between subjects with Alzheimer's disease, subjects with multi-infarct dementia, and controls (identified clinically with the criteria of the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association[3] and the *Diagnostic and Statistical Manual of Mental Disorders Third Edition, Revised (DSM-III-R)*.[4] We found that magnetic resonance imaging had a blind agreement with clinical diagnosis in 14 (61%) of 23 cases, and single photon emission tomography in 24 (77%) of 31 cases.[5] Furthermore, all 22 subjects with dementia tolerated single photon emission tomography whereas six were unable to tolerate magnetic resonance imaging. For single photon emission tomography we used a gammacamera with three detectors with a total acquisition time of only 15 minutes.

It thus seems that single photon emission tomography with hexamethylpropyleneamineaxime labelled with technetium-99m is not only a clinically useful tool separating these disorders but the procedure best tolerated by elderly and demented subjects.

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General practitioners and skin biopsy

SIR,—Several articles in recent issues focus on the performance of skin biopsies by general practitioners.[1-4] Matters of concern are incomplete clinical information[1 4]; inaccuracy of clinical diagnosis[2-4]; incomplete excision[1 2]; use of wrong fixative[1 4]; unnecessary operations on benign lesions[2 4]; increased workload generated for pathology departments[2-4]; and inadequate management of malignant tumours.[4] One potential drawback is not addressed by these authors: incorrect interpretation of the histology report by the general physician.

Dermatologists are well aware of the fact that any incongruity between clinical diagnosis and histopathological description and the doctor's conclusion may cause severe harm to the patient. This especially holds true for false negative reports of skin malignancies. If clinical suspicion of malignancy is not confirmed by the histopathological report then the dermatologist performs another biopsy or keeps the patient under regular control. How many patients with so called "benign" histopathological labels are wrongly reassured by the general physician, causing serious delay or mismanagement?

In this context I have scrutinised my experience over 15 months to the end of December 1991. Out of 278 patients with clinical suspicion of malignancy there were six with benign histopathological diagnoses that had to be challenged on clinical grounds. These patients underwent a second biopsy, either immediately (three within 1-2 weeks) or delayed after unsuccessful treatment attempts with various topical remedies (three after 6-10 weeks). The table shows the clinical and histopathological diagnoses.

An important difference between this series and the quoted reports on general practice skin surgery is the type of biopsy under consideration. Biopsy specimens of suspected skin malignancies in my practice are often partial (punch biopsies), whereas general physicians will usually perform excisional biopsies. The chance of correct histopathological diagnosis increases with completeness of biopsy procedure.

Clinical diagnosis of malignant skin lesions can be difficult even for the experienced dermatologist. In case of doubt, appropriate interpretation of the histopathological findings is crucial. The risk of woeful delay in patient management after incorrect judgment of the histopathological report by the general practitioner cannot be overemphasised.

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Clinical and histopathological diagnoses in patients requiring a second skin biopsy

Sex	Age (years)	Clinical diagnosis	First histopathological diagnosis	Delay (weeks)	Second histopathological diagnosis
F	57	Basal cell carcinoma	Inconclusive	10	Basal cell carcinoma
M	64	Intraepithelial carcinoma; squamous cell carcinoma	Inflammation	6	Intraepithelial carcinoma
M	73	Squamous cell carcinoma	Inflammation	7	Squamous cell carcinoma
M	73	Actinic keratosis; basal cell carcinoma; squamous cell carcinoma	Seborrhoeic keratosis	1	Squamous cell carcinoma
F	76	Basal cell carcinoma	Inflammation	1	Actinic keratosis
M	82	Basal cell carcinoma	Benign adnexal tumour	2	Basal cell carcinoma

Deciding whether to be a doctor

SIR,—Having read J Parker-Williams's comments on selecting and helping potential doctors, I am glad that I did not graduate from St George's Medical School.[1]

I agree that secondary schools and medical schools do not provide enough information for a potential doctor to make a properly formulated decision. They cannot convey the significance of sleep interrupted by frequent, sometimes petty, queries and emergencies; of a social life completely disrupted every six months; of stress induced by jobsworth nurses and technicians and overbearing seniors; of scrabbling for precious training posts; or of studying for examinations with very low pass rates while working excessively long hours. The average candidate cannot fully comprehend the deadly dullness of routine blood drawing; of chasing results and investigations through reluctant pathology departments; and endlessly overbooked outpatient clinics—the normal working day of most junior doctors.

The preregistration year is undoubtedly a shock to most newly qualified doctors, not only because of the excessive demands placed on them but because of the lack of support from colleagues and seniors. Many people have doubts, fears, and uncertainties, which are only natural at the start of a career in medicine. The wise keep their own counsel, as seeking advice often singles out a person, who is then perceived as weak. Parker-Williams labels these people as misfits unworthy of having thousands of pounds spent training them and questions their commitment to medicine. It seems he would rather have medical schools churn out emotionless automatons.

A more professional approach to postgraduate training, education, and counselling would be most welcome, but on the basis of Parker-Williams's opinions I fear that we have a long way to go.

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1 Parker-Williams J. Deciding whether to be a doctor. *BMJ* 1992;**304**:319. (1 February.)

SIR,—M J Kelly has presented the benefits of showing potential medical students what their future may hold,[1] but why is no support system available in the United Kingdom for those highly intelligent, expensively educated young men and women who drop out of the medical profession shortly after qualifying?

I write as a lay person and as the parent of a recently qualified young doctor, who, last summer, after just four months as a preregistration house officer, felt quite unable to continue. This sudden decision came as a shock to all those with whom he worked. He was regarded as hard working and extremely competent.

Should my son choose, of his own volition, to get in touch with his medical school at some stage in the next year he will almost certainly be helped to get back into the system. Unless he makes the first move, however, nobody will communicate with him. He is rapidly, it seems to me, becoming just a statistic.

The last thing I would wish to see is a system that attempts to retain people by force. There will always be those who realise, too late, that they are in the wrong profession. My son may be one of them. I am convinced, however, that among those who drop out there are some who, with extra support—perhaps the chance to work part time for a short period—would go on to make good doctors.

In my own profession, teaching, it is often said that the best practitioners are those who understand at first hand the difficulties experienced by their pupils. Could this not also be true to some extent in medicine?

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Child health surveillance lists

SIR,—In July last year we reported the variability of the criteria used by family health services authorities to admit general practitioners to child health surveillance lists[1] despite the existence of national guidelines.[2] In the same issue Waine