violence accounts for about half the women murdered in Britain. Those experiencing domestic violence may legitimately believe that their partners may kill them.

For a well-researched reply to Summerfield's paper equating PTSD to 'victimhood' and an inadequate 'stiff upper lip' see Mezey.[3] Most psychiatric conditions reflect changes in human thinking over time[3] and are part social construct. Chronic PTSD has neurobiochemical and anatomical consequences (for example, loss of hippocampus volume) that can be objectively monitored.[3,4] Not everyone with PTSD is seeking compensation. There is evidence for the liberating effect for patients in receiving an explanation of their life-disrupting PTSD symptoms.[3–5] In making a diagnosis of PTSD the patient's trauma is acknowledged and their symptoms are recognised as an understandable human response to extreme events. The diagnosis can lead to the victim achieving autonomy and rejecting 'victimhood'.[3,4] PTSD can be successfully treated.[4] In a general practice study, PTSD was present in 35% of those who had experienced domestic violence, and was indicative of experiencing the severe end of the spectrum of domestic violence.[6] I agree with Dr Fitzpatrick that the outcomes of interventions in families' lives are not adequately researched.[7] However, if the framework of PTSD helps a doctor recognise domestic violence when he would not otherwise have done so, then his patient at least has the opportunity of receiving a helpful intervention. Does Dr Fitzpatrick enquire as to the cause of the black eye, PTSD, depression or the bruise on the baby's belly? Or would this enquiry erode civil liberties and intervene in family life too much? Discussing safety and options for action with a woman experiencing domestic violence may erode her civil liberties but she might prefer that to being murdered or further damaged. While Dr Fitzpatrick's rosy view of 'egalitarian and less abusive relations between the sexes' may reflect a reality, it does not reflect the reality of the battered patient in front of him.

Fiona Duxbury
The Leys Health Centre, Blackbird Leys, Oxford 0X4 7EX
E-mail: duxburycrosse@doctors.org.uk

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Travelling costs

I would like to urge your readers and their patients, particularly those with cancer, to complete the online survey into the Hospital Travel Costs Scheme (HTCS), under which those on low incomes are supposed to be able to claim back their travel expenses for getting to treatment. The Department of Health consultation aims to find how awareness of the HTCS can be raised among NHS staff and patients, and to work out how patients can claim their expenses back, bearing in mind that many receive their treatment away from the hospital. We know that many cancer patients struggle to find the money to travel to and park at hospital: on average patients make 53 trips costing £325 in total during the course of their treatment. However Macmillan's Cancer Costs report revealed that only 4% of those facing travel costs receive help through existing schemes such as the HTCS and two-thirds of those not getting help with these costs were unaware that these schemes even existed. This survey is a vital opportunity for patients to make their voices heard and could save future cancer patients hundreds of pounds and spare them the stress of trying to make ends meet. People can take part in the online survey from 1 February by visiting www.dh.gov.uk and clicking Policy and Guidance then Policy A-Z then H and selecting Hospital Travel Costs Scheme.

Jessica Corner
Professor, Director of Improving Cancer Services, Macmillan Cancer Support, 89 Albert, Embankment, London SE1 7UQ
E-mail: jcorner@macmillan.org.uk

What makes a good doctor?

I was most impressed by the piece of writing by Emyr Gravell[1]. It makes one reflect on what is happening to the medical profession in the UK.

What makes a good doctor? Don't most of us put the care of our patients as our first concern, and this is at the cost of our families who support us in our endeavours to be a good doctor.

We forget the endless hours each day spent with our thoughts preoccupied with what we can do better for our patients and the effort and time we put in to better ourselves to provide the care our patients expect. How can the government expect to drive our already busy schedule further (already causing burnout in younger GP's)? By turning them into tick-box doctors instead of what they really aim to be — 'good doctors' — who continue to make sacrifices at the expense of their family life? Instead of rewarding us for providing a fantastic service the government are constantly out to make life even harder. I wish there was a regulatory body for politicians, which defined a 'good politician'. They seem to think that they are 'gospel' and have absolutely no idea what an average UK GP contributes to the welfare of their patients.

