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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1 Evans AJ, Maskrey N, Nolan P. Admission to child health surveillance lists: the views of FHSA general managers and general practitioners. *BMJ* 1991;303:229.

2 Royal College of General Practitioners and British Paediatric Association. *Guidelines for the training and accreditation of general practitioners in child health surveillance*. London: RCGP, BPA, 1989.

3 Waite C. Child health surveillance lists. *BMJ* 1991;303:202.

4 British Paediatric Association, General Medical Services Committee, Royal College of General Practitioners with the support of the Joint Committee on Postgraduate Training for General Practice. *Training and accreditation of general practitioners in child health surveillance*. London: BPA, GMS, RCGP, 1991.

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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1 Smith R. Fiddling with medical negligence. *BMJ* 1992;304:198-9. (25 January.)

2 Harvard Medical Practice Study. *Patients, doctors, and lawyers: medical injury, malpractice litigation, and patient compensation in New York*. Boston: Harvard Medical Practice Study, 1990.

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

that the road to the concentration camp, like the road to hell, is paved with good intentions.

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1 Widgery D. Desert storms. *BMJ* 1992;304:125. (11 January.)

FHSA medical advisers

SIR,—Tom Walley and John Bligh's editorial on the role of medical advisers to family health services authorities—of which I am one—seems paradoxical.¹ On the one hand we are described as the general practice equivalent of hospital clinical directors, which suggests a powerful managerial role. On the other hand we are described as bridge builders filling "the gap between primary care and the wider health service," which suggests passive mediators. Neither accurately defines the important nature of the role.

Both the main political parties agree that the future direction of development is for district health authorities and family health services authorities to merge into joint commissioning authorities. The medical adviser is the key to determining not only the priorities for developing the health service but, especially, the means by which to achieve them.

It is essential that the academic and planning skills of public health medicine are interlocked with the clinical and executive skills of medical advisers if we are incisively to influence the development of health services in primary care. In this way we can develop meaningful needs assessment in the community and provide better intelligence to the commissioning authority for use in purchasing. We will then be in a powerful position both to determine minimum standards and to ensure that consumers' interests are more objectively weighed alongside providers' priorities.

Currently, medical advisers are acting as agents of change but have neither the power nor the desire to direct clinically, as in a provider unit, the enormously varied range of work in general practice. But we will not be effective by merely filling gaps and building bridges. Forward looking family health services authorities are developing their capacity for research and development, led by medical advisers. This will enable them to break down the barrier between primary and secondary care by facilitating innovative practice that substitutes care in hospital for more appropriate and often cheaper care in the community. As purchasers we will have the power to redirect resources to develop services from the secondary sector in primary care. This seems to me to mean creating some gaps and burning some bridges.

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1 Walley T, Bligh J. FHSA medical advisers: friends or foes? *BMJ* 1992;304:133-4. (18 January.)

SIR,—Tom Walley and John Bligh's editorial discusses the role of medical advisers to family health services authorities.¹ I hope that family health services authorities and local medical committees will review this role, which should be to be a friend of general practice rather than a foe. These posts are provided for in regulation 33A, which states that "the FHSA shall appoint a doctor to assist it in the exercise of its functions pursuant to . . . enquiries about prescriptions and referrals." Many medical advisers now have a far wider remit than that, and there is often much more evidence of their activity in these other fields than in those for which they were originally appointed.

Family health services authorities are free to

seek medical advice from whom they choose, but not all medical advisers will have the necessary experience to provide advice on public health, community paediatrics, and audit. Advice on planning, resource allocation, and service development has traditionally come from local medical committees, and they must now ensure that they are not sidelined if family health services authorities obtain their advice from their own medical adviser. The value of advice from a local medical committee is that it is a distillate of the views of many general practitioners from a wide variety of different practices. The medical adviser may well have a much narrower experience and be less able to offer a balanced broad view.

Some medical advisers are active in medical audit advisory groups and have made valuable contributions to the establishment of audit and its support structures. Local medical committees should ask whether involving an employee of a family health services authority in audit is appropriate, given the profession's clear view that audit is not a "management" exercise.

