noises of International Physicians for the Prevention of Nuclear War but by the noise of the engines of American B52 aircraft on constant patrol in European skies. Widgery should realise