European study of referrals from primary care was also unable to provide analysis in terms of list size (Fleming DM, Birmingham Research Unit, personal communication). In British general practice, it is difficult to obtain accurate list-based data for practitioners who do not practice with individual lists.

I would suggest that referral rates based on number of consultations provide little useful data for comparison unless they are combined with a variety of supplementary information. However, given the unique quality of each doctor–patient interaction, I doubt that even very sophisticated standardization calculations would necessarily provide any more meaningful insight into differences.

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Introduction to psychosexual medicine

Sir,

I was astounded by the dismissive review of *Introduction to psychosexual medicine* (January *Journal,* book reviews, p.45). Your reviewer, states that the book is 'Freudian in content... and cannot be regarded as a good reference book for non-Freudians.' To my mind this smacks of a 'reds under the bed' orientation.

The book has been widely welcomed by prominent 'non-Freudians' in the field, including John Guillebaud of the Margaret Pyke Centre. Dr Guillebaud went as far as to recommend that it be 'found on the shelves of all readers of the *British Journal of Family Planning* and indeed most practising doctors'. He also predicted that 'this book will become a classic'. As a general practitioner with an interest in psychosexual medicine, I have found *Introduction to psychosexual medicine* to be the best reference book to date and shall continue to recommend it.

I fear that the reviewer confuses psychosexual counselling and psychosexual medicine. The book concentrates on psychosexual medicine and may therefore be partly outside his scope. Those of us who have the advantage and responsibility of examining patients physically, may indeed have a patient remark 'I would not have your job for anything' as one initiates a vaginal examination. It is crucial that the doctor or nurse receiving such a communication does not ignore what may be a plea for help with a sexual problem. The real skill lies in gently elucidating if one is dealing with such a problem which may often be revealed during a psychosomatically oriented genital examination; or with an 'innocent remark'.

I hope your review has not encouraged a dismissive attitude; it is all too easy not to hear patients' real communications.

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Sir,

I was disappointed to read the review of *Introduction to psychosexual medicine.* Dr Skrine's book was written by doctors primarily for doctors. Any doctor with an understanding of the very specialized nature of this style of psychosexual work would find it difficult to understand how someone who is not a doctor working in the field can assess this publication.

This review barely relates to the book it purports to describe. How can there be no reference to the fundamental matters that it covers? There is no mention of the doctor–patient relationship, seminar training or of the use of the genital examination. On the other hand the word Freudian is used twice. I have looked through the book and the good doctor's name is mentioned only once.

Of course I am prejudiced on the subject, being an associate of the Institute of Psychosexual Medicine. Institute members constitute by far the largest proportion of doctors working in this field and the Institute has the greatest number of doctors in training of any body in the country. Perhaps it is strange that it has taken so many years for the Institute to produce a book providing an overview of its work. One reason is that no book can equip one with skills to tackle these problems. The Institute is naturally cautious and hopes that no one will go to a book looking for magic answers. Dr Skrine's publication contains this warning. It is unfortunate that your reviewer looked to it as another manual with instructions on how to do it.

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Academic general practice

Sir,

In your editorial (January *Journal,* p.1) you point out that many papers submitted by service general practitioners have to be rejected because they are 'academically flawed'. Fortunately there are other journals where they may appear and the vitality and stamina of the enthusiasts is fortified.

Professor Conrad Harris (August *Journal,* p.313) has pointed out that many published papers are 'deeply uninteresting' for most general practitioners. There seems a danger that through its principal publication the College is discouraging the keenest doctors from research, still our weakest area. In the meantime academic general practice is presenting itself as remote from the daily activities and problems of the rest of the profession.

A paper may be flawed practically as well as academically and I believe the first fault is as bad as the second. I appreciate the efforts of College members to establish and present the academic credentials of general practice. Nevertheless service general practitioners need the encouragement of seeing their observations in print and the College has a duty to facilitate this. I suggest the *Journal* experiments with an unreviewed, short reports section, leaving correspondents to criticize and amplify the observations. Academics take this for granted: non-academics should have the same opportunity.

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General practice in the 1840s

Sir,

The McConaghey memorial lecture (June *Journal,* p.228) was interesting and stimulating. It gave us a brief picture of what general practice was like in the 1840s and explained how as early as 1844, general practitioners were calling for their own college.

