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Editor's choice

Child care in general practice

May I, as a retired children's physician married to a GP and the nephew and grandnephew of family doctors intrude on your pages, first to applaud Dr Iona Heath's appreciation of my friend Dr John Horder and second to express my whole agreement with what your editorial¹ has to say about the role of GPs in the care of children. I may in this context extend Winnicott's aphorism that 'there is no such thing as a baby — rather a nursing couple' — to older children, whose existence depends on being part of a family (which is why I prefer the title of family doctor for your speciality rather than GP). A paediatrician is an American species of GPs for children which I am sorry to say is what the College of Child Health seems to favour; with the corollary that they see parents as agents against whose ministrations (one remembers Larkin's memorable but unprintable lines) children need the protection of doctors. It is my long experience that nearly all parents, except psychopaths, naturally want to do their best for their offspring, but instead of providing them with what they feel they themselves lacked as children, they can only give them what they got, which is all they have to offer. They need help, not prosecution, since most children would prefer to remain with their parents (those who have taken on their role) rather than be abandoned to the tender mercies of being 'in care', provided that the family in which they belong is adequately supervised. Infanticide is another matter not to be confused à la Meadow with abuse. My first contact with John Horder was the result of a mutual interest in the paediatric education of recruits to family practice ('training', as Winnicott once remarked, is for privates with the foot guards, performing animals, and jugglers!): an education in the norms and abnormalities of growth and development involving both psyche and soma, and including illness and what to do about it (I well remember a Paddington GP who when knocked up at night by a mother worried about her baby shone a torch in its face from his bedroom window and wrote on the back of a cigarette packet 'run to Paddington Green' [the baby

had meningococcal septicaemia]). As for the relevance of neonatology I well remember what a torture it was for my dying wife to submit to many a failed venepuncture until one day a GP in training got it in first time. When I asked him where he got this skill, he replied — 'in your neonatal unit, don't you remember me?' (And could it be that the basic science of psychology is social anthropology?). One last thought ... why not attach a community paediatrician to every practice — not necessarily as a full-time principal?

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DOI: 10.3399/bjgp12X659169

The eagle is landing

As a GP in Edinburgh, I read with great interest the article 'The eagle is landing,' in your September 2012 issue.¹

Some 12 years ago, I was diagnosed with glossopharyngeal neuralgia, secondary to Eagle syndrome. The saga started quite simply during a family holiday, with a discharging ear infection treated with ciprofloxacin. I saw three consultant ENT surgeons, for ear pain radiating to the back of the throat, and swallowing difficulty. I also saw a general physician for nausea, an ophthalmologist for blurred vision, and a neurologist for tingling of the tongue associated with difficulty in articulation. The pain and weight loss resulted in my being unable to practice for 4 months.

I was investigated, with blood tests, MRI, and CT scans which were all reported normal, hence the very uncomfortable situation of 'medically unexplained symptoms'. As a GP this was particularly bewildering and professionally undermining. The diagnosis of Eagle syndrome was finally made by a consultant radiologist following a re-referral to neurology some 15 months later.

The aetiology is, in my case, unclear. I personally suspect that the ciprofloxacin and/or the ear infection may in fact have

caused some calcification in the stylohyoid ligament. What further complicated my case was that repeated treatment with ciprofloxacin seemed to help the undiagnosed neuralgic symptoms. This remains unexplained.

The lack of knowledge of this condition in all the clinicians involved (including myself) lead to an inability to recognise the clinical features and delayed the diagnosis. However, on a positive note this did allow time for natural resolution of symptoms over 2–3 years.

My experience was a humbling one, and I feel that I have more empathy with other patients who have medically unexplained symptoms. Although I consider mood disorder in such patients, I do accept that an unknown physical aetiology may be present.

Following my experiences, I was left wondering how many cases I had potentially missed. Over the last 10 years I have considered the diagnosis in only two or three patients and not diagnosed any patients with Eagle syndrome. Therefore, my personal opinion is that this is a rare condition. The symptoms, that can range from distressing to life threatening, and cross several specialities, make Eagle syndrome a difficult diagnosis. I would certainly welcome further awareness, research on aetiology, management, and natural history of this interesting condition.

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DOI: 10.3399/bjgp12X659178

Altruism

I can half agree with your comments, but not the other half.¹ Your quote from Aneurin Bevan can be interpreted in various ways, in particular, many terminal patients have stated that they would prefer to expire in 'a gush of warm sympathy' at home or in

their local cottage-hospital rather than many miles distant from friends and family in a big sterile impersonal clinical setting.

