table to all consultations and not just those of a 'psychiatric' nature. In addition, it avoids the jargon on psychotherapy which often alienates doctors and instead focuses on the behaviour of doctor and patient.

Evaluation is essential for any innovative project and Whewell and colleagues used changes in accuracy (as measured by kappa) to measure the effectiveness of their training course. The use of accuracy measures would be of more value if these could be linked to changes in consultation behaviour, especially if this behaviour were then targeted in the training course. While it is legitimate to use kappa as an index of accuracy it raises a problem mentioned by the authors, that of defining a 'case'. Two previous studies[6,7] have used Spearman's rho as the measure of accuracy, a method which avoids having to define a case. Comparison of the results of these two studies suggests that while there may be major differences in the prevalence of emotional disturbance in the two centres, the overall accuracy of the general practitioners is very similar. The importance of this is that accuracy is strongly predicted by the interview behaviour of the doctor[6,8] and as such is amenable to change.

Of interest is the way in which accuracy changes after training. The results of Whewell and colleagues are almost identical to those of Gask and colleagues[3] — accuracy increased in the majority of general practitioners but falls in the doctor with the highest score before training. The power of the teaching method used may unsettle the previously skilful interviewer and reduce his or her performance, presumably temporarily. This is an important reminder of the usefulness of video feedback in teaching communication skills which, if used well, can be a powerful and rewarding tool.

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Using the census to define needs

Sir,

In their papers on census data (October 1987 *Journal*, p.448 and 451), Hutchinson and colleagues drew attention to this rich source of sociodemographic data for small areas and described how it might be used to define the degree of deprivation of a practice population in order to make a case, for example, for extra staff. We would like to draw attention to other applications of linking census data with primary care data, both in evaluating new methods of health care in general practice and in targeting health care where it is most needed.

Research in general practice is bedevilled by difficulties in interpreting the difference that exists between practices in relation to almost every measure of process and outcome of medical care. Rarely are we able to relate how much of this difference is due to the health and social circumstances of the patient population and how much is related to the medical care offered. Linking the socioeconomic data from the census to individual general practice populations provides a method for standardizing to some extent the patient populations under study. Such data may be of considerable use in setting up randomized controlled trials of new methods of health care delivery which need to use whole general practices as a unit of randomization.

In order to target health care more effectively, we have recently drawn up maps of our practice area of 2.8 square miles, on the basis of enumeration districts, to display the areas in the top 10% for Southampton for unemployment, single parents, overcrowding, large families and occupational classes 4 and 5. We have found that these areas tend to reflect the areas of risk for health problems such as childhood accidents, so that rational preventive programmes could be centred on single high risk streets.

In the course of this work, however, we found that only 557 of the 2250 children under five years old living in the practice area were actually registered on our list and that 72 general practitioners from 18 practices were involved in the care of the others. Clearly, if we are to take advantage of this method of determining needs, individual practices will need to group together into neighbourhood prevention groups in order to develop effective strategies for treatment.

In our view systematic knowledge of pathology in relation to local geography could become as useful a part of the general practitioner's stock-in-trade for preventive work as knowledge of individual family pathology is now for treatment. We therefore hope that the 1991 census will be designed to make this linkage as easy as possible. This would include improving the geographical precision of postal codes and the provision of small area statistics for areas defined by postcodes.

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Intimacy and terminal care

Sir,

I was interested in the letters by Dr Carnwath and Dr Wilkinson (June *Journal*, p.276) in response to my article (March *Journal*, p.121). Dr Carnwath provided an historical perspective, for which I thank him, and I would also like to thank the many colleagues who wrote directly. Many cited instances from their own working experiences of the quality of a pre-existing sexual relationship having repercussions for patients giving and accepting intimacy in the terminal care setting.

Dr Wilkinson correctly states that many complex and intertwined factors determine where a patient dies — the physical nature of the dying as well as the psychological factors. My paper, however, was attempting to concentrate on the neglected area of intimacy and terminal care. Dr Wilkinson argues that 'Mr B.'s screams were not necessarily for a wife who could brush his hair but perhaps for anyone who loved him enough to brush his hair'. She is perfectly correct; that was the interpretation I made and was the impetus to have him admitted to a hospice, where he might find some 'tender, loving care'. His wishes were indeed the cue for action. After her bereavement, Mrs. B. spoke more openly about the coldness in

their marriage, but also said she had been comforted by his hospice admission because 'he received the care he needed there'. She subsequently gave a large donation to the hospice.

