letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk

Clinical guidelines... must be pertinent, brief, valid and accessible.

Editor – Dr Gill's interesting article (*Clin Med JRCPL* July/August, pp 307–8) highlights the plethora of guidelines ('2,200 in the USA'), their varying quality ('opinion-based' rather than 'evidence-based'), and most importantly that their usage averages only 55 per cent with a variation about the mean of 0–100 per cent.

Has the time come for a simple, comprehensive guide from a reputable authority, which can be carried easily in a (white-coat) pocket in book form or electronically? Perhaps the College should take a lead in this? Possibly the *Oxford Handbook of Clinical Medicine* could be used as a well-tried and tested model. Such a vade-mecum would provide an easily accessible source of information, which would be widely respected clinically, and, one might add, legally in the courts! It would also give due credit to our forebears who already invented the wheel!

STEPHEN BARBER
Consultant Physician and Elderologist, Gibraltar Health Authority

General practitioners with special clinical interests

Editor – In their recent editorial (*Clin Med JRCPL* September/October 2001, pp346–7), Roger Jones and Richard Stevens do not cover the real reason why about 4,500 general practitioners provide clinical sessions outside their practice. For the last 25 years I have done two sessions a week in chest medicine at my local district general hospital (I have the glass tumbler to prove it). I have certainly not done it for the money; I have done it for the involvement with the hospital and its medical staff. It is the cure to one's 'isolation' in general practice.

I have long been an advocate for the college's greater involvement with its general practitioner members but I do not think that the way forward is to create general practitioner specialists in the community. Rather we should be encouraged in greater numbers to work in local district general hospitals and give some good old home spun advice to our consultant colleagues.

CLIVE WALKER
General Practitioner, Weybridge and Hospital Practitioner, St Peter's Hospital, Chertsey

In response

Variety is, as Clive Walker points out, the spice of life for general practitioners. Isolation is a real problem and there is accumulating evidence that the provision of a varied job description, in which clinical care is combined with other activities – clinical, academic or policy-related – is an antidote to burnout and disillusionment. In London, for example, a number of successful experiments, involving a 'mixed portfolio' approach to job descriptions and careers structures has had a substantial effect on recruitment and retention in areas where general practice has been struggling. The advent of salaried general practitioners, under the Personal Medical Services scheme, and the widespread involvement of general practitioners in the development of Primary Care Groups and Trusts has enabled fresh thinking about the kind of job that a general practitioner should sign up to for 40 years.

Clearly the initiative to develop general practitioners with special clinical interests is only one approach. Some general practitioners, like Dr Walker, derive tremendous benefit from contact with hospital colleagues, whilst others may find equal inspiration and refreshment in activities such as undergraduate teaching, postgraduate training, research and the development of health policy. We should welcome this increasing variety in the work of general practitioners, which is likely to lead to a happier, healthier workforce and, ultimately, to better patient care.

ROGER JONES
Wolfson Professor of General Practice Guy's, King's & St Thomas' School of Medicine, London

RICHARD STEVENS
Chairman, Primary Care Society for Gastroenterology, Oxford

Ethical Dilemmas?

Editor – Mr Walker's viewpoint is interesting and controversial (*Clin Med JRCPL* September/October 2001, pp383–4). He, like many others, seems to have made a distinction between ethics and morality. Our culture is quick to insist that God is unnecessary for understanding morality. The ethical theories of Kierkegaard, Hume and Didenot have been influenced by their previous religious presuppositions[1]. Even Kant failed to provide a rational basis for ethics apart from God. Why then is the church least qualified to take such a decision on ethical matters such as in the example put forward by Mr Walker?

Science has its limitations: although most would believe that time, matter and chance could explain most things. The former two are quantifiable – but chance?

While it is true that a judiciary can act as an independent institution, yet if morality is absent then the dilemmas we face are a consequence of living in a morally suicidal society.

A reasonable and coherent ethical theory cannot be achieved without first establishing the purpose and destiny of human life. Neither science nor an independent judiciary system offers such an explanation

I fully endorse Mr Walker's claim that an independent arbiter is required to resolve these issues – I call such God.

Reference

1 Zacharias R. Can man live without God? Milton Keynes: Nelson Ward Ltd, 1995.

RP ARASARADNAM
Specialist Registrar Gastroenterology/Medicine, Central Sheffield Teaching Hospitals

In response

Editor – Dr Arasaradnam's letter illustrates an important point: God does play a central role in many people's moral