Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Evolutionary medicine

Dr Charlton (July 1997 *JRSM* pp 397–99) provides a lucid argument to structure medical teaching on a scaffolding of evolutionary biology. The *ad hoc* nature of the information taught in a medical school is partly concealed by strong traditions surrounding medical training which give physicians a sense of unity. All medical students, for example, dissect dead bodies and are exposed to rituals of the operating theatre. As a result, physicians have a social cohesion that crosses geographical boundaries and also happens to help tie together a curriculum that, in Charlton's words, lacks the intellectual structure that ought to characterize a scholarly discipline.

During their training, not all practitioners of public health are exposed to the powerful social influences that help bind physicians together. Thus many schools of public health are deeply and sometimes destructively divided between groups who follow a biological paradigm and those who have been trained in a non-evolutionary interpretation of the social sciences. Those involved in health education, for example, often share no common intellectual framework with those working on infectious diseases. Moreover, the successes in public health have been driven largely by technical developments in biology, such as vaccination or clean water supplies, while the areas of least progress tend to relate to human behaviour, such as efforts to reduce teenage pregnancy or drug abuse.

Evolutionary medicine cannot tell us how to behave in the modern world, but it can do much to expose the underlying predispositions explaining some of our behaviours. For example, evolutionary biology provides valuable insights into child abuse and domestic violence[1]. It will take time, patience and compelling examples to bring the evolutionary perspective into the syllabi used in teaching medicine and public health. The task is a necessary one, and it could prove one of the most important changes open to us in medical training for the next millennium.

Malcolm Potts
School of Public Health, University of California, Berkeley, CA 94720, USA

REFERENCE

1 Daly M, Wilson M. *Homicide* New York: Adeline, Hawthorne, 1988

In his otherwise valuable essay on evolutionary medicine Dr Charlton misrepresents the intention behind our book *Evolutionary Psychiatry: A New Beginning*.

He accuses John Price and me of attempting to synthesize Freudian theories with natural selection, alleging that such endeavours are 'illegitimate and doomed to fail'. At no point in our book do we make any such attempt. On the contrary, we are at pains to point out that Freud's attempt to place human psychopathology on a biological footing failed because of his dogmatic insistence on the central motivating importance of sex, his obsolete conceptions of the functioning of the central nervous system acquired working in Brücke's laboratory in the 1880s, and because, throughout his life, his evolutionary formulations remained unashamedly Lamarckian.

However, Freud should be given credit for his suggestion in his essay 'A phylogenetic fantasy' that certain states of mind, such as paranoia and anxiety, were remnants of responses which were biologically adaptive in human beings up to the time of the Ice Age.

Even so, these issues are entirely peripheral to the main thrust of our book, which argues that psychiatric symptoms are manifestations of ancient adaptive strategies which are no longer necessarily appropriate but which can best be understood and treated in an evolutionary and developmental context. We propose theories to account for the widespread existence of affective disorders, borderline states, and schizophrenia, as well as offering evolutionary solutions for puzzles such as sadomasochism and the function of dreams. This approach is richly compatible with Dr Charlton's 'syllabus for evolutionary medicine', yet readers of his article could have no idea of this from his misleading and slighting reference to our book.

Anthony Stevens
Fardel Manor, Near Ivybridge, Devon PL21 9HT, England

Medical profession and justice

Lord Woolf's article (July 1997 JRSM, pp 364–67) was thought-provoking. As a surgeon who has acted as an expert witness, particularly in pretrial assessment, I have been amazed at the futility of some of the cases presented to me; I have no qualms about making it clear when a case has little hope of success. This may explain why my medicolegal practice is not extensive.

Exhortations and guidelines are of no value in preventing the abuses of the legal aid system which, I believe, are much more widespread than those which are featured in the Press. The roots of the problem are twofold—the adversarial system of British jurisprudence, and human nature. Lawyers' activities are paid on a fee-for-service basis as are medical reports. There is an obvious incentive to increase the revenue; every telephone call, each letter increases the fees. If litigants qualify for legal aid, they will naturally be pleased at this increased effort on their behalf which costs them nothing. Similarly, consultants will not submit adverse reports for fear that a source of income will evaporate. I have read many wordy reports which failed to offer a clear opinion; the writer was obviously dissembling in that he was unable to give a detrimental opinion.

The solution lies in a system which removes the adversarial elements as well as the fee for item of service. Some lawyers should be paid as full-time assessors of prospective litigation, as has been proposed by the government; if this was extended so that these lawyers were assisted by medical experts who were paid a flat retainer, a fairer system would result. In addition, legal aid could be abolished and some of the saving used to pay these adjudicators; there would be a saving to the public purse over and above this.

There may be a cry of 'nationalization', but so be it if it halts the misuse of the present system.

I G Schraibman
Oakley House, Beaufort Avenue, Sale M33 3WL, England

Breast cancer clinic led by a nurse practitioner

I strongly support the concept of a nurse-practitioner-led follow-up breast clinic (May 1997 *JRSM*, pp 258–9). As director of the St Mary's Hospital Breast Care Group until my departure in early 1997, I instituted a similar arrangement. A well-trained nurse practitioner allows for continuity of care; and other advantages are the