

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

they can no longer afford because premiums rise with age. They expect the same service now that they have more need of health care, from the NHS. This may lead to a higher rate of requests for referral to secondary care. It can take a lot of time, patience, and repeated visits to try to educate this group to have more realistic expectations of the service and to keep patients away from unnecessary and expensive secondary care.

In conclusion, we believe that population age, the availability of family support, rurality, and patient expectations may have as much, if not more, of an influence on GP workload as population deprivation. Furthermore, any reduction in GP funding may lead to an inadequate gatekeeper role and increased use of expensive secondary care. We're all GPs and we're all in at the deep end paddling hard to keep afloat.

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Author's response

What is the NHS for? Steven and Jackson give several examples, based on 'idyllic, rural' north-east Fife, including counselling for patients no longer able to afford private medicine, home visiting across the country miles, providing extra support for older patients whose offspring live far way, and the

general increased needs of older patients.¹

All these types of issue, variously reflecting needs and demands, can keep GPs busy, but in the same way that the purpose of the NHS is not just to pay staff, neither is it just to be sure that staff are busy.

It is no news to anyone that increasing age is the main driver of consultation rates in general practice, whether in affluent or deprived areas. Successive GP contracts have been weighted to reflect this. But while GPs serving affluent areas have to cope with the multiple morbidity of ageing, GPs serving very deprived areas are dealing with higher levels of multiple morbidity and social complexity at every age after childhood. GP contracts and workload studies have taken little account of this, partly because workload can only increase so much, and after that, both practitioners and patients have to adapt to what is possible. The maldistribution of GP manpower in the UK, that is worse in England than in Scotland, is an established fact and not a hypothesis.² The 'Deep End' title implies the consequent depth of unmet need within everyday general practice in deprived areas.

Many of the issues that concern general practice in the Deep End are similar to those affecting all practices, including the challenges of ageing populations. One reason for focusing on the Deep End is that life expectancy is unnecessarily short in very deprived areas, and as Julian Tudor Hart has shown, well-organised, mainstream general practice can make an important difference. General practice could be better supported to improve health and narrow health inequalities in very deprived areas — not just a 'laudable aim', but a major policy objective of all political parties. This is not the only purpose of the NHS, as Dr Steven and Professor Jackson describe, but the case deserves a hearing, and respect.

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Asymptomatic COPD and NICE guidelines

The continuing discrepancy between national and international guidance is unhelpful for patients, doctors, policy makers, and researchers because the Global initiative for chronic Obstructive Lung Disease (GOLD) does not require the presence of subjective symptoms (cough, sputum production, shortness of breath), whereas NICE guidance states that symptoms are a requirement for diagnosis and classification of chronic obstructive pulmonary disease (COPD).¹ Why does the National Institute of Health and Clinical Excellence (NICE) persist with this discrepancy when there is substantial evidence that reported symptoms are unreliable for diagnosis?

For example, among 5000 people from those included in the Third National Health and Nutrition Examination Survey in the US, 70% of those with undiagnosed early airways obstruction, and up to 50% of undiagnosed stage 3 chronic obstructive pulmonary disease denied having cough or phlegm, and 40% denied a wheeze.¹ A longitudinal study of over 2000 patients with COPD, from 12 countries, found that 'among subjects with severe airflow obstruction, a substantial proportion did not report symptoms'. About 40% of those in the GOLD severe category denied being breathless (modified MRC dyspnoea scale 0 [10%] or 1 [30%]).² Likewise, among a large population survey in China of 20 000 people over 40 years of age, 8% were found to have COPD of whom 35% had no symptoms (they said 'no' to the questions: 'do you have cough, phlegm,