bound to fail, like others before them. It is inappropriate to apply scientific method (implied by the term 'validate') to spiritual matters because, although the ability to recognize spiritual concepts, such as goodness, truth, beauty and love, is what sets man apart from other animals, they cannot be measured.

Spiritual healing is but one application of intercessory prayer; the results of such prayer can be seen only by the eye of faith. I believe this to be the principal difficulty but it is worth noting that it is never possible to isolate the method of treatment by spiritual healing from other forms of treatment, particularly medical intervention, nor to produce controls, nor to define sufficiently explicitly the objectives of spiritual healing; they involve more than the restoration of diseased tissues.

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Alternative medicine

Sir,

As I started to read Charles Freer's editorial (October *Journal,* pp.459-460) my heart sank. It seemed to be another attempt to justify conventional medicine and to put alternative medicine in its place, but in the last paragraph all was put right and I was able to have optimism for the future.

Most medically qualified alternative practitioners do not see their therapies as an alternative to conventional medicine, merely complimentary. What alternative practitioner would try and treat myxoedema without replacement therapy, or acute appendicitis without surgery? Many conventional practitioners who have been in practice for some time become aware of the inadequacies of what they are able to offer. Who has not found frustration with the self-employed man with backache desperate to get back to work but who does not respond to rest and analgesia?

It is right to point out that the holistic approach is not peculiar to alternative medicine; there are many truly holistic conventional practitioners and many unholistic alternative practitioners. I would suggest, though, that it is much easier to take a holistic approach when using many alternative therapies. To take a full homoeopathic history, for example, necessitates at least a glimpse of the whole person.

Most general practitioners would, I imagine, like more time in which to see their patients. The health care of the country could not conceivably be done if the NHS doctors were to give the time that alternative practitioners are able to give to their patients.

The public wants a wider approach to healing and this includes alternative medicine. At the present time the medical profession does not provide sufficient practitioners practising these skills to satisfy the need. The need is being met by lay practitioners, but is this what the medical profession wants?

Having spent almost 20 years doing general practice within the NHS, and one year doing mainly homoeopathy and acupuncture privately outside the NHS, I can see the advantages and disadvantages of both systems and approaches. I believe both can learn a lot from each other. Alternative therapies can indeed compliment and broaden our clinical skills, and greatly increase the satisfaction of the practitioner. Perhaps the medical profession has to decide if it wants to embrace different approaches to healing and, if it does, who is going to practise them, and whether as part of the primary health care team or outside it. I suggest that there are many advantages to both doctor and patient if alternative medicine is practised within the primary health care team.

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Sir,

I applaud the idea that future primary health care teams should include complementary practitioners (October *Journal,* pp.459-460) whose work should be available to all members of the community, irrespective of financial status. But until that day, work in improving communications should take place between doctors, complementary practitioners and the patient. The doctors should endeavour to acquaint themselves with the non-orthodox techniques so that optimal use can be made of such services.

The complementary practitioners must put their own houses in order and, by feeling more secure in their position in health care, break down the alternative 'barrier'.

The patient should be invited to discuss his treatment holistically, but with the knowledge that he must be prepared to take responsibility for his illness, with the understanding that the quality of his life can be improved by a concerted effort between both practitioner and patient.

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Developing family practice in Kuwait

Sir,

I was most interested to read the article 'Developing family practice in Kuwait — a summary of progress to date', by Professor Fraser in the news and reports section (October *Journal,* pp.500-501).

When Kuwait decided to develop its primary care system, it approached the Royal College of General Practitioners for advice. Following the visit of the President, Dr John Lawson, and Dr Alastair Donald to Kuwait, they undertook to produce a United Kingdom based training scheme for young Kuwaiti doctors, whose career intention was in primary care.

In Edinburgh during the last few years, we had been involved with overseas doctors in a variety of different ways. Professor John Howie and myself have been involved with the health service of the Ministry of Defence and Aviation in Saudia Arabia. I visited Kuwait with Professor John Walker in connection with the development of appropriate assessment for the Diploma in Family Practice. We have also been running short courses in Medical English for overseas doctors in association with the Institute for Applied Language Studies and the Edinburgh Postgraduate Board for Medicine. So it was not altogether surprising that the Royal College of General Practitioners turned to us to help develop this scheme, and we were invited to design a special introductory course to meet the needs of these young Kuwaiti doctors planning to enter primary care.

The problem was that though these doctors were graduating from English-medium Arab universities, they needed help with their English language, in addition to an introduction to the concepts of primary care. The Department of General Practice and Institute for Applied Language Studies combined to organize a course to provide English teaching based on primary care sources, plus individual clinical attachments and tutorials in primary care, so fulfilling the two objectives simultaneously. This seems to be an effective and stimulating way to improve the English of foreign medical graduates. With increasing interest in primary care worldwide, this scheme could be developed for more general application.

Britain is regarded as having the best primary care system in the world, and so it is understandable that overseas countries should turn to us for assistance. If we want to continue our historic role in medicine we need to take positive steps to meet their needs.