Family health services authorities have a responsibility to consult widely and to take advice from representatives of the profession. This must include the local medical committees, which should ensure that communications with the authorities have been adapted to meet the requirements of the authorities' new responsibilities, particularly in relation to planning and monitoring the provision of general medical services. Local medical committees and individual general practitioners should establish relationships with their medical adviser and work with him or her, ensuring that the adviser is well acquainted with developments in general practice and with its needs and aspirations. Medical advisers must show that they can be of benefit to individual general practitioners and to general practice as a whole in their locality. If they are to assume responsibilities beyond the monitoring of prescribing habits and referral patterns they must develop close links with local medical committees, where they will have every opportunity to show that they are indeed friends of general practice.

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1 Walley T, Bligh J. FHSA medical advisers: friends or foes? *BMJ* 1992;304:113-4. (18 January.)

Distinction awards

SIR,—I have recently seen the Advisory Committee on Distinction Awards' analysis of distinction awards as at 31 December 1990.¹ Yet again I am struck by the sheer number of awards—to nearly 36% of all eligible practitioners.

Apart from the impossibility of distinguishing merit at the level of the C award fairly, surely awarding selective supplementary income so widely does nothing to promote adequate remuneration for the profession as a whole. Is it not time to scrap this anachronism?

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1 Department of Health. Distinction awards: analysis by type of award, specialty and percentage distribution at 31st December 1990—England and Wales. *Health Trends* 1991;23:127.

Vincent van Gogh's illness

SIR,—It is a fundamental truth in clinical medicine that common illnesses occur more commonly, and we think that this admonition against diagnosing

rare medical disorders when a common disease fits the course and symptoms of an illness equally well or better is particularly apt in the case of Vincent van Gogh.¹

The prevalence of manic-depressive illness is 1%; that of acute intermittent porphyria is less than 0.008%. When the classic course and symptoms of manic-depressive illness are present its diagnosis is extremely reliable.² Vincent van Gogh's premorbid personality, cyclic pattern of affective episodes, lucidity between attacks, absence of cognitive deterioration, seasonal exacerbations, bursts of productivity, altered sleep and energy patterns, hyperreligiosity, volatile irritability and violence, visual and auditory hallucinations, and alcohol misuse (also a common cause of gastrointestinal complaints) are the hallmarks of manic-depressive illness. His convulsive disorder may have been precipitated by misuse of absinthe or due to a coexisting complex partial seizure disorder.

Vincent's affective symptoms clearly predated any history of seizures, and his family history is more consistent with manic-depressive illness. His brother Theo also suffered from an affective disorder, and their sister, Wilhelmina, spent many years in a psychiatric institution. Vincent and his youngest brother, Cor, both killed themselves, an outcome that they share with 15-20% of people with untreated manic-depression³; moreover, 70-80% of all suicides are associated with affective disorder.² Suicide in acute intermittent porphyria, on the other hand, is rare. Clustering of affective illness and suicide is common in families of people with manic-depression³; in contrast, only one first degree relative of 13 probands with acute intermittent porphyria had any form of mental illness (it was not manic-depressive illness).⁴ Finally, manic-depressive illness is far more common in highly creative artists and writers than in the general population^{2,5}; acute intermittent porphyria shows no such relation. In fact, acute intermittent porphyria has been associated with neuropsychiatric impairment and extremely poor manual dexterity.⁶

It is incorrect to dismiss manic-depressive illness because of the "facile reversibility and relatively short duration of Vincent's crises." Short duration and reversibility are perfectly consistent with manic-depressive illness, particularly early in its course.²

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- 1 Loftus L, Arnold W. Vincent van Gogh's illness: acute intermittent porphyria? *BMJ* 1991;303:1589-91. (21-28 December.)
- 2 Goodwin FK, Jamison KR. *Manic-depressive illness*. New York: Oxford University Press, 1990.
- 3 Egeland JA, Sussex JN. Suicide and family loading for affective disorder. *JAMA* 1985;254:915-8.
- 4 Ackner B, Cooper JE, Gray CH, Kelly M. Acute porphyria: a neuropsychiatric biochemical study. *J Psychosom Res* 1962;6:1-24.
- 5 Jamison KR. *Touched with fire: manic-depressive illness and the artistic temperament*. New York: Free Press, 1992.
- 6 Tishler PV, Woodward B, O'Connor J, Holbrook DA, Seidman LJ, Hallett M, et al. High prevalence of intermittent acute porphyria in a psychiatric patient population. *Am J Psychiatry* 1985;142:1430-6.

Correction

Deaths from haemolytic disease of the newborn in 1990

A printer's error occurred in this letter by Ruth Hussey and Cyril Clarke (15 February, p 444). Throughout the letter anti-C should have been printed as anti-c.