

whose pathological identification is often difficult, variable, and contentious. His observed difference in sensitivity would be more likely to reflect pathological sensitivity than clinical sensitivity. Thirdly, his example illustrating unchanged sensitivity and specificity in the clinical diagnosis of cancer ignores the changing incidence of various cancers and differing hospital populations of patients with cancer and fails to mention that the comparison standard—necropsy—has itself changed in the past 30 years. It has never been a standard procedure.

The author's suggestions for the future may be of practical value in France, but they are not in the United Kingdom. Firstly, assessment of error in postmortem diagnosis requires a standard detailed postmortem examination—a process that could currently occur only in a centre of excellence with adequate staffing and funding. The error rate found could never be applied widely outside such a centre because of the variable quality of both consent and coroners' postmortem examinations. Secondly, current legislation does not allow post-mortem examinations to be performed in a way that would allow proper sampling.

Saracci's article appears in the Audit in Practice section of the journal, but its suggestions have little value in England and Wales without radical reform of the Human Tissues Act and the coroners' system together with considerable changes in the teaching and practice of necropsy. They are not likely to be part of audit in practice in the United Kingdom for many years.

RYK JAMES
M A GREEN

Department of Forensic Pathology,
University of Sheffield,
Sheffield

1 Saracci R. Is necropsy a valid monitor of clinical diagnosis performance? *BMJ* 1991;303:898-900. (12 October.)

The rise of post-traumatic stress disorders

SIR,—I wish to add a few comments to Gary Jackson's editorial on post-traumatic stress disorders.¹ This term arose out of work with American veterans of the Vietnam war, who first attracted attention because so many became spectacular social casualties, unable to take up ordinary roles and liable to violent and self destructive behaviour. In contrast, British service personnel who saw intense, albeit shortlived, fighting in the Falkland Islands have a high prevalence of post-traumatic stress disorders five years later (nearly one in four) but have unremarkable work and social lives.²

I studied peasants displaced by the war in Nicaragua, all survivors of atrocities, and found that features associated with post-traumatic stress disorder were common, but these people were nevertheless active and effective in maintaining their social world as best they could in the face of the continuing threat of further attacks.³ Indeed, this threat rendered a "symptom" of the disorder like hypervigilance adaptive. When these people did seek treatment it was for psychosomatic ailments, which are not included in the definition of the disorder. Studies of, for example, Cambodian war refugees, both in border refugee camps and in the United States, show similar findings.⁴ The diagnosis of post-traumatic stress disorder says little about ability to function.

Medical models, focusing on individual psychopathology and liable to Western ethnocentrism, have inherent limitations in capturing the complex ways in which individual people, communities, and indeed whole societies abroad register overwhelming tragedy, socialise their grief, and reconstitute a meaningful existence. What seems central, and anthropological reports concur, is that

it is in a social setting that the traumatised who need help reveal themselves and the processes that determine how victims become survivors (as most do) are played out over time. Arguably, a telling example of what happens when social networks are not supportive arose when the American veterans came home to find that their nation and, more subtly, their families were disowning their guilt for the war and blaming them instead. This rejection was surely an important factor in the subsequent genesis of their social dysfunction. At the moment the diagnosis of post-traumatic stress disorder does not address these issues.

D SUMMERFIELD

Medical Foundation For The Care of Victims of Torture,
London NW5 3EJ

- 1 Jackson G. The rise of post-traumatic stress disorders. *BMJ* 1991;303:533-4. (7 September.)
- 2 O'Brien LS, Hughes SJ. Symptoms of post-traumatic stress disorder in Falkland veterans 5 years after the conflict. *Br J Psychiatry* 1991;159:135-41.
- 3 Summerfield D, Toser L. "Low intensity" war and mental trauma in Nicaragua: a study in a rural community. *Medicine and War* 1991;7:84-99.
- 4 Mollica R, Wyshak G, Lavelle J. The psychosocial impact of war trauma and torture on Southeast Asian refugees. *Am J Psychiatry* 1987;144:1567-72.

Postoperative feeding

SIR,—Nicholas D Maynard and David J Bihari highlight the advantages of enteral nutrition and the dangers of parenteral nutrition.¹ Enteral nutrition, which can be given to a much wider range of patients postoperatively than traditional teaching dictates, protects mucosal integrity and reduces bacterial translocation, whereas parenteral nutrition is associated with problems with the catheter and hepatobiliary and other complications.