Gopi Patel
GP
E-mail:jgopi@btinternet.com

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The God Delusion

What an idea to advocate putting *The God Delusion* under Christmas trees.[1]

If Dawkins is to be taken respectfully then don't insult him with Christmas. Alternatively, reject Dawkins and enjoy our festival.

Jamie Erskine
GP, PO Box 86 Banjul, The Gambia

Conflicts of interest
Committed Christian, Ironic sense of humour

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The book review of Richard Dawkins book *The God Delusion* by Simon Curtis in your December 2006 issue was most disappointing.[1] With such a controversial book which has such major flaws in it's arguments it is a pity that the *BJGP*, which I am sure has a readership that includes many people from a variety of faiths, did not balance this review with an alternative, more informed, viewpoint. Simon Curtis has clearly been swept along by Mr Dawkins populist atheism without stopping to ask important critical questions.

Alister McGrath, Professor of Historical Theology at Oxford University and a former atheist himself, has written extensively on atheism, particularly the ideas of Richard Dawkins. He describes '*The God Delusion*' as 'perhaps his [Dawkins'] weakest book to date, marred by its excessive reliance on bold assertion and rhetorical flourish, where the issues so clearly demand careful reflection and painstaking analysis, based on the best evidence available. Attractive precisely because it is simplistic, Dawkins demands the eradication of religion'.[2]

This simplistic opinion of Dawkins, that the elimination of religion would be a solution to the world's ills, is an unhelpful stance for the *BJGP* to support without balance. McGrath goes on: 'The question of the future role of religion is far too important to leave to the fanatics, or to atheist fundamentalists. There is a real need to deal with the ultimate causes of social division and exclusion. Religion's in there, along with a myriad of other factors … But it also has the capacity to transform, creating a deep sense of personal identity and value, and bringing social cohesion. Let's skip the rhetoric, and cut to the reality. It's much less simple — but it might actually help us address the real social issue that we face in modern Britain'.[2]

There are a great many well-read and clear-thinking doctors and scientists who do not accept the views of Richard Dawkins. Many would say that, given the evidence, to be an atheist requires a greater leap of faith than to be a believer. Their views cannot be simply dismissed when the ills of society are at stake.

I therefore recommend that you balance your published review with a further comment from someone who has really grappled with the issues. I would also suggest that you review Alister McGrath's book *The Dawkins Delusion* when it is published in February 2007.

Simon Fraser
GP, Shirley Health Centre, Grove Road, Shirley, Southampton, SO15 3UA
E-mail: simon.fraser@gp-j82088.nhs.uk

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Carpal tunnel syndrome

As a clinical neurophysiologist, I deal daily with referrals to investigate carpal tunnel syndrome (CTS). Bongers *et al*'s study of CTS in general practice[1] concerned me on a number of points.

Firstly, in 70% of patients, the clinical diagnosis of CTS was not confirmed by investigation. In our experience in Cardiff, both GPs and hand surgeons only get the diagnosis of median nerve entrapment and resulting CTS correct two-thirds of the time. As a result, we regularly see those who have undergone bilateral carpal tunnel decompression, but are still symptomatic, as their symptoms originate from undiagnosed cervical radiculopathies.

I am also concerned that the basis on which the diagnosis has been made is unstable. A meta-analysis by D'Arcy and McGee[2] demonstrated that the following were of little or no value in diagnosing CTS: age, bilateral or nocturnal symptoms thenar atrophy, sensory abnormalities, Tinel sign, Phalen sign, pressure provocation test, and the tourniquet test.

Finally the assertion that there is no gold standard investigation for CTS is incorrect. Although not perfect, nerve conduction studies have been shown to have a specificity of 99% and a sensitivity of 89% in diagnosing CTS.[3]

I would also like to suggest that a possible reason for women being affected by CTS more than men is that common causes include endocrinological and rheumatological disease, both of which are more common in women. There is also a distribution of fat in the arms which is also sex specific.

Gareth Payne
Department of Clinical Neurophysiology, University, Hospital of Wales, Cardiff, CF14 4XW.
E-mail: payneg@cf.ac.uk

Jerry Heath
Department of Clinical Neurophysiology, University Hospital of Wales

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Peer review

Dr Welsby's belief that GPs are the only people capable of assessing general