that a combination of opportunistic and systematic strategies may be the best way forward. Either way, case-finding must be an ongoing activity since new patients will continually be entering the high risk group as they age.

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Privatising primary care

I couldn't agree more with the excellent editorial by Allyson Pollock and David Price ('Privatising Primary Care') in August's *British Journal of General Practice*. The representatives at the BMA's Annual Representative Meeting this summer voted to oppose the privatisation of the NHS. It's unfortunate, in my opinion, that my college, the RCGP, has not taken this line, but perhaps the *BJGP* could consider publishing papers regarding evidence as to the effectiveness or otherwise of privatised primary care, for example in the US. I have been going to the US fairly often over the last 30 years and it is my experience, both personally and from talking to medical friends, that only a small proportion of the population there receive what we would consider an adequate primary care service. American publications by Barbara Stansfield and the Commonwealth Fund of New York support this point of view.

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Domestic violence in practice

Fitzpatrick describes the interest in inter-personal violence as a 'vogue for wallowing in degradation reflecting a misanthropic view of humanity and a pessimistic outlook towards the future'.[1] He states that, because of wider social progress, there is a decline in the scale of domestic violence.[1] Fitzpatrick also describes his experience elsewhere:

> *'I inquired whether (my GP colleagues) had noticed a recent upsurge in domestic violence. But no; like me, they had certainly encountered the occasional case, but thought it not a very common problem …'*[2]

Unfortunately, research reveals that domestic violence remains common and often undetected by doctors.[3]

Far from misanthropy and pessimism, recognition of the existence of inter-personal violence and its damaging effects is the first step towards raising support for the sufferer, whether that support takes a social, medical or psychological form. Failing to recognise the problems caused by inter-personal violence may well be misanthropic.

Fitzpatrick suggests that improving the quality of human relationships should be a social not a medical project, and presents these approaches as alternatives. Fitzpatrick believes that reframing social problems as illnesses encourages individual dependency.[1] However, the naming of the condition described by writers ancient and modern (for example, Samuel Pepys in his diary, and testimonies of 'shell shock') as 'post-traumatic stress disorder' (PTSD) liberates the patient by acknowledging that an individual's symptoms are a recognised response to life-threatening trauma. Armed with this understanding of how domestic violence is affecting them, patients often find the strength to improve their situation.

Fitzpatrick quotes cases of transcendence of abusive experiences (Bryan Magee and John McGahern)[1] Indeed, research shows that 2/3 of those experiencing life-threatening trauma are resilient to developing PTSD,[4–6] but one can hardly ignore the other third. These are the ones who do not manage to transcend their experience, and who are thus more likely to be seeing their GP. It would be helpful and humane if their doctors recognised their PTSD, and correctly attributed its source. If the doctor has not asked about past trauma in the consultation, other less helpful socially constructed labels such as 'frequent attender', 'heartsink patient' and 'personality disorder' may be attached to the patient instead. The alternative of not recognising the source of their problems is more likely to leave these patients as disabled victims. My paper[3] gives doctors the tools to become less ignorant of inter-personal violence in a way that is respectful of patients.

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