Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Backing Bush

Why should readers of the *BJGP* be subjected to your and your contributors' glib views on the recent US presidential election?[1,2,3] At least one of your readers is happy that Bush was re-elected. Kerry voted against the 1991 war against Iraq. Had he been in power then, we would have faced a Saddam in charge of a 'greater' Iraq enriched by Kuwait's oil wealth. He was often ambivalent in his support for the war on terror, managing to portray himself as being both against it and critical of it not being fought with more vigour.

In Bush we have that rare thing, a politician who says what he means and does what he says. I am grateful for his, and Blair's, resolve to overthrow Saddam's regime. I don't mind you disagreeing with me. I do mind the cosy assumption of so much of the media that the re-election of Bush is 'perplexing' and that only an idiot could support him.

RICHARD WATSON
General Practitioner, Glasgow.
E-mail: Richard.Watson920@ntlworld.com

REFERENCES

1. Jewell D. December Focus. *Br J Gen Pract* 2004; **54**: 889.
2. Frey J. Book Review. *Br J Gen Pract* 2004; **54**: 966–967.
3. Goodman N. A book and a Bush. *Br J Gen Pract* 2004; **54**: 969.

GPs on the move

Ballard, Robinson and Laurence[1] uncover some interesting factors that have made French GPs relocate to practice in London. As an English GP who moved from her London practice 4 years ago, I was particularly interested to see if I had any motives in common with those found in the study. I was unsurprised to see that personal factors remained the main driving force for the migration of these French GPs. This was also my main motivating force, as well as the issues that face GPs in the UK in the inner city. Furthermore, I currently work as a university faculty GP, in a teaching practice in innercity Hamilton, Ontario, Canada, where I see many doctors who have also migrated from their countries of origin. This population has moved for personal reasons also, but their stories tend to be that of persecution or hardship in their country of origin, and a desire to migrate to a better economic future for themselves and their families. Another factor pertinent to Canada, is that many Canadian-trained doctors also migrate, mainly to the US. It seems that the impetus for the migration of these doctors would mainly be financial — in the US the remuneration for GPs is very handsome indeed compared to the Canadian system.

I think that a follow-up study to address the issues of migrating GPs should look at why GPs specifically choose to leave the UK. Literature that exists in this area consists of a survey from 1990–1994[2] that concluded that areas with a high deprivation rate and with high needs had higher than average exodus rates of GPs (for example 7.8% in Kensington, Chelsea and Westminster). A more recent study of a qualitative nature might help to address the concerns of the GP recruitment and retention crisis that are highlighted by the authors in their introduction. After all, shouldn't we be trying to find out why GPs want to leave their places of professional origin, rather than finding out why other GPs want to come to the UK?

GINA AGARWAL
Assistant Professor, Department of Family Medicine, McMaster University, Ontario, Canada.
E-mail: agarg@mcmaster.ca

REFERENCES

1 Ballard KD, Robinson SI, Laurence PB. Why do general practitioners from France choose to work in London Practices? A qualitative study. *Br J Gen Pract* 2004; **54**, 747–752.
2 Taylor DH Jr, Leese B. General practitioner turnover and migration in England 1990–94. *Br J Gen Pract* 1998; **48**: 1070–1072.

Dirty magazines

I read with great interest Dr Charnock's[1] paper about bacterial contamination of waiting room magazines. I wonder whether he made any attempt to differentiate between titles? Were there similar numbers of bacteria on *Readers Digest* as *The Field*? Is *Cosmopolitan* as dirty as *Good Housekeeping*?

RICHARD JENKINSON
General Practitioner
Bransgore New Medical Centre, Ringwood Road, Bransgore, Christchurch, Dorset, BH23 8JW. E-mail: richard.jenkinson@gp-J81050.nhs.uk

REFERENCES

1. Charnock C. Swabbing of waiting room magazines reveals only low levels of bacterial contamination. *Br J Gen Pract* 2005; 55; 37–39.