Against this background the authors' assertion that "the time has come for formal comparisons of enteral with parenteral nutrition in severely ill patients" is inappropriate. Unless new evidence emerges to suggest a particular advantage from specific nutrients administered intravenously such a study would be unethical. There is no doubt that patients who are unable to eat must be given nutritional support, nutritional support should be administered enterally, and parenteral nutrition is required only when intestinal function is unavailable or inadequate. Consequently most parenteral nutrition is supplemental rather than total, and the term total parenteral nutrition should be restricted to those few patients who have no intestine or no intestinal function.

Finally, with reference to the authors' remarks about the dangers of Intralipid it is worth pointing out that use of this energy source in the short term permits supplemental and possibly total parenteral feeding through a peripheral vein, thus avoiding the more serious complications. Furthermore, during long term central parenteral nutrition the risk of venous thrombosis is considerably reduced when some of the energy requirements are provided by Intralipid.

C R PENNINGTON

Departments of Pharmacology and Clinical
Pharmacology,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

- 1 Maynard ND, Bihari DJ. Postoperative feeding. *BMJ* 1991;303:1007-8. (26 October.)
- 2 Pithe AD, Pennington CR. The incidence, aetiology and management of central vein thrombosis during parenteral nutrition. *Clin Nutr* 1987;6:151-3.

Disasters in the inner city

SIR,—I read David Adshad's personal view on general practice in an inner city on the same day that I learnt that an enthusiastic doctor with an

impressive research record had resigned from a partnership in inner city Leicester to take up a post in semirural practice. David Adshad says that the fires that occurred were only one factor in his decision to leave his inner city practice. I would like to illustrate from our recent experience some of the other factors that may have played a part.

Workload—Demand for appointments and home visits has risen in the past year—for example, night visits during April to September this year increased by 16% over the same period in 1990. Attempts to educate patients towards using the service more responsibly are frequently met with incomprehension or hostility.

Violence—Although we and our staff have not yet been physically harmed, obscene language and aggressive behaviour are common both in the reception area and in telephone conversations.

Crime—We have reported to the police five burglaries or acts of vandalism against practice property or personal property in the past month.

Income—In the first full year of the new contract the practice's net profit rose by only 6% despite our achieving higher rate targets and offering a full range of other income generating services.

Premises—We work from a grossly inadequate building. The cost rent scheme will meet only 60% of the cost of bringing it to an acceptable standard. It is a daunting decision to fund the rest of the cost from a practice income that may be declining.

Recruitment—We received just six applications for a partnership vacancy despite our close association with a university department of general practice.

None of these problems amount to a disaster. Taken together they illustrate the morale sapping strain on inner city doctors. We feel abandoned by both the Royal College of General Practitioners and the BMA. Training seems to produce general practitioners with a vocation to practise in comfortable market towns. If the fall in applications to vocational training schemes and the steady loss of talented doctors from urban deprived areas continue I foresee the implosion of general practice in these areas as doctors are squeezed by mounting demand and dwindling resources.

ADRIAN HASTINGS

Saffron Group Practice,
Leicester LE2 6UL

1 Adshad D. Disasters in the inner city. *BMJ* 1991;303:101. (19 October.)

The right to know

SIR,—Though many would agree that the new legislation allowing patients to have access to their written medical records is on balance a positive step, the question of the need for modifying medical records to make them more comprehensible to patients is not as clear cut as Paul McLaren's editorial seems to imply.¹

Medical records must serve primarily as a medium for condensing clinical information in a form that can be rapidly assimilated by other health care workers who are concerned with a patient's care. Although summary records held by patients may be helpful in some circumstances, they cannot be expected to replace conventional medical records. It is not merely the jargon inevitably used in medical records that will be incomprehensible to many outside medicine; many of the concepts of disease processes and their treatment are complex and cannot be adequately explained to those with little medical knowledge in a format constrained by the need to be concise.

Before concentrating our attention on the way in which we write our medical records we must ask what motivates patients to seek access to their records. Two probable reasons are that patients wish to know more about their condition and its