Sir,

Geoffrey Marsh's vision of the future is frightening (editorial, July *Journal*, p.266). General practice has two main functions. One is to provide high quality diagnosis and management of disease. In order to do this the general practitioner must not only be knowledgeable but understand the limitations of his or her knowledge. The doctor must also have access to a number of other professionals, on behalf of patients, and should remain the conductor of an orchestra of skills. Marsh makes a plea for specialization within practices, but this carried to extreme leads to 'specialoids' not specialists (personal communication). As John Fry pointed out many years ago, those who see three times as many runny nosed children as anyone else do not thereby qualify as paediatric specialists. If present day doctors have shortcomings in the diagnosis and management of disease, it seems rash to state that 'Nurses will be the clinical powerhouse of the future primary health care teams'.

The other main function of the general practitioner is the provision of personal care.[1] Sir Theodore Fox in his celebrated paper 'The personal doctor' expressed it beautifully when he wrote: 'Unquestionably the practitioner needs helpers in his surgery or office and should be able to call on a wide range of skilled ancillaries outside: but the particular object of his independent existence may be defeated if he leaves all dressings to the nurse, sympathy to the receptionist, messages to the secretary, and the solution of home problems to the social worker. If somebody else is to do all the small things for the patient under the doctor's distant supervision, personal contact will be reduced to the minimum: and if this happens, the patient might just as well go to hospital'.[2] Personal doctoring is about mutual trust and good judgement: judgement which is tailored to the individual and not derived from guidelines or protocols, judgement which involves those who seek help and which treats them as adult autonomous human beings. Yet Marsh is happy that our successors will abandon 'many time honoured tasks, such as routine care of patients with chronic illness'.

Dubious strategies of health promotion and prevention have distracted general practice from its central role and will continue to erode the time and energies of both doctors and nurses to no good purpose other than the inculcation of 'holy dread'.[3]

Finally, it is sad to see a distinguished member of the Royal College of General Practitioners stating that, among others, practitioners in the complementary therapies will be vital to provide a truly holistic community based caring system.

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Sir,

The central thrust of Geoffrey Marsh's thesis is clearly wrong (editorial, July *Journal*, p.266): that by delegating much of patient care and consequently allowing list size to rise (a figure of 4000 having been mentioned previously[1]) one can hope to maintain personal involvement and holistic care. In advocating removal of general practitioners from primary contact with patients and suggesting we act as specialists he is relegating us to the role of technician and supervisor.

One of the central, enduring strengths of British general practice is the primacy of the relationship between patient and general practitioner; a relationship built over time, on faith and trust, with the doctor witness to a patient's trials and tribulations, sharing his or her fears and anxieties through major and minor illness, no more sensitively portrayed than in Kenneth Lane's book *The longest art*.[2] Marsh misses the point if he thinks chronic illness can be managed in a mechanistic way. Most chronic physical illness is relatively simple to manage if one approaches it as a disease requiring a technical solution, but when viewed as an illness, it requires a truly holistic view to interpret and understand the patients' perceptions and concerns, the effect on psychological well being and the implications for family, friends and colleagues at work. The doctor–patient relationship in these cases is often stressful and demanding but the reward comes from the privilege of sharing some of the most intimate and private moments of a person's life.

As David Metcalfe has said in the context of antenatal care, it would be easy to delegate the palpation of a woman's abdomen but it would rob one of the opportunity to share and understand the woman's personal experience of pregnancy, and deny the reassurance that comes with touch — 'the doctor's healing hand' (personal communication).

On a further point, Marsh's advocacy of employing auditors, by implication not members of the primary health care team, goes against all the advice from the medical audit advisory groups, and confirmed by the 10 year north of England audit study,[3] that audit should be an internal process and that effective change only takes place if there is a sense of ownership of the task.

Marsh's views are not representative of all general practitioners. He is in danger of offering the government the opportunity to make substantial economic savings under the guise of technical efficiency and one wonders at what cost to patients' well being.

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Acute herpes zoster, postherpetic neuralgia, acyclovir and amitriptyline

Sir,

On the basis of his study, David Bowsher claims that 'the nature of postherpetic neuralgia is changed by acyclovir treatment of acute herpes zoster' (June *Journal*, p.244). We are writing to suggest that this claim is not justified.

The study in question is retrospective. For the results to be of value it is essential that the group of patients who received acyclovir are similar to those who did not. Unfortunately this does not appear to be the case. When one looks at the distribution of the initial attack of shingles there are important differences between the two groups. While 17% of patients treated with acyclovir had shingles in the trigeminal nerve, 30% of those not given the drug had shingles in this nerve. The difference in shingles distribution could account for some of the difference in pain reported.

