LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Divine healing

Sir,

I was much impressed by the editorial Diving healing: the Christian view (January *Journal,* p.3). As a follower of one of the main monotheistic religions, Islam, it was encouraging to note that in the past divine healing has made an important contribution to general practice and, in particular, to 'whole person' medicine. The practitioners of alternative therapy from the Third World, particularly the Indo-Pakistan sub-continent, have been practising whole person medicine for a long time and records show that divine healing plays an important part in treating multitudes of people in the Third World where science has not yet made its impact.

I am pleased to note that the College is taking an interest in this field in conjunction with the Churches Council for Health and Healing. However, it should not be forgotten that too much emphasis on the practice of alternative medicine may unconsciously encourage the growth of quackery.

The application of spiritual healing is more obviously useful in the field of psychiatric illness. I have been involved with the listening clinics since 1980 and am convinced of the beneficial effects of spiritual healing which is not too remote from the application of modern principles of scientific treatment and plays the role of 'a helping person who listens to patients' complaints and offers a procedure to relieve them thereby inspiring the patient's hopes and combating demoralisation'.[1]

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References

1. Shepherd M. What price psychotherapy? *Br Med J* 1984; **288:** 809-810.

Sir,

Divine healing is not a form of alternative therapy. Health and healing is not secular in the sense of being only of this age (Latin *saeculum)* but our field of work has tended to relegate the things which deeply bind society and general practitioners only advise patients on matters to do with their physical, psychological and social well being. Where have we gone wrong?

Let us hope that the working party set up by the College and the Churches Council for Health and Healing realizes that regular monthly services at a shrine are one way of expressing the ineffable: that to worship and adore the true and living God who created all things (including health and healing of all kinds) is central. Such services are not an alternative to our work but complementary to it. There is no professional rivalry between clergymen who conduct the services and general practitioners who are responsible for the health of those attending.

It is disturbing to read at the end of Dr Martin's editorial (January *Journal,* p.3) that this working party does not think that at present patient care is in the spiritual sphere as well as the temporal. The Churches Council for Health and Healing is aware that patient care is in both spheres — does the profession need to learn it too?

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Sir,

I wish to comment on Dr Edwin Martin's interesting editorial (January *Journal,* p.3). In the last paragraph it is suggested that 'general practitioners may come to consider a patient's health in physical, psychological, social and spiritual terms' and a working party between the College and the Churches Council for Health and Healing 'is considering the effects of extending patient care into the spiritual sphere and ways of encouraging this extension'.

I am assuming that this possible extension might, in due course, be recommended to the College Council. If so, it seems important that the Council should consider the matter carefully before altering the familiar trinity which was itself considered carefully. Two questions have to be asked. First, does the suggested fourth word 'spiritual' add something of importance which is not already to be found in the other three? Secondly, if it were added, what might be the consequences for medical practice?

One has to ask what 'spiritual' means, to see if it has a meaning which differs, for example, from 'psychological'. *The shorter Oxford dictionary* gives a range of meanings: immaterial (that is, not physical), pertaining to the higher moral qualities (especially regarded in a religious aspect), sacred (not carnal or temporal), supernatural, ecclesiastical and intellectual. 'Psychological' is defined by the same dictionary to mean: mental: pertaining to the mind and relating to psychology.

There is therefore both difference and overlap in meaning. If one looks into the roots from which these two words are derived in Latin, Greek or Hebrew (for example 'pneuma' and 'psyche'), the overlap is much greater and the difference much less.

Of the six different meanings of 'spiritual', immaterial and intellectual can be included in the meaning of 'psychological'; supernatural and ecclesiastical cannot. Can the meanings sacred or moral be found in the trinity?

They are distinct and important aspects of life. But, if one or both of these words represents the additional meaning implied by 'spiritual', are doctors to be asked to consider a patient's health in sacred or moral terms? What would either imply for practice?

They could imply paying attention to what a patient holds sacred or being aware of a moral dilemma or choice in a patient's life. On the other hand the three more familiar aspects of health are ones to which doctors not only pay attention but which they sometimes influence and change by their active intervention. Would it be right for a doctor to seek to influence the 'spiritual' in either of these senses of the word?

If the College were to endorse this additional term, it must first define it and weigh carefully the possible consequences of its introduction.