The act of communicating

I read the discussion paper on communication skills by Professor Skelton with interest.[1] Having been involved in the teaching of communication skills to medical students and GP registrars for some years I feel that the paper raised interesting issues about the subject and its future. Traditionally the model of medical expertise used to design teaching (and assessments) considered the three domains of knowledge, skills and attitudes. A fourth domain of problem-solving skills was later added. In this model, communication and consultation

teachers use a skills-based approach to facilitate learning. We tend to speak of consultation skills, often forgetting the important aspects of knowing what to do (knowledge) and the manner in which to do it (attitude) as well as how to do it (skill). The domains are not independent and more recently educationalists are thinking in terms of roles or competences. For successful completion of a task or role, different aspects of medical competence have to be integrated.[2] Thus, as Skelton concludes, we also need to think outside the narrow limits of 'skills' and consider our trainees' professional attitudes as well.

To some extent this is happening within medical schools which include modules called 'Personal and Professional Development' or similar. These courses integrate learning about communication/consultation with other aspects of professional competence, such as interprofessional teamwork, reflective practice and management. However, the integration is not always successful as timetables listing 'communications skills' and 'working in teams' suggest.

Laurence Olivier, on the set of the film 'Marathon Man' is reported to have advised his co-star, and exponent of method acting, Dustin Hoffman 'to just act' rather than try to immerse himself totally in character. Acting may thus be seen to be reduced to technical skills. Is communication solely a set of skills or should we expect more? Or to put the question another way: are underlying attitudes important if observed behaviour with patients and peers is acceptable? We know that attitudes may be inferred from behaviour but correlation between observed behaviour and attitudes is not always high.[3] If we learn the techniques of 'patient-centred' consulting and demonstrating empathy without really liking patients or agreeing with patient partnership is this a problem? If our assessments rate such behaviour highly and assessment drives learning, perhaps we do not need to soul-search too much. Or do we?

JE THISTLETHWAITE
Associate Professor
Department of General Practice and Rural Medicine, James Cook University, Townsville, Australia. E-mail: jill.thistlethwaite@jcu.edu.au

REFERENCES
1. Skelton JR. Everything you were afraid to ask about communication skills. *Br J Gen Pract* 2005; **55**: 40–46.
2. Schuwirth LWT, van der Vleuten C. Changing education, changing assessment, changing research? *Med Educ* 2004; **38**: 805–812.
3. Kaplan RM. Behaviour as the central outcome of healthcare. *Am Psychol* 1990; **45**: 1211–1220.

The duty to die cheaply

In the December 2004 issue you publish a piece by Peter Goldsworthy,[1] 'The duty to die cheaply'. Maybe it was meant to be funny, but I was not amused. On the contrary, the picture of a professional man, a GP to boot, drinking himself to incapacity and making a fool of himself was disgusting. I think the only people who would find such a story amusing are those who split their sides laughing when they see somebody drop his trousers. An article like this has no place in a medical journal.

O FLEMING
Retired GP, Sheffield.
E-mail: dottofleming@waitrose.com

REFERENCES
1. Goldsworthy P. The duty to die cheaply. *Br J Gen Pract* 2004; **54**: 972–975.

Editor's response

Thank you for commenting in forceful terms about the Peter Goldsworthy short story we published in December. We always value feedback even when, as in this case, you are not best pleased with our efforts.

I don't agree however either with your comment that such a piece has no place in a medical journal, nor with your specific criticisms re Goldsworthy. As to the former point, what sort of material does have a place in a medical journal? In my view a medical journal has to encompass more than dry academe, and we can all learn and reflect from a wide range of material — polemic, fiction, personal reflection, the visual arts, music, poetry, etc. This is more true perhaps of a medical journal where the medicine happens to be general practice. In general practice, surely, all of life is there, including the warty nasty desanitised bits. With regard to Goldsworthy, his story does have a certain dark mordant wit, but I don't think that we are expected to laugh at our colleague's behaviour. We are repelled by his performance, we cringe, although we also know that doctors do behave disgracefully on occasions. This story forces us to look at ourselves, in my view. It is also a superb piece of short story writing technically — austere, every word counting, drawing the reader along (I take it that you made it to the end?). In my view the *BJGP* has performed a service in bringing Goldsworthy's work to a wider readership.

I may not convince you, but c'est la vie — a lively debate about what the *BJGP* does is always welcome!

ALEC LOGAN
Deputy Editor
British Journal of General Practice
aleclogan@dial.pipex.com

Correction

Oakeshott P, Kerry S, Dean S and Cappuccio, F. Nurse-led management of hypertension. *Br J Gen Pract* 2005; **55**: 53. The following forest plot accompanies the letter.

Fall in systolic blood pressure (SBP) after nurse-led intervention in UK primary care.