Table 1. Course providers in a range of broad subject areas.

Broad subject area	Number of providers
Accounting and finance	2
Acupuncture/homeopathy	6
Community and primary health care	6
General practice	9
Computing skills and information science	6
Health care ethics/philosophy of medicine	9
Health promotion and science	9
Health law	4
Management	28
Medical education/training	10
Occupational medicine/public health	14
Paediatrics	7
Palliative medicine	4
Psychiatry/psychology/psychotherapy/counselling	14
Sports medicine	4
Therapeutics/toxicology/dispensing	6

Subjects included in other available courses:

Addictive behaviour	Anaesthetics	Audiological medicine
BASICS	Biochemistry	Bioengineering
Dermatology	Medical statistics	Diving medicine
Environmental health	Forensic medicine	French for medical professionals
Gerontology	History of medicine	Rheumatology
Research methods	Human sexuality	Medical physics
Rehabilitation	Mental handicap studies	Osteopathy for doctors

service for medical education, and its availability has been made known to all regional advisors in general practice, many of whom order copies for each of the GP tutors in their region.

Nearly 200 courses suitable for GPs have been identified in the UK, partly by directly requesting course information from university departments and other providers, and partly by obtaining further information about courses advertised in journals and medical magazines. Lindsay Smith[2] identifed seven master's degree courses available for GPs from UK departments of general practice, with another 11 planned within the next five years. Master's degree courses such as these form the backbone of higher professional training in general practice. However, the personal interests and development needs of individual GPs differ widely, and higher professional training within general practice should be directed towards such interests and needs. Many courses are available covering wide areas of medicine, and reflecting these variations of interest.

Lack of time has been shown to be the largest single factor preventing GPs from attending CME meetings.[3] Since the ability of doctors to spend time studying varies between individuals, and within an individual's lifetime, not all will want to undertake master's[3] degree courses owing to the time commitment involved. To satisfy the needs of these individuals there are also many courses to certificate or diploma standard, and shorter distance-learning courses that help to satisfy the requirements for PGEA. It is unfortunate that the UK National Accreditation panel for Distance Learning courses does not publish, and make available, regular lists of such approved packages as a service to medical education.

The table below summarizes the diversity of such courses as are currently available, and indicates the number of providers in each broad subject category.

A wide range of higher professional courses exist that are suitable for GPs, and an annually updated directory of such courses is available mainly through regional advisers and GP tutors. I would welcome information about new courses for inclusion in the directory.

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Defensive medical practice in context

Sir,

Lumbar spine X-ray requests are common. According to Porter and Hibbert, between 23% and 44% of those who consult their GP with back pain are eventually X-rayed.[2] However, only one out of 2500 X-rays detects something that has an impact on patient care that was not suspected from medical history and physical examination.[2] Moreover, evidence-based guidelines are stating that plain X-rays are not recommended for routine evaluation of patients with acute low back problems.[3] Thus, it is important to attempt to understand why such referrals continue to take place. A number of suggestions have been made, including genuine diagnostic uncertainties, patient-initiated demand, and defensive medical practice.[4] Last year, in the *British Medical Journal,* Summerton suggested that 98% of GPs are undertaking defensive medical practice because of fear of complaints, and diagnostic testing was highlighted as a particular problem.[5] However, as was empasized in the article, there are many other factors which may influence a GP's decision-making, and it is important that defensive medical practices are considered in the context of these other options.

Using a modified X-ray request form, 52 GPs in Huddersfield agreed to indicate their primary reason for ordering a lumbar spine X-ray for patients between the ages of 16 and 65 years. Based on a small, local pilot study, four options were presented:

- To make a diagnosis
- To exclude a diagnosis
- At the patient's request, and
- For medico-legal reasons (i.e. fear of complaint or being sued).

The demographic and practice characteristics of the GPs were representative of the district as a whole.

Over a 12-month period, 224 modified X-ray request forms were returned. The results were as follows:

- One hundred and twelve of these requests were for female patients; 105 were for male patients (7 not stated).
- Medico-legal concerns ranked considerably lower in terms of decision-mak-

Table 1. Primary reasons for ordering a lumbar spine X-ray.