JOHN HORDER

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Sir,

I was most interested to read Dr Martin's editorial (January *Journal,* p3). This is a complex subject with refusal to admit evidence of the supernatural on the one hand and excessive credulity on the other. Dr Martin's assessment is helpful in pointing out some of the problems.

I believe that God's healing power is not restricted to supernatural means. Christians have long recognized natural healing processes as a demonstration of God's power. For example Ambroise Paré, the sixteenth century French surgeon, said 'I dressed his wound; God healed him'.

Could I bring to the attention of the working party of the College which is looking into this subject a set of cassette tapes of talks by the late Dr Martyn Lloyd-Jones entitled 'Medicine and the supernatural'? The album of four tapes comes with a book by Dr Lloyd Jones, *The doctor himself and the human condition*.

The album is available from The Martyn Lloyd Jones Recording Trust, Crink House, Barcombe Mills, Nr Lewes, East Sussex BN8 5BJ at £14.50 inclusive of postage and packing. It should be of particular interest to Christian doctors but others could also learn much from it.

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Prevalence of disability in an Oxfordshire practice

Sir,

Drs Sullivan and Murray have criticized the absence of a validated measure of disability in my paper (August *Journal,* pp.368-370). I did not set out to make an objective measurement of the prevalence of disability in my own practice and this is made quite clear in the first paragraph of the paper. The limited objective involved was to see how much disability I identified in the course of routine patient care on known data. Surely this makes it clear that I did not set out to screen patients for disability and to scale the level of disability. I regard my paper as modest, although it was the first that I could trace by a doctor keeping a disability register in general practice.

My own view is that disability and handicap registers will ultimately prove even more valuable than chronic disease registers about which a great deal has already been written. After all, patients consult doctors because they want to be relieved of pain or the disabling effects of a particular disorder and I feel that we are inclined to be too interested in the disease itself and too ready to ignore its social consequences. These are all too often left to others — the occupational therapist, physiotherapist or physician in rehabilitation medicine. The result is a lack of integration of patient care with no one taking overall responsibility except when the patient is severely disabled and even then it is not the general practitioner who is in charge as a rule. Thus I feel that disability in general practice is a neglected field and one which I would like to see greatly developed. I hope to do a study of the prevalence of disability in patients over 75 years of age, which will require me to produce exactly the type of objective measurement to which my critics were referring.

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Out-of-hours visits to children

Sir,

I read with interest Dr Walker's paper on out-of-hours visits to children (September *Journal,* pp. 427-428) and noted his comment on the dearth of direct data on the level of out-of-hours work involving children, especially during the trainee year. While a trainee in a single-handed practice in a semi-rural area I recorded all out-of-hours visits at nights and weekends. The on-call rota involved three single-handed practices with a total population of 6500. Of 169 visits, 36 were for patients in the up to five years age group (21%) and 12 were for patients in the six to 15 years age group (7%).

In the up to five years age group the morbidity pattern was: respiratory 44%, accidents 22%, abdominal (including gastroenteritis) 20%, exanthemata and unspecified fever 11% and genitourinary 3%. None of these cases required hospital admission. In the six to 15 years age group the pattern was: respiratory 57%, accidents 17%, genitourinary 17% and abdominal 9%. Two of these cases required hospital admission.

The figures involved are small, but the morbidity pattern is not dissimilar to the figures from Leicestershire quoted by Dr Walker in his discussion. It might be that more useful information could be obtained by a larger, collaborative study involving all the trainees in one area over a training year. Comparison would then be possible with inpatient statistics from local hospital paediatric units.

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Known epileptic patients brought to the accident and emergency department

Sir,

An epileptic attack appears to many lay people to be a medical emergency that warrants prompt medical treatment. Therefore, the epileptic person may precipitately appear in an accident and emergency department. If prompt first aid is carried out and it is ensured that the epileptic is not in a position to injure himself further and that after the attack he is placed in the semiprone position, it is not necessary to summon an ambulance. However, once the ambulance is called, unless the epileptic has fully recovered, he will be brought to the accident department. We therefore decided to investigate to what extent emergency attendances of known epileptic patients to an accident department were of real benefit to the patient.

During a four-month period all known epileptics who attended St George's Accident and Emergency Department because they had suffered a further convulsion, without an acute precipitating cause, were documented. Eighteen epileptic patients were brought to the depart-