known to be accompanied by significant psychiatric morbidity[2] and may be a precipitant to suicide in older people.[3] In a pilot study aimed at setting up a 'pain management group', a retrospective case note study was performed on 40 consecutive referrals to the service by local general practitioners. In all cases, documentation was made of all medical diagnoses and medication. Results of all radiological investigations performed within the past year were also sought. Patients were asked if they had experienced any pain within the past week, and, if so, for a description of its severity; in cases where cognitive impairment was suspected, patients' reports of pain were corroborated by relatives/carers.

Of the 40 referrals, 31 were women and 9 were men; ages ranged from 70 to 94 years (sd ±6). A total of 23 out of 31 people had experienced pain within the previous week, but there was no association with age or sex. Osteoarthritis (confirmed by radiological changes) was the commonest suspected aetiology associated with pain, accounting for 15 out of 23 cases. In 7 out of 23 cases, no analgesics had been prescribed within the past month. In all these cases the pain was described as being constant during the previous week (confirmed by descriptions from a carer/relative), and all 7 had a diagnosis of dementia. Although people with cognitive impairment were less likely to have been prescribed analgesics, this was not statistically significant (possibly because of the small sample size). However, the finding does raise the issue of detection and treatment of pain in dementia. Cognitive impairment may result in both the under-reporting of pain and poor compliance with analgesic treatment as a result of memory disturbance. It is possible that, in many of the cases above, treatment for pain had been attempted on previous occasions, but aborted.

Although it is known that the incidence of painful medical illnesses increases with age, and that there was no control group in this study, the finding that a large proportion of those with dementia have chronic pain without analgesia calls for similar studies aimed at examining the detection and treatment of pain in people with cognitive impairment by general practitioners.

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Fragmentation of the health service and the future of general practice

Sir,

At the recent RCGP scientific symposium in Aberdeen, the plenary on the future of general practice presented four views: an alliance between public health and primary care, the political fragmentation of the health service and primary care, the relationship between research and service general practice, and a registrar's view including the rural/out-of-hours debate. The future may seem uncertain, but the present looks chaotic. Attempts to draw parallels between primary and secondary care does not help matters. There are other uneasy alliances: recruitment and the profile of associates, guidelines and equity, and joint clinical managerial posts; and other uncomfortable issues: the internal market, the increasing role of nurses and the increasing accountability of health care professionals.

It is claimed that we are in a cultural transition marked by a quest for diversity; 'never again one voice' echoes the poet Michael O'Siadhail.[1] In our changing culture, we must resist the fragmentation of general practice threatened by the myriad of conflicting demands and constraints. In doing so there is a real danger that we will create a 'flat' plurality which irons out diversity: a featureless, visionless and unimaginative profession. Alternatively, there is the possibility that we shall experience a new Babel — a great project to build a new general practice — but alas, our diversity becomes merely an instrument of division: a divided, directionless and frustrated speciality.

Each of the views proffered in the RCGP symposium plenary session is limited and can provide only a partial answer to the question of the future of general practice. A hallmark of our evolving culture is the movement towards polyvocalism, in which organizations are held to account and consumer views are fed into policy making. One result of such a move will be to qualify the phenomenon of increasing consumer expectations. The College's task is to embrace all of the views and possible answers to the question of its future and to balance diversity with unity. Paradoxically, the diversity experienced at Babel retarded the inevitable iniquity that arises as a society or organization progresses.

Like an adolescent, the College is interested in forming relationships before it has the courage or confidence to do so: the discussions on the future of general practice need to be brought out from behind the bike shed. There will never be uniform nor fair solutions to the apparent chaos but there will always be uniting aims, values and principles to which the College must remain true.

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The DCCH examination

Sir,

I recommend to fellow members of the RCGP the Diploma in Community Child Health examination organized by the RCP(Edin), RCGP and Faculty of Public Health Medicine. It is especially suitable for GPs in the UK and overseas. Very detailed paediatric knowledge is not tested; however, a positive attitude to evidence-based child health promotion and a lot of common sense are needed.

I like this examination for several reasons: it is highly relevant to general practice; it boosts candidates' interests in quality assurance and audit; it is well organized. Playing with the children, and even an infant, in the Objective Structured Clinical Examination is much fun. Moreover, it gave me an excuse for a much needed vacation.

Any GP who enjoys working with children will benefit greatly from taking this examination.

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