The following letter appeared in the *Lancet* in 1840 and emphasizes the struggle of general practitioners during this period especially regarding their very low income.[1]

'Advertisement of clergymen for some medical slaves in Surrey

Sir,

I send you a copy of rules of a "medical club" recently established in the lower part of the county of Surrey. It appears to me to be the very maximum of insult to the profession to offer a club upon such degrading principles, conducted by clergymen. It is to be presumed that medical men, like clergymen, have received a liberal education, and, like clergymen, ought to be treated as

gentlemen. The remuneration offered by this club is almost upon a par with the wages of a labourer who is employed to break stones on the road. In the first place he is to receive three-half-pence per week from each family that he attends, whether large or small. Take the average; a man and wife, with three children, in number five; and suppose there are 20 families in each parish, who may be able to avail themselves of the "benefits" of the club; that would amount to 2s 6d per week for each parish. He is next to receive sixpence for the extraction of each tooth. Presume that he extracts 20 a year; that will make 10s per year. Next comes midwifery, for which he is allowed a fee of either 3s, 5s, or 7s, according to distance provided he arrives before the birth of the child, the maximum fee being less than an uneducated old woman is in the habit of receiving. Take the medium fee of 5s, and suppose he has six cases a year in each parish, that will amount to £1 10s for each parish; so that he will have the medical and surgical charge of about 300 persons, scattered over three extensive rural parishes, for the following sums:

For 20 families in each parish, at 1½d, per week for each family, for the year	19	10	0
Midwifery, for three parishes	4	10	0
Tooth-drawing	0	10	0
	£24	10	0

the whole amounting to an average of 9s 5½d per week. It is clear that he cannot keep a horse; so that in a time of great sickness, lamentable neglect, with a probable loss of life, must be the result. Should there be two midwifery cases at the same time, he will be allowed 5s for another medical man's fee, which may be either £1 1s, or £1 11s 6d, so that, in that case he would lose £1 6s 4d, he, consequently, cannot calculate even upon 9s 5½d per week.

It is to be regretted that gentlemen holding high and responsible duties should place themselves at the head of such mean, paltry, and degrading societies; instances of this kind call loudly for medical reform. I am, sir, your obedient servant,

George Bottomley

Croydon, 8 October, 1840.

B N NATHAN

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References

1. Bottomley G. Advertisement of clergymen for some medical slaves in Surrey. *Lancet* 1840; 1: 162-163.

The Journal *is grateful to the* Lancet *for permission to publish the above letter.*

British Diabetic Association educational holidays

Sir,

During my general practice training I had the opportunity to work as a medical officer on two British Diabetic Association educational holidays for children. These holidays are intended to educate children about their diabetes and how to live with it while at the same time allowing them to have an enjoyable time. The children find that they are able to participate in activities which up until then they might have thought were impossible. They learn about their dietary treatment, blood testing to monitor control of their diabetes, insulin injection and identifying the warning signs of hypoglycaemia.

The staff on the holidays are all volunteers and work together as a team. The warden is responsible for organizing the daily activities. There are usually two medical officers, three nurses, three dietitians and four or five male and female leaders. The senior medical officer is usually a consultant or registrar with paediatric experience.

Working as a medical officer on these holidays has provided me with a greater understanding of the day-to-day management of diabetes, and the potential problems that diabetics might encounter in trying to lead a normal life. This experience has been invaluable. I would suggest that potential general practitioners might also benefit from working on one of these holidays.

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INFECTIOUS DISEASES UPDATE: AIDS

Monitoring the prevalence of HIV

THIS paper sets out the case for unlinked involuntary anonymous testing for human immunodeficiency virus (HIV) infection in selected groups in the population in the United Kingdom. The introduction briefly describes current estimates of the prevalence of HIV infection: 'it is uncertain whether transmission solely by such contact [heterosexual] will produce a self-sustaining HIV epidemic throughout whole or parts of heterosexually active society in England and Wales. Such uncertainties about a major epidemic of largely fatal infection make it imperative that such surveillance methods be reviewed regularly'. The paper goes on to review present methods of ascertaining the prevalence of HIV infection: a byproduct of case finding using named tests as part of clinical investigations, at the request of patients and the mandatory test which is carried out for potential blood donors. The selection bias inherent in these methods is emphasized.

In a section on the case for the unlinked anonymous method the review cites studies in New Mexico and the United States of America where unlinked anonymous testing has been carried out. In a small study in London the prevalence of infection found in a named testing programme was less than half the 25% found in the same population when studied unlinked and anonymously. In an American unlinked anonymous sentinel hospital study of patients admitted for reasons unrelated to HIV infection, the prevalence of HIV infection was 0.3% and in the same mostly mid-western cities the prevalence among military recruitment applicants was of the order of 0.1%.

The review acknowledges the limited value of unlinked testing if the only information which accompanies the sample is sex and age group. The value would be enhanced if changing prevalence were estimated in vulnerable groups, and hence additional information should be sought about patients attending genitourinary medicine clinics and those identified as injecting drugs. The review identifies pregnant women as a stable sub-group of the total heterosexually active population and comments that the trend in HIV infection in pregnant women should mirror that in the heterosexual population. However, unless special steps are taken it will not be possible to separate women who acquired their infection through intravenous drug misuse from those who acquired it through heterosexual intercourse.

If the present estimate of the prevalence of HIV infection in pregnant women in