	Number (%) of requests indicating this was the primary reason for referral (*n*=224).	
Make a diagnosis	118	(58%)
Exclude a diagnosis	62	(27%)
Patient request	42	(18%)
Medico-legal	2	(1%)
Total	224	

ing than either diagnostic usage or patient request. Even if it is assumed that acquiescing to a patient's request is, for some GPs, a way of avoiding possible complaints, the medico-legal factors still do not approach the diagnostic concerns.

This study confirms that defensive practice occurs, but it is not the dominant factor influencing practice in relation to lumbar spine X-ray requests. In order to have a significant effect on such requests, the approach adopted needs to be oriented towards education rather than risk management.

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The challenge of angina

Sir,

May I add to the article entitled 'The challenge of angina' by George Kassianos (*Members' Reference Book* 1996, p.259)?

The risk factors for coronary artery disease (CAD) include tobacco, excess alcohol, physical inactivity, stress and diet — the latter perhaps being the most important.

Recent work indicates that CAD is not only preventable, but reversible. A small but growing number of American doctors have recently and independently confirmed this. They include Dean Ornish, professor of cardiology and advisor to the White House; John McDougall, director of nutrition, St Helena Hospital, California; Colin Campbell, professor of nutritional biochemistry, Cornell University; William Castelli, director of the Framingham Heart Study; and William Roberts, editor of the American Journal of Cardiology.

Their clinical experiences, backed up by several controlled trials (Ornish,[1] Thorogood[2] and Esselstyn[3]) using annual angiography, revealed plaque dimunition and an increasing patency of coronary arteries in those subjects consuming a mainly plant-based diet (10% total calories from fat). In the controls who adopted the diet devised by the American Cardiological Society (30% total calories from fat), plaque formation was only slowed down.

By reducing all fat (and animal protein, which is now being incriminated with fat; see, for example, *The Cornell-Oxford-China diet and health project* by Colin Campbell and Richard Peto) to the level consumed by most people prior to the agricultural revolution, CAD (which, until about 200 years ago, occurred mainly in Palace, Church and wealthy circles) would be largely eliminated. Anthropological literature suggests an increase in fat intake in the past two centuries from 10% to 40% of total calories, and in animal and protein intake from 10% to 60–70% of total calorie intake. In rural societies, such as China and Japan where diets are still largely plant-based, CAD is quite rare. Also significant is that starch energy has dropped in the West from about 80% to 40% of total calorie intake.

My own clinical experience is confirmed by the writings of the above-mentioned researchers. However, may I quote two of my cases:

1. An engineer, aged 70 years, with a 13-year history of angina, needed medication to walk from his car to the surgery door, but on adopting a plant-based diet he was able, one month later, to walk the mile from home to the surgery, and three months later to walk two miles to the market and back.
2. A headmaster retired as a result of suffering from angina at the age of 48 years. Now aged 52 years, he has accepted an almost vegan diet. He noticed an improvement within days and, as his activities increased, he began taking full and active advantage of his retirement on a full official pension.

The benefit is attributed to a gradual reduction in plaque size with an increase in coronary artery diameter as indicated by serial angiography, and by a prompt reduction in blood viscosity and red cell clumping leading to increased capillary flow and oxygen perfusion.

A recent book summarizing the above has just been published.[4]

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Red pepper effect

Sir,

We describe an unusual case report and wonder if any other practitioners have come across a similar occurrence.

A 40-year-old man of previous good health presented with an 11-day history of anal pain. Apart from local tenderness, no other signs were obvious. Four days later a perianal abscess was drained. No associated pathology was found. Normal lower gut flora (E. Coli and Klebsiella) were found on culture. Barium enema, colonoscopy and sphincter studies were all within normal limits. Since then he has had at least seven reoccurrences of the perianal abscess, each time with spontaneous discharge.

The patient has noticed that over the last four months, during which time he has eaten a red sweet pepper daily, there has been a progressive reduction of both the anal discharge and the discomfort. Green and hot peppers are of no help. On stopping the consumption of red peppers there was a reoccurrence of the anal discomfort and discharge within five days. He has found that the minimum effective amount of fresh red pepper is about 150 gm on alternate days. It must be chewed. The healing effect is lost if the pepper is liquidized; tinned red pepper is of no help, nor is green and hot pepper.

It would be interesting to know if this 'red pepper effect' is local or systemic.

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CORRECTION: In the September Journal, the author of the letter entitled 'The investigation and management of patients with heart failure' (p.551) was Eric M Saunderson, not Eric M Sanderson.