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

third world countries by ensuring that doctors posted abroad continue to receive the salary they were on before departure, providing the placement is adequately organized and arranged, usually by a missionary society. Consequently they do not lose out in either career or financial terms. In the UK this is only likely to be possible for research registrars in tropical medicine or allied specialties and their time abroad does not always leave any tangible benefits.

I believe there are plenty of doctors who would be willing to work in the third world but are prevented from doing so by the lack of help. My own practice has a long standing arrangement to allow a partner to take a sabbatical year away after every five years of service. Perhaps others could do the same? I would be delighted to hear from any doctors who would be interested in helping change the present poor picture of British medical help to third world countries.

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Cryptorchidism — a significant risk factor for testicular cancer

Sir,
I was interested to read the letter by Lucy Pendered (February *Journal*, p.81) reporting the increasing awareness of the young men in her practice population towards testicular cancer. Her results were similar to those which I found in rural Devon while I was a general practitioner trainee. In addition, I found that while 48% of male respondents examined their testes, only 10% of them did so in a formal and routine manner.

Any benefit of a disease prevention or screening activity must be balanced against the financial, social and psychological costs of such an activity before that activity is promoted. Testicular cancer is a potentially curable disease occurring predominantly in young and otherwise healthy men and while the benefits of cure are considerable, the low incidence of the disease, the low general practice attendance rates of young men and the possible psychological consequences may lead some to question the validity of testicular examination as a suitable screening activity.[1] Education rather than screening could solve this dilemma and would reduce the average delay before the patient seeks professional help, which at present seems unacceptable.[2]

However, one should not forget that men with a history of undescended testes are at considerably greater risk of developing testicular cancer and our screening activities could be more profitably directed towards this population.

Cryptorchidism occurs in 2–3% of full term male infants and in the majority of these it resolves by the end of the first year. It has been estimated that testicular cancer develops in 1% of men with inguinal testes and 5% of men with abdominal testes and this represents a considerable increase of risk.[3] The incidence of carcinoma *in situ* found by biopsy in asymptomatic men with such a history may be as high as 3%.[4]

Thus, while we take great care to screen male infants for undescended testes, we should not forget about these patients after we have written the referral letter to the paediatric surgeon, but remember their increased risk of testicular cancer once they reach adolescence.

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GPs' response to request for information

Sir,
As research officers in the department of anaesthetics at the University of Wales College of Medicine, we are involved in designing and executing clinical trials looking at the effects of anaesthetic, analgesic and sedative drugs. In a recent study we planned to examine the effects of intravenous benzodiazepine sedation in a population of healthy young male volunteers. In applying for this trial the volunteers had to undergo a thorough medical examination including biochemical, haematological and urine analysis. As a further precautionary measure we also wrote to their general practitioners. In the letter we explained the purpose and design of the trial, giving details of the drugs to be administered, and asked whether, as far as they knew, there was any reason why their patient should not be included in this trial. We enclosed a simple form requiring only the deletion of one of two statements: 'I know of no reason why X should not take part in the study'./'X's medical history indicates that he should not be included in the study'. We also enclosed a stamped addressed envelope for the return of this form. The letter was on College of Medicine headed paper with the patient's name in bold type at the top.

Of 36 such letters sent, we received only 12 replies, and four of these had failed to make the deletion, rendering the response meaningless. We appreciate that general pracititioners receive a large amount of unsolicited mail, but we are surprised that the response rate was so low to a letter which directly concerned the welfare of a patient in their care.

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Reports from inner city practices

Sir,
Dr David Widgery and I are interested in collecting reports from general practices in urban deprived areas, with a view to reviewing them and possibly compiling an anthology. We would be very interested to read reports from any general practitioners working in deprived areas.

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Request for back issues of the *Journal*

Sir,
The Catholic Mission Hospital in Nuagaon, India is a charitable hospital catering for a rural and suburban population. I would be grateful if any readers could donate back copies of the *Journal* to the hospital when they have finished with them. The *Journal* would then be kept in the hospital library.

G K Prusty

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