You quote Nye's 'efficient if cold altruism'. While we need to question the efficiency of the organisation of larger institutions and distances, we also need to take a moment to consider their 'altruism'. The 'big hospital' is no longer altruistic in its management style or operation: it works for money from the commissioners of care, and often is seen as being sly in its pursuit of profit. A number of the staff remain altruistic, enthusiastic, and dedicated, but this attitude does not fit with management styles, and is being actively driven out of clinical staff, with barriers to flexibility and altruism and rewards for the opposite throughout juniors' careers. We can already see the effects; no longer looking at what is possible, but at what seems to benefit the individual, in terms of career progress.

We need a shift in managerial attitude away from the merely financially measurable, to a holistic approach to all the functions of the hospital. We need a pervasive change in attitude in the community, to rediscover the values of altruism, mutual support, and community pride. Many may consider these too close to religious aims or virtues, but is that wrong?

Real achievement can be made in the face of adversity outside huge institutions. If people will persist in getting ill and having accidents in our rural areas, it is prompt access to local services that is needed, along with the ability to tolerate difficult conditions, stabilise patients, and fix those who then do not need to make long, expensive journeys to big hospitals, rather than the ridiculous campaign for a big, efficient hospital right next door to every patient.

So, yes, I treat wet, muddy patients on occasion, and manage them in the expectation they will have a cold shower back at the camp-site, but also have to pick out those where I believe this will not do, and instruct them to get someone to drop them off at a 'big hospital' on the way home some hours later, or even commit one of our rare precious ambulances to do the job.

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DOI: 10.3399/bjgp12X659187

Health inequalities in primary care

I was very pleased to read Chris Weatherburn's reply and to feel that my article may have prompted consideration of some important issues. However, the thought that I may be guilty of 'vague political rhetoric' and peddling abstract ideals prompts me to reply. Additionally, and less egotistically, I feel compelled to counter the implication that we, as GPs, are already doing all we can to tackle health inequities.¹

Social injustices will not get resolved in the consulting room. However, as I tried to point out, injustices can be exacerbated by our failure to acknowledge social determinants of our patients' health and behaviour. Or, as Dr Weatherburn more positively suggests, injustices may be ameliorated by efforts to empathise and respond to our patients' needs. But we can do more than that. Outside the clinic, the RCGP can advocate politically, commissioners can maintain this issue on their agenda, and researchers can provide evidence for decision-makers. The rest of us would do well to consider our own values and priorities, for, to a considerable degree, tackling this issue will demand that we are honest about whether, or to what extent, we are prepared to put social justice before self-interest.

Events this year have not been encouraging.

In March, Julian Tudor Hart had to remind us that progressive taxation was a fairer way of funding the health service than means-tested patient charges (co-payments).²

In May, Alan Milburn highlighted the 'palpable unfairness' limiting access to careers in medicine for people from poor backgrounds. 'Medicine has made far too little progress and shown far too little interest in the issue of fair access,' he said, warning of a society of 'entrenched disadvantage at the bottom'.³

In June, the BMA's strike action prompted *The Daily Telegraph* to cynically quote back to us the words of RCGP President Iona Heath: 'Dr Heath has written [that] people motivated by "economic self-interest" are "indifferent to the fate of others". I wonder whether she will be going on strike...'⁴

As members of a profession committed to improving people's wellbeing I feel certain that we are capable of making more positive contributions toward resolving health and wealth inequities in the future. My article was intended to prompt discussion rather than to claim to define solutions. Nonetheless,

it is apparent to me that while the problem of wealth and health inequity worsens, any amount of complacency is not an answer.

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DOI: 10.3399/bjgp12X659196

Possible increased potency of current levothyroxine

Last year one brand of generic thyroxine marketed by Teva was withdrawn by the MHRA. This followed reports of concerns about its effectiveness, including those highlighted by the Vision users group. Since then we have seen an increase in patients with abnormally high T4 levels and suppressed TSH levels in our practice.

An audit comparing thyroid results last year when Teva thyroxine was available and the present time shows a significant rise in T4 levels in some patients who have remained on the same dose of thyroxine throughout.

There may be several reasons for this, including increased potency of current generic thyroxine, changes in concordance, changes in drug interactions, and changes in laboratory testing.

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