dation for careful and regular blood surveillance, or of the paucity of evidence for its efficacy in general practice. The recommendation of lofepramine for the elderly may be more soundly based as it has fewer anticholinergic side effects but these side effects still do occur.

Unlike Matthews and Eagles, we believe that most general practitioners are qualified to prescribe clomipramine to their patients without referral to a psychiatrist, and that many can prescribe a monoamine oxidase inhibitor or lithium and provide the supervision that is required.

Our advice to general practitioners is based on the evidence of Hollyman and colleagues.[3] Patients presenting with a probable or definite major depressive disorder[4] should be treated initially with a first generation tricyclic antidepressant such as amitriptyline, unless contraindicated. A diagnosis of probable major depressive disorder depends upon persistent depressed mood for at least a week, preferably two weeks, together with at least four of the following symptoms: change in appetite or weight; sleep change; loss of energy; loss of interest; self-reproach; poor concentration; recurrent thoughts of death or suicide; and visible agitation or retardation. Second generation antidepressants have a place as second line treatments where side effects of first line drugs necessitate a change of regimen in spite of the disadvantages. The first generation tricyclic antidepressants are well tried, established in efficacy, have known side effect profiles and are much less expensive than second generation drugs. They are therefore much more appropriate as first line treatments.

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Quality or inequality in health care?

Sir,

During the stimulating debate on 'Quality or inequality in health care' at the Royal College of General Practitioners' Spring meeting in Newcastle, some speakers maintained that general practitioner fundholders were drawn from the better quality practices and that fund holding would further improve the quality of the care for their patients. I was reminded of the paper by Howie and colleagues (February *Journal,* p.48) in which they reported their research which made a convincing case for relating the quality of personal family doctor care to the length of consultation.

Being by nature a 'slow' doctor myself, my work as a locum in various Glasgow practices over the last few years has been enlightening. In some 'quality' practices the consultations were at 10 minute intervals; others had five minute appointments and many extra appointments. In the former I saw 12 patients in two hours and then had time to attend to all the paper work; in the latter, mainly in the peripheral housing schemes, I saw 35 to 40 patients in three hours. I am in no doubt about the quality of care, or lack of it, in these situations.

The main difference is clearly patient demand. In practices in deprived areas where patient demand is high there are substantially fewer patients per doctor than average and therefore the doctors receive less remuneration in capitation fees. There is little time for health promotion clinics and little hope of achieving targets, so income from these activities is limited. Deprivation payments are high but do not nearly compensate, which explains why these doctors are the poorest paid in the UK.

In their paper, Howie and colleagues stated 'doctors generally feel constrained by their commitments and, although many faster doctors expressed dissatisfaction with short consultations, they did not see a change in organization as a realistic option.' The greatest differences they found between longer and shorter consultations were first in the number of psychosocial problems identified and dealt with, and secondly, in the number of other health problems identified and dealt with. My observations (only impressions and not properly researched) confirm Julian Tudor Hart's inverse care law.[1] It is the patients in these areas of high social deprivation,[2,3] with the greatest demand on services and the shortest consultation times, who would benefit most from longer consultation times, where their doctors could try to help solve their problems and offer advice to improve their physical, psychological and social health.[4,5]

The motivation of the doctors in these areas is high and they have been justly called medical missionaries. What has the new contract to offer them? What is the RCGP's role in supporting them? At the very least we must try to keep up their morale and avoid 'peripheralizing' them, like the parts of our cities in which they work.

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Standardized patients in general practice

Sir,

Rethans and colleagues are to be congratulated on their careful and thought provoking studies of the use of standardized patients (March *Journal,* p.94,97). I wish, however, that more emphasis had been placed on a most important caveat towards the end of their second paper. 'The finding that doctors perform below predetermined standards does not prove that doctors are incompetent; it should at least be tested against the hypothesis that standards for actual care are still not realistic'. In other words, an alternative interpretation of the results is that the preset standards of care are invalid because they fit so poorly with the actual practice of doctors who should be presumed to be competent.

In much standard setting work of this type, I suspect that even the best intentioned general practitioners cannot throw off their essentially hospital based education, traditionally so dependent on received (and frequently untested) truths. Intuitive-

ly, many general practitioners ignore these received truths in the privacy of their surgeries, but are still insufficiently confident to defend in public their legitimate modifications of clinical method. A good example is the recent finding that, in suspected acute appendicitis, if rebound tenderness is elicited, rectal examination is unnecessary for immediate diagnostic purposes[1] — something that I imagine many experienced clinicians in general practice have long suspected.

