importance of diagnostic accuracy is not diminished by these findings.[2]

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Female genital cosmetic surgery

I read with great interest the January editorial on female genital cosmetic surgery.[1]

The Royal College of Obstetricians and Gynaecologists defines female genital mutilation as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons.[2]

The practice of female genital mutilation is generally condemned, and under the Female Genital Mutilation Act 2003 it is illegal in the UK. However, the distinction between female genital mutilation and female genital cosmetic surgery is not clear and it could be argued that many aspects of female genital cosmetic surgery fall within the definition of female genital mutilation. After all, much of female genital cosmetic surgery is purely cosmetic with no medical benefits attached, and as Liao and Creighton point out, much of the drive behind women requesting female genital cosmetic surgery arises because there is a Western societal preference for small labia.[1]

The World Health Organization further classifies female genital mutilation into four major types. Type 2 excision includes 'partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora'[3] — does this not accurately describe labial reduction?

At a time when there is such a big international drive to stamp out female genital mutilation because it is viewed as a violation of human rights, is it right that in western countries female genital cosmetic surgery is actually on the increase? May we be seen as hypocritical in condemning countries that practice female genital mutilation if we willingly refer girls for female genital cosmetic surgery?

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GPs at the Deep End

The 'GPs at the Deep End' have the laudable aim of reducing health inequalities. Watt hypothesises there is an inequitable distribution of GPs in deprived areas.[1] He suggests that deprived areas require more GPs than affluent areas because the high disease prevalence in deprived areas leads to greater GP workload. We would like to challenge the assumption that deprivation is the main influence on GP workload. We believe at least four other factors influence this and that the four factors have complex interactions.

First, in the same issue of the *BJGP*, Salisbury *et al* found that age is associated with disease prevalence and also with consultation rates with GPs in England.[2] Therefore, GPs working in affluent areas may have an equally high workload as those in deprived areas if they have a large proportion of older patients. In Monifieth, Scotland, we not only have a large proportion of older patients but also a large proportion of patients living in care homes. The care homes we look after include a home for those with high care needs, such as survivors of head injuries. In the past these very sick patients would have been looked after in secondary care. Today, they require us to make more house visits than the average.

Second, people in affluent areas are likely to have higher social mobility. This results in families being more geographically widespread and less able to help one another. This may lead to increased dependence on health professionals such as GPs.

Third, distance from the GP and poor transport links may increase the number of house visits required of GPs in leafy affluent areas compared to their colleagues in more tightly-knit urban deprived areas. Additionally, in rural or semi-rural areas it can take well over an hour to do just one visit, and visits in a single day may be spread out over a large geographical area.

These factors may interact. For example, professional people often retire to northeast Fife to an idyllic rural location. They may have few friends and family in the area and rely on their car for transport. As they age they may become ill and require home visits due to lack of family support and poor transport links.

Finally, GPs are widely acknowledged to have an important 'gatekeeper' role. We suggest that educated, professional patients are more likely to be informed about their health and about potential treatments for illness. Retired professionals or affluent groups have often also been used to having private health care attached to their work that