I am very much aware that other individuals in this country have been involved with overseas doctors, and perhaps the time has come for the College to reconstitute its International Division to direct and co-ordinate our efforts in this direction.

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The quality initiative

Sir,

The College's quality initiative has impressed me, but the policy statement, *Quality in general practice,* disturbs me. Our early endeavours to delineate 'quality' in no way qualifies us to deliver autocratic opinions on the way forward.

I would contest the assumption that a professional man's career should progress with a series of recognizable hurdles along its path. General practice is a discipline which has room for a great diversity of people. I worry about the effect that vocational training is having on the capacity of young doctors for original thought, and a more rigidly structured career pattern will further discourage originality.

If College examiners are finding that large numbers of candidates are inadequate then training needs to improve. It is probably a mistake to allow candidates to sit the membership examination at the time they complete their vocational training. Three years after obtaining the Joint Certificate on Postgraduate Training for General Practice would be a much more suitable time. By then doctors would have the benefit of a much greater breadth of experience. It is possible, of course, that if the examination were to cease to become a passport to a partnership, the number of candidates would go down. I can see nothing wrong with associate membership as a way of staying in touch with College activities. A further advantage might be that many enthusiastic doctors might find that large amounts of their time were no longer taken up with marking papers and conducting oral examinations.

The policy statement talks of teamwork and organization but says very little of the role of the patient. It also says very little about single-handed practices.

The idea of incentives for doctors seems so difficult that it can only be deeply divisive within the profession. The varying bodies which represent our concerns and interests need to work together and the present arrangement whereby the General Medical Services Committee deals with terms and conditions of service seems satisfactory. The College should not intrude in this area and should concentrate its efforts on defining quality in practice and encouraging its attainment. It is on this point that I feel that the document has gone off at a tangent to the central issue of what is good quality and how we can improve it.

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Choosing a new partner

Sir,

I was intrigued to read Dr Thomson's letter (October *Journal* p.498) about his efforts to appoint a new partner. I would make two points:

1. He should not be disappointed or even surprised that so few applicants did not have the MRCGP, as many would still be in their training year and therefore not eligible to sit the examination.

2. Why has he excluded all the unmarried applicants? It would seem that many prospective senior partners feel that single applicants are unsuitable for general practice. Is he not aware that the late William Pickles, the founding president of the RCGP was a bachelor when he entered general practice — I am sure he is not the only one.

Thankfully I did not apply for Dr Thomson's post as I would not wish to work with such a short-sighted, senior partner — to exclude applicants solely on their marital status is to exclude some excellent prospective partners.

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Testicular torsion presenting with abdominal pain

Sir,

The danger of failing to recognize testicular torsion is well known. Late diagnosis is still common, and Williamson[1] in a large series showed that some 40% of testicles are not viable. Delay in diagnosis adversely affects the prognosis,[1] and it was recently brought to our attention that when the patient presents with abdominal pain only, and no scrotal pain, then delay and consequent orchidectomy are likely. It is essential that general practitioners and casualty officers know that patients with testicular torsion may have no scrotal pain at all, but only pain in the abdomen. Two case histories illustrate the problem and emphasize that the scrotum must always be examined in a patient with abdominal pain.

Case One. A 22-year-old man experienced sudden onset of abdominal pain and vomiting while playing hockey. Later he was visited by his general practitioner who found no signs of pain in the abdomen or scrotum. The practitioner was asked to visit again two days later because the pain was worse and had moved to the scrotum. There were now obvious signs in the scrotum, and torsion was confirmed at operation. The colour of the testicle improved after untwisting and applying hot packs so it was replaced and both testicles were fixed. The wound never healed, it discharged pus and three weeks later the necrotic testicle had to be excised.

Case Two. A four-year-old Indian boy was visited at home because of sore throat and abdominal pain. Examination showed inflammed fauces, tender cervical lymphadenopathy and a normal abdomen but the external genitalia were not examined. Mesenteric adenitis was diagnosed. A second visit was requested the next day because the child had developed testicular pain and this time a swollen tender testicle was noted. At operation the testicle was black and had to be excised. The right testicle was fixed.

These two cases illustrate the difficulty when there is no complaint of scrotal pain at first presentation. In both these patients the pain was abdominal and only moved to the scrotum after the initial presentation. Williamson reported that 11% of patients had no scrotal pain, 39% had some pain in the lower abdomen and 19% experienced inguinal pain. Cass[2] stated that 12.5% of 49 patients experienced only abdominal or inguinal pain and 52.5% had scrotal pain with some radiation to these regions. Pain initially confined to the abdomen was noted by Greaney[3] in 11% of 19 cases.

Moore[4] pointed out that the initial pain of torsion should not be felt in the scrotum at all, the extrascrotal pain representing the anatomy of testicular innervation. The testicle is innervated by spinal segments T10 and T11 but the scrotum is supplied by L1 anteriorly and by S2 and S3 in its posterior part.[5]

In the first two decades of life testicular torsion is encountered more often than epididymitis but nevertheless in this age