The mean length of time between the onset of herpes zoster and commence-

ment of treatment of postherpetic neuralgia was 5.7 months for those initially treated with acyclovir and 29.3 months for those not treated with acyclovir. This implies that the patients who had been given acyclovir were assessed at a much earlier stage in their postherpetic neuralgia than the others. This is another factor that might seriously confound the results.

There appears to be a difference in the type of pain reported by the two groups of patients with postherpetic neuralgia. This difference may be due to a number of factors, including those outlined above. It is therefore misleading to state that the differences are due to initial treatment with acyclovir while ignoring other possibilities.

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Differential diagnosis of otitis media and externa

Sir,

I fear Dr Price's letter (August *Journal*, p.349) may cause some confusion in the diagnosis of otitis externa.

Otitis externa is a condition in which the patient complains of itching or soreness rather than pain, with or without discharge from the affected ear(s). Primary otitis externa is almost unheard of in children. Its presentation in adults is almost invariably linked to exposure to conditions of high temperature and/or humidity or else to a history of frequent swimming, previous episodes of dermatitis, and/or trauma, such as from cotton buds, an ill-fitting hearing aid mould or ear syringing. Secondary otitis externa, which is much more common in children than primary otitis externa, may be caused by the external auditory meatal skin becoming inflamed by being bathed in the pus and secretions of suppurative otitis media draining through a tympanic perforation.

Dr Price is correct in observing the fleeting nature of aural discharge in children, rapid resolution with appropriate treatment being the norm, but he is incorrect in asserting that hospital doctors do not see the condition. As a hospital consultant, I can assure him that we do: the young patient is usually referred urgently with a provisional diagnosis of mastoiditis.

Adopting Occam's razor, I would venture to suggest the following as an aide memoire: a history of upper respiratory tract infection followed by aural pain and discharge favours a diagnosis of otitis media with secondary otitis externa. A history of itching or soreness plus discharge favours a diagnosis of primary otitis externa, particularly if provoked by exposure to heat, humidity or trauma. Primary otitis externa tends to be bilateral while otitis media and secondary otitis externa tend to be unilateral. Children tend to suffer from secondary otitis externa while adults tend to suffer from primary otitis externa. It remains most illuminative to examine the normal ear first as a reference point from which to establish the condition of the affected ear.

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Social indicators of health needs

Sir,

The World Health Organization's 'health for all' strategy in 1981[1] ranked health inequalities linked to poverty as an important priority, which has unfortunately not been taken up as a target in the government's white paper *The health of the nation.*[2] Nonetheless, the concept of deprivation allowances for general practice in the 1990 contract for general practitioners is a major step in the right direction. The Jarman underprivileged area score, which is the basis for this, has been widely criticized in its construction, validation and application.[3-6] It was designed as a measure of workload and not deprivation, and it has not been applied in the way recommended by its author.

Because of the problems in its application, adjustments have been made for Wales (taking into account standardized mortality ratios and council housing) and for Scotland (using enumeration districts and the Jarman UPA(8) scores excluding the unskilled factor). It is clear that for England similar adjustments are indicated. Indeed, a simpler method of assessing deprivation at enumeration district level or practice level is needed for the whole of the United Kingdom. The excellent paper from Hopton and colleagues (June *Journal*, p.236) attempted this and suggested in particular, assessment of housing tenure at practice level. Balarajan and colleagues[7] have also suggested a different deprivation index, their main indicators being council housing tenure, access to a car, socioeconomic group and country of birth.

We work on a large post-war peripheral council housing estate in south Bristol and have thought for some time that housing tenure was linked to deprivation. The most disadvantaged (those on low income, unemployed people, young families and single parent families) are housed in the least desirable and least appropriate dwellings, namely the high rise blocks and three storey flats with no lift. Thus the powerless and voiceless are marginalized.

The new data from the 1991 census will soon be available and will necessitate some adjustments to the Jarman index. It is important that at the same time other alterations are made to ensure a more sensitive allocation of resources for deprivation, so they reach those who are disadvantaged.[8] The alternative is to use a simpler practice-based method of deprivation assessment as indicated above.

It is important that this issue is tackled now because many practice populations similar to our own in 'forgotten areas of deprivation'[9,10] are being stripped of resources, and the opportunities for disadvantaged people having 'an average chance of health'[10,11] are diminishing.

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