cared for. The sub-group of the working party responsible for the second edition consisted of five senior doctors, all experienced in this field. It is this experience – plus wider consultation – which influenced any shift in emphasis.

We suggest that the report by Zeitlin[1] which looked at the incidence of RAD in anally abused children[2] may help to clarify the problem. He pointed out that, even if as many as 1% of all children under 8 years have been buggered, then – on the basis of this study – RAD would need to be present in only 4 per 1000 non-abused children to give a 50% chance that children with this finding have not been abused.

Harvey and Nowlan[3] also considered the issue of prevalence of anal abuse and the sensitivity and specificity of RAD. At the likely prevalence of anal abuse in the general population (less than 0.5%) a high specificity of 99.99% would be necessary to achieve a 90% predictive value. (Specificity = the percentage of non-abused children who do not show the sign).

The point is also made that inevitably an association will be found between anal abuse and RAD if this sign has formed one of the grounds for diagnosis.

The view of the working party – as indicated in the report – is that it is not prudent to place strong emphasis upon so variable a sign.

The paragraph referring to fissures and fissuring is rather confused. The College report does not regard tiny superficial splits in the perianal skin as anal fissures, which are defined in the Glossary of Terms (p67). However, Drs Hobbs and Wynne are incorrect in assuming that true anal fissures do not occur in lichen sclerosis. This condition often surrounds the anus and extends into the anal canal. The associated anal fissure(s) may cause great discomfort and result in faecal retention. The avoidance and treatment of constipation is of major importance in the management of children suffering from lichen sclerosis.

The term 'laceration' was not defined as it was thought to have a sufficiently well recognised clinical meaning. After healing, it would normally result in 'a healed scar'; any fresh laceration would merit a detailed description – as in any physical injury.

Again, it is difficult to understand the complaint about the introduction of 'new and ill-defined terms'. These terms were not invented by the working party but were included because they are not infrequently to be found in new reports published since the first edition. Indeed these terms are quite adequately explained in the Glossary of Terms (Appendix 1b, p66).

The report does not – either correctly or incorrectly – state that the use of a colposcope is an 'especial indication for having two doctors examine the child'. It is however undoubtedly the case that it is helpful for two doctors (or one doctor and one experienced nurse) to work together 'since this allows easier examination and collection of samples'. This would seem to be self evident and, we would have hoped, uncontroversial. The second doctor could usefully be one in training in this area of practice.

The report includes a good deal of new information, particularly with regard to the range of normality in female genitalia at different stages of development and the significance of physical findings; also with regard to sexually transmitted diseases and newer forensic techniques. Physical signs remain only one aspect of a complex diagnosis. The purpose of this new edition is to facilitate more accurate diagnosis, with fewer false positives and false negatives. It would be hard to say which of these is the greater disaster.

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Communication in medicine: a core curriculum

Editor – Communication skills are central to our effectiveness as doctors. The Royal College of Physicians' report on the subject of doctor-patient communication is therefore a significant contribution underlining the importance of the development of skills in this area by young doctors[1]. In addition, it adds more detail to the *Core curriculum for SHOs*[2]. The challenge for all of us involved in the education and training of doctors is to develop effective ways of implementing such recommendations and policies.

We are in our fourth year of evaluating the benefits of linking an established SHO rotation in hospital medicine based at Newcastle General Hospital to a general practice post with the Northumbria Vocational Training Scheme for General Practice. This rotation provides young doctors, who are either intent on a career in hospital medicine or undecided about a career pathway, with an opportunity to sample and learn from general practice. Trainees undertake three posts each of four months' duration, one of which is in an established training practice. A curriculum is fashioned in the general practice post to suit individual trainee needs with an emphasis on communication skills, team-work, prescribing, record keeping and the psychological and social aspects of patients' problems[3]. Communication skills are taught initially at a two day residential course which uses a small group format to introduce various models of the consultation with the

help of videotape. This is followed-up in the practice by regular videotaping of the trainee's consultations which are then analysed during protected teaching sessions. Helpful feedback allows trainees to gain insight into their own performance and identifies the areas which need improvement. The development of communication and consultation skills is seen by the trainees as one of the most important benefits of the general practice post and useful in their future careers.

Patients deserve doctors who see the importance of communication and who have been shown to have acquired the appropriate skills. Our experience confirms that opportunities exist for the education and training of doctors in hospital specialties and general practice to be combined in a complementary manner to the ultimate benefit of patients[4,5].

References

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Continuing professional development in public health medicine

Editor – We read with interest the paper by Doyle and colleagues discussing the professional development of public health physicians (July/August 1997, pages 405–9). The authors unfortunately limit their work to the needs of public health personnel who have a medical background, and omit to include in their evaluation the needs of other workers who did not attend medical school but work within public health departments throughout the country.

After graduation, on deciding to re-direct a medical career and become a public health doctor, a trainee has to develop a completely new set of skills to those taught in medical school, accepting that most medical students touch upon medical statistics, epidemiology and so on as undergraduates. Public health trainees are then shepherded through their education in these new skills in a very structured way. In our experience, public health trainees quickly achieve consultant status, quicker than most medical disciplines. This pattern probably reflects supply.

The flavour of this article in only representing the needs of public health medicine employees with medical backgrounds may illustrate the ethos of public health doctors and the Faculty of Public Health Medicine (FPHM) in protecting jobs and salaries for only medical graduates. The FPHM does not routinely allow others with suitable backgrounds and qualifications into its rank and file and there is little support for any attempt to broaden membership[1]. This protective attitude, although perhaps slowly changing, is reflected in the lack of public health consultant posts advertised where non-medical staff are allowed to apply.

Interestingly, the notion of equity was the fifth highest priority for continued professional development in Doyle and colleagues' survey. The FPHM and public health doctors in the NHS should perhaps seize on the notion of equity and achieve the following objectives:

- To allow anyone with suitable experience and qualifications to become a Member of the FPHM
- To give everyone within existing public health departments access to the same level of resources currently available only to those with medical backgrounds.
- A defined career structure for the development of those in public health departments who do not have a medical degree.
- Award others with similar levels of skill and experience within their departments the same financial rewards.

Reference

1 Scally G. Public health medicine in a new era. *Soc Sci Med* 1996;**42**:777–80.

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Medication for older people

Editor – We read with interest the summary of the College report *Medication for older people* (May/June 1997, pages 254–7). We agree completely with the emphasis of the report on evidence of polypharmacy and iatrogenic disease in the elderly but feel there is another aspect of medication for older people that is worth highlighting, namely missed medication. Poor compliance at home may account for treatable morbidity and has been addressed