unsure about how best to ask or how to react when parents refuse to give consent. Transplant coordinators are committed to increasing public and professional awareness of the need for donor organs and aim at training and educating health professionals in approaching bereaved parents. They also offer support to medical staff and parents both before and after organ donation.

In the United Kingdom there are currently over 70 children awaiting kidney transplants alone, so it is a matter of urgency that the medical profession overcome any reluctance to approach bereaved parents and follow the example of America and other countries where parents are asked as a matter of course.

I was glad to have been given the opportunity to donate my child's organs (the doctor who asked had tears in his eyes and the words didn't come easily), and all parents are entitled to the same opportunity whether or not they consent.

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1 Finlay I, Dallimore D. Your child is dead. *BMJ* 1991;**303**: 1524-5. (22 June.)

Informed consent

SIR,—Dr Niels Lynöe and colleagues have highlighted a subject of medicolegal and ethical concern that needs urgent attention.[1] When researchers seek patients' freely given fully informed consent their enthusiasm to reach their target has to be tempered by respect for the patients' rights and feelings.

In projects studying non-urgent treatments for chronic conditions few of us have problems in discussing the pros and cons with outpatients and reviewing them a few days later. Things are not, however, so simple in the coronary care unit. Tied to their sickbed with electrocardiographic electrodes and Swan-Ganz catheters, patients are hardly in a position to go away and think. In this situation "Whatever you think is best, doctor" is commonly heard (although one patient recently called her solicitor to the coronary care unit to review the consent form). It is at least advisable that patients have an opportunity to discuss what is being asked of them with a doctor not participating in the research. Few of us in Britain want to get to the position in America, where consent forms run to five pages; trust between doctor and patient remains paramount.

These problems have been addressed in detail in the context of clinical trials sponsored by pharmaceutical companies. Following the example of the United States Food and Drugs Administration, the European Community's Committee on Proprietary Medicinal Products gives detailed requirements for informed consent in its guidelines on good clinical practice, which came into force in July this year.[2] These specify that the investigator must provide the patient with a comprehensive explanation of the study, whenever possible both orally and in written form. The information sheet must be approved by the ethics committee. In addition to describing the aims, benefits, risks, and inconveniences of the study the sheet must give information on all the treatments and placebos to be used and on possible alternative treatments not being studied. It must be clearly stated that the subject has the right to withdraw at any time and that personal information may be scrutinised during audit by "properly authorised persons."

It is audit (by the sponsor's independent quality assurance department and by government drug control agencies) that gives teeth to good clinical practice. The pharmaceutical industry and its government regulators have devoted considerable effort to the question of informed consent. Doctors in other aspects of medical research would find much of value in the results of these labours.

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1 Lynöe N, Sandlund M, Dahlqvist G, Jacobsson L. Informed consent: study of quality of information given to participants in a clinical trial. *BMJ* 1991;**303**:610-3.
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We may never understand each other

SIR,—I have always wondered why family doctors in the United Kingdom are called general practitioners. Dr Robert Lefever's personal view left me with the impression that hospital doctors practise some branch of medicine with (implied) suboptimal success whereas general practitioners are the masters of some "art" that started as medicine but subsequently evolved and mutated to the point of even losing its medical name.[1]

Dr Lefever is certainly laudable if he can tackle the side effects of adultery, the demanding task of helping people to overcome their addiction to smoking, the crises of adolescence, and the diagnosis and management of back pain with equal zeal and success, but I wonder how many of his colleagues can make such a claim. I note that he is in private practice, and this (unless his work is part of a charitable scheme) makes a lot of difference: the average general practitioner has to cope with the unfortunate crowd of those who cannot afford a private physician.

I agree that hospital medicine as practised in today's specialised environment is not ideal. I do not think, however, that denigrating hospital medicine and extolling general medical practice serves any useful purpose. There are hospital consultants and junior doctors who amply show all the values and holistic approaches that Dr Lefever attributes to himself, and there are general practitioners who do not even bother to see the patients they refer to specialists. The great divide lies between good and bad practitioners of the Hippocratic art of medicine, regardless of their level of training or place of work.

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1 Lefever R. We may never understand each other. *BMJ* 1991;**303**: 725. (21 September.)

SIR,—Dr R Lefever is right in declaring that "science . . . brought us together . . . it is art that divides us."[1] He does not, however, address the reasons which underlie this divide, which I have called the clinical chasm.

There is much talk currently about a seamless service. Most of this seamlessness depends on the relationship between the primary care clinicians and those providing secondary care.

Managers are trained generically; they can (and do) move from family health services authorities to district health authorities, regional health authorities, and back again. They do not have a vested interest in maintaining a distinct role within a particular organisation. If the command of the day is "Become seamless" they can become seamless.

For clinicians—the doctors and nurses who come directly into contact with patients—the training and value systems are more environmentally dependent. Doctors, for instance, are trained in hospitals where, traditionally, the consultants ruled supreme and where all other beings, medical or otherwise, were inferior. This is the main reason that there is such a stigma about general practice, even among the general practitioners themselves, who often have chips on their shoulders about their hospital colleagues. General practitioners rarely return to hospital service, and so must rationalise their position in the same way that hospital doctors must defend theirs.

In the current climate, the negative feelings are exacerbated by the threats to each empire. The acute sector is seeing its influence being eroded. Patients prefer being cared for at home; consultants are becoming the technicians carrying out tasks at the general practitioners' behest. The primary care physicians are gaining in power, influence, and independence so that, paradoxically, it is becoming more difficult to think of medicine as being homogeneous.

It is pessimistic, however, to conclude that "we may never understand each other." Rather, we must now seriously consider ways in which our separate cultures can be integrated, so that patient care may reap the benefit as soon as possible. It may be that we can change deeply felt beliefs by appropriate postgraduate education; what is more likely is that the whole basis of medical education will have to change. Only when care becomes patient centred and ignores all traditional boundaries will it have become truly nameless.

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1 Lefever R. We may never understand each other. *BMJ* 1991;**303**: 725. (21 September.)

The prince and the psychiatrists

SIR,—It would be difficult to deny that Prince Charles's oration to the Royal College of Psychiatrists was mutually and uncomfortably sycophantic in its form; its content, however, was much more radical than Dr David Widgery would have us believe.[1]

A monstrous carbuncle was indeed diagnosed: with chemical coshes, reductionist theories, and training heavily biased towards the organic, in the setting of a materialistic society demanding fix it quick answers. Laing, Szasz, and the anti-psychiatrists were angrily and passionately saying this 25 years ago—although clearly not in the well mannered, but gently subversive, way of Prince Charles.

These themes are in tune with a widespread feeling that many psychiatric approaches are out of touch with our patients' experience of suffering and alienation, and perhaps it is a pity if it takes the royal touch to make us sit up and listen. But I believe that the college has taken Prince Charles's message seriously and thinks hard about training psychiatrists for a role beyond diagnosing and treating disorders of neurotransmission.

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1 Widgery D. The prince and the psychiatrists. *BMJ* 1991;**303**:723. (21 September.)

SIR,—Dr David Widgery thinks that the psychiatrists who heard the Prince of Wales's address at the annual general meeting of their college were overawed and uncritical.[1] Doesn't he know that