I am also attempting to explore whether the ability to 'rehearse' the death of a spouse is a common psychological coping mechanism. Many bereaved patients volunteer 'I had not imagined it like this' or 'I had always hoped he could die at home'. Perhaps we all should consider our 'death plans', and discuss our needs with those close to us, so we may come some way towards achieving them.

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Treatment of cutaneous warts in general practice

Sir,

The article by Steele and Irwin (June *Journal,* p.256) will, we hope, encourage more general practitioners to undertake the treatment of cutaneous warts in general practice. We also hope that health authorities will be willing to assist by making supplies of liquid nitrogen more generally available. However, lest anyone interprets the 87% cure rate of common hand warts in six weeks as representative of the results of wart treatment we would draw attention to the large number of reasons given by Steele and Irwin for excluding patients from their study. It is our belief that a large number of excluded patients are those that are difficult to treat in hospital dermatology clinics — particularly those with multiple, periungual, plane or mosaic warts. To these can be added the patients with deep plantar warts who were not particularly responsive to the combined treatment with liquid nitrogen and wart paint in Steele and Irwin's study. We agree that treatment with liquid nitrogen is generally inappropriate for such patients and general practitioners would be wise to select carefully who they treat by this method.

One aspect of Steele and Irwin's study that we find surprising is the low incidence of pain and the excellent tolerance of the combined treatment by their patients. In our experience liquid nitrogen is always a painful treatment and we are astonished that patients could tolerate the addition of wart paint and rubbing with a pumice stone so soon afterwards. The work of Bunney and colleagues[1] has shown that with an interval of three weeks between treatments most common warts can be cured with fewer than the six applications of liquid nitrogen administered by Steele and Irwin. We would certainly recommend fewer treatments at longer intervals. It might also be more practicable to organize wart clinics at intervals of three to four weeks as the numbers of patients attending are not likely to justify a regular weekly clinic.

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Medicine in South Africa

Sir,

I wish to correct certain erroneous impressions created by the letter from Gerard Reissmann (June *Journal,* p. 278). He asserts that 'medicine in South Africa is not independent', but what exactly this means or is intended to mean is not made clear.

Doctors in South Africa, and those who are members of the College of Medicine (or South African Academy of Family Practice/Primary Care) in particular, are practising independently and free of any constraints. Membership of the College of Medicine (or the Academy of Family Practice) is open to any doctor regardless of race, colour or creed. The only conditions for membership are that the doctors concerned should maintain a suitable standard of practice and agree to continue to improve their medical knowledge by attending various lectures and symposia.

Both the College of Medicine and the Academy of Family Practice have an unblemished record in promoting the ideals of providing medical care to all sections of the community in South Africa and they have been vociferous in their condemnation of actions on the part of the authorities which might be detrimental to the delivery of health services. Both are independent bodies and are beholden to none except their own members and their own constitutionally elected councils. They are truly independent and indeed 'apartheid' has never been applicable in any of the medical bodies or associations in South Africa.

As a founder member of one of the first overseas faculties of the Royal College of General Practitioners — the Cape of Good Hope faculty — and a fellow since 1967, I am distressed to read a letter calling for the breaking of links between our respective colleges. It would be a sad day for medicine if, in striving to improve the health of all sections of the South African community, we cannot rely on the help and moral support of our colleagues in the United Kingdom.

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Training in the north east Thames region

Sir,

An unsigned highly critical one-sided editorial in a monopoly journal (June *Journal,* p.245) is not a good mechanism for trying to repair damage and encourage dialogue. It is reminiscent of a principal striking a patient off his list and, when asked why, telling the patient he has an illness that the doctor does not wish to treat. Whether the patient has an identifiable illness or not, a doctor who really cares does not do that, unless of course he wishes to lose the respect of his other patients, who may then decide to seek their medical care elsewhere. The editorial purports to give the facts but, as the north east Thames region's general practice subcommittee was not invited to comment on the allegations made, the editorial appears to have a monopoly of truth. Even more important than upholding the standards of a profession is the rule of justice and fair play; evidence from one side should be matched with that from the other and if doubt remains the accused may not be condemned.

The Joint Committee on Postgraduate Training for General Practice was presented with a region which was not complying yet again with national norms and which, of course, had to be punished. The College merely followed suit but perhaps members of council should have satisfied themselves that the body to which they had delegated certain educational functions had acted properly. Why did council not seek the views of the region's general practice sub-committee and two faculties before coming to its own decision? The editorial states 'The College had always accepted Joint Committee approvals without question, now it had to accept a Joint Committee rejection'. Why the 'had to'? A thinking council could have taken a step back and proposed that the matter be explored a little more thoroughly. But no, a sledgehammer approach was adopted.