phageal echocardiography is almost as sensitive but less specific than magnetic resonance imaging. Visualisation of the upper ascending aorta, arch, and proximal head and neck vessels may be limited. In addition, it cannot visualise the aorta outside the chest. It has important advantages, however, in that it is widely available, safe, and quick and can be used at the bedside. Contrast enhanced computed tomography provides an alternative approach but is not as accurate as magnetic resonance imaging or transoesophageal echocardiography.³ In particular, it is unreliable for detecting the entry site.

In practice, the diagnostic method chosen will depend on the facilities available and the condition of the patient. For critically ill patients transoesophageal echocardiography should be considered first. It can be carried out immediately, provides accurate information, and does not put patients at risk because they do not have to be moved from intensive care facilities. Magnetic resonance imaging is better for establishing the diagnosis in patients with suspected chronic dissection and for following up surgical intervention. When these methods are not available because of lack of equipment or trained staff, computed tomography is a viable alternative. There is now little place for arteriography in the diagnosis and management of acute or chronic aortic dissection.

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Training for house officers

EDITOR,—In a survey of preregistration house officers in eight English regions Jonathan H Gillard and colleagues found that 61% of respondents disagreed or strongly disagreed with the prospect of four months in general practice in the preregistration year.¹ Lisson Grove Health Centre has been taking preregistration house officers from St Mary's Hospital, London, for four month rotations in general practice since 1981. The 30 doctors who did the rotation in the first 10 years of the scheme were recently sent a questionnaire to evaluate it; 26 questionnaires were returned (response rate 87%). When asked if they would recommend the general practice rotation to a friend 24 respondents (92%) said yes, compared with 57% in Gillard and colleagues' study. Another question asked if the doctors had ever regretted missing four months of hospital medicine and surgery; 25 respondents had not. The general practice house officers work a 40 hour week (excluding on call), receive up to three hours of individual tuition a week, and spend nearly 60% of their working day with patients.

I conclude that house officers who have no direct experience of preregistration house jobs in general practice are, understandably, nervous about the prospect. Doctors who have experienced such a rotation have a different view. I find it particularly sad that the doctors questioned in Gillard and colleagues' study had negative views about a house job in general practice when they were critical of

their hospital rotations. A house job in general practice would at least provide them with an opportunity to explore an alternative to house jobs in hospital. Gillard and colleagues discussed the educational implications of their findings: there were serious deficiencies in the education the house officers received in post; and the house officers performed inappropriate tasks and worked excessive hours.

If changes are required to improve the quality of the preregistration year (more contact with patients, more teaching specifically for house officers, a shorter working day, fewer inappropriate duties) I suggest that introducing a general practice rotation would be an effective way of doing this.

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Standards of care should not depend on the patient's status

EDITOR,—In writing about a patient who changed his practice Robert Wilkins describes an unfortunate episode of poor medical care.¹ The idea that standards of medical care should not depend on the status of the patient is clearly sound. The idea that one's medical colleagues—brilliant or otherwise—should be treated like everyone else seems, however, to be an oft repeated myth. The problem lies not with our inability to ignore such matters but with the notion of uniform practice applied to everyone else. The world is not divided into doctors and the rest but rather into a huge diversity of people, who merit equivalent standards of care individualised according to many factors, one of which will often be occupation. To discuss more fully a sore throat with an opera singer or a painful knee with a carpet fitter is perfectly proper. It is to regard some patients as less important than others that is blameworthy.

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Health in Israeli occupied territories

EDITOR,—The Association of Israeli-Palestinian Physicians for Human Rights cannot support the sanguine picture of health services in Gaza painted by M Shani and T H Tulchinsky.¹ We regularly see avoidable medical tragedies arising out of major deficiencies in the health care provided and because the concerns of military occupation are placed above the needs of even critically ill patients.

The authors state that all health services are free for small children up to the age of 3 in Gaza and the West Bank and that treatment is provided in Israeli hospitals when services are not available locally. One of many counter examples handled by the Association of Israeli-Palestinian Physicians for Human Rights, however, was of Tufiq Hassib, a 2 year old boy who needed urgent treatment for a metabolic disorder that was unobtainable in the occupied territories. The authorities had refused him treatment in Israel on the grounds that its

liability was limited to the territories. To minimise delay we gave Tufiq's family the funds to buy government health insurance on the understanding that he might then be accepted for treatment in Israel, but he died before this could begin.

We do not agree with the assertion that ambulances from Gaza and the West Bank have unhindered access to Israeli hospitals, including during the curfew. After the territories were sealed off Rula Shriteh, a 4 year old girl from Gaza with internal bleeding after a traffic accident, was held up for three hours before her family could locate an ambulance driver who would risk taking her to an Israeli hospital without a permit. The father of a 15 year old boy who had died in hospital in Israel was forced to carry the body through a checkpoint on foot since no Palestinian ambulance was allowed through. Ambulances in Gaza and the West Bank are forbidden to carry communications equipment, which rules out a swift response to urgent calls or transmission of details about critically ill casualties.

Per capita expenditure on health care in Israel is around \$500; in the occupied territories it is \$18-23. There were 6.1 hospital beds/1000 people in Israel in 1992; in the occupied territories there were 1.1 (only half the figure in 1975). Gains in some aspects of health care, such as infant mortality and immunisations, cannot offset the overall consequences of such disparities in the provision of health care for the 800 000 residents of Gaza. This is the health service that Israel will bequeath to Palestinian management in accordance with the peace agreement. The Association of Israeli-Palestinian Physicians for Human Rights believes that Israel has a responsibility to help provide for the upgrading and development of the health service, and to this end we have submitted our proposals to the current Israeli-Palestinian negotiations.

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Somatoform pain disorder after road traffic accidents

EDITOR,—Brian Dalal and Glynn Harrison provide a fine example of the problems that afflict medicolegal psychiatry nowadays.¹ The first is the compulsion to reject the simple in favour of the complex; the second is the propensity to reinterpret perfectly understandable human behaviour in terms of psychopathology and append a psychiatric label, which adds to the mystique of psychiatry and glorifies the diagnostic status of the psychiatrist. Thus, although people may consult a cardiologist, a neurologist, a chest physician, or an endocrinologist and be told that there is nothing wrong with them, it is virtually impossible for anyone to leave a psychiatrist's consulting room without having had some label attached.

All plaintiffs in actions to recover damages for personal injury are well aware that the more they complain the more money they will get. How, then, can Dalal and Harrison be so confident that the 15 subjects who had unexplained pain were "suffering" from the "recommended" diagnostic term of somatoform pain disorder. Might they not, quite simply, have been making heavy weather of their complaints, knowing full well the advantages of so doing?

Dalal and Harrison do not tell us the therapeutic benefit derived by those who received antidepressants for their unexplained pain. How do Dalal and