The hypothetico-deductive approach is a much more valid model for clinical method in general practice.[2] The essence of the model is that an accurate diagnosis may be reached on the basis of a few pieces of highly discriminatory information and that, in many circumstances, a small number of important positive findings virtually negates any diagnostic value that might be added by routinely collecting further less important data (especially negative findings). To take one small example, I cannot imagine that many experienced general practitioners would consider it productive to carry out a comprehensive abdominal examination (inspection, percussion, auscultation, palpation) in every case of acute diarrhoea. The value of each of the components of abdominal examination depends greatly on the age of the patient, the likely diagnostic probabilities arising from a well taken history, and the need (if any) to exclude unlikely but dangerous possibilities (such as acute appendicitis).

The level of diagnostic confidence reached from the history alone may be so high as to render further data collection superfluous. According to this way of thinking it is as much bad practice to collect data in a rote based way as it is to miss information which would have been essential to diagnosis.

It would have been possible in the studies of Rethans and colleagues to work out the optimum hypothetico-deductive pathway(s) for each individual case, rather than selecting criteria which appear to be more generally syndrome based. This might have resulted in a more valid assessment of diagnostic quality.

A lesson to be learned from the great and continuing difficulties that our discipline has in attempting to release itself from the constraints of rote based, inflexible and unintellectual traditional models of medical education is that we must not create a new structure which is similarly based on received, but untested, wisdom. Once standards are set, however valid or invalid, they tend to become immutable. Until we know more about clinical decision making processes appropriate to general practice, it may be dangerously early to set standards.

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General practitioners and work in the third world

Sir,

John Holden, in his paper on general practitioners and work in the third world (April *Journal,* p.163), has shown that previous service in developing countries has not been a hindrance to general practitioners when later seeking an appointment to be a practice principal in the UK.

It should also be emphasized that, for those wishing to go overseas, the vocational training of general practice is good preparation, though preferably with some additional experience of general surgery and obstetrics. The growing technological gap between hospital practice in this country, and many of the poorer nations overseas, makes it difficult for those who have progressed through the hospital specialties to adapt to the limited facilities, and the wide ranging clinical workload which they may find abroad.

In Nigeria, to have the MRCGP is a distinct advantage, in that it enables doctors to be placed immediately on to the specialist medical register, and to avoid the assessment test of the Nigerian Medical Council, which might otherwise delay registration, and the beginning of active clinical work. Many general hospitals, both mission and public service, which have been accredited by the National Postgraduate Medical College of Nigeria for the postgraduate training of general practitioner registrars for their fellowship examination, would be particularly pleased to have members of the Royal College of General Practitioners on their staff.

I believe the RCGP should take note of its potential role in helping to bridge the gap between medical practice at home and in developing countries. Two ways suggest themselves: identifying possible six month training posts in general surgery and obstetrics for those with the MRCGP wishing to serve overseas; and strengthening the section in the RCGP library devoted to primary and secondary care overseas.

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Sir,

I was sorry to read that the number of general practitioners who have worked in the third world before entering general practice has fallen (April *Journal,* p.163), especially when they reported no difficulty in finding practice partnerships afterwards and thought the experience valuable. Having spent two such periods abroad, the first after my trainee year and the second after five years as an established principal, I would echo Dr Holden's advice that doctors 'should be encouraged to pursue the possibility'.

However, there do seem to be innumerable obstacles in the way. There are, as Dr Peppiatt reports (April *Journal,* p.159) a large number of small missionary societies, and while I can personally vouch for the excellence of his organization, the Methodist Church Overseas Division, such standards are not uniform and there is no umbrella organization among missionary societies coordinating recruitment, health advice, psychological testing and debriefing. Doctors wanting to work in the third world will find that unless they are existing members of a particular missionary organization, access to placements abroad is difficult and funding is not available. Most non-governmental organizations will not consider applicants for terms of less than two years and it is unlikely that many doctors could fund themselves for these periods of time.

The Overseas Development Administration of the British government have no schemes for placement or exchanges with third world doctors. There is no society or group of doctors who have spent time abroad whose experience and expertise could be used. The Royal College of General Practitioners may wish to consider if it should have a role, such as the creation of travelling fellows. Dr Holden states that the Joint Committee on Postgraduate Training for General Practice allows work abroad to count towards equivalent experience for vocational training but 'each case is considered on its merits' so one assumes this is a retrospective decision, which is perhaps of little help to a vocational trainee.

In the Netherlands the government shows its commitment to medical aid to