exists, is expected to determine a cause for death, review hospital records and statements from medical personnel concerning treatment, and recommend whether or not an open inquest should be held. When recommending an open inquest, a frustrating and discouraging aspect is finding medical personnel who are willing to give expert testimony in their specialty at an inquest on behalf of the inquest prosecutor and also to act as assessors.

If health care workers are unwilling to assist, the forensic pathologist is often the sole witness to give the prosecutor necessary insight. Pathologists are unable to, and at times even prohibited from, expressing opinions on matters outside their expertise, e.g. radiology, obstetrics, surgery, pharmacology, etc. Given these constraints, how effectively can medical inquest cases be evaluated by magistrates?

Court proceedings are generally unpleasant for health care workers. However, does the medical profession not have an ethical responsibility to assist the court, given that the standard by which conduct is tested at an inquest is based on what the reasonable doctor would do?

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1. Thomas R. Where to from Castell v. De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard for disclosure. *S Afr Law J* 2007; 124: 188-215.

Training an old-timer as a GP in Britain

To the Editor: I was born in England and have always hankered to work in Britain. In 1972, I was set to train in community medicine in Britain but accepted a post in the USA instead. In 2002, on turning 60, after 17 years as a lecturer in primary care and 5 years working in municipal clinics in Cape Town, I renewed a lapsed application to the British Joint Committee on Postgraduate Training for General Practice. I had to complete 6 months as a GP registrar and pass a summative assessment before becoming eligible for the Certificate of Equivalent Experience entitling me to work as a GP in Britain. The Merseyside (Liverpool) Postgraduate Deanery offered me a GP registrar training post with an outstanding solo dispensing practice in rural Cheshire. In September 2003, after completing the requirements, I received a Certificate of Equivalent Experience.

The summative assessment comprised a trainer's report, an audit of epilepsy care in the practice, a multiple-choice examination, and – by far the most testing – 2 hours of technically perfect video consultations. Counterbalancing the stress-inducing assessment was the support that British GP training affords trainees. I was generously supported by my trainer and the practice staff, while the dean encouraged registrars to attend conferences and training courses. Of course, the patients made the exposure ultimately worth while, by challenging, amusing, teaching, frustrating and professionally affirming one as patients generally do.

Despite misgivings about being a trainee at the age at 60, and notwithstanding the taxing assessments, I found this training worth while for adapting to British GP culture and being assimilated into the Local Primary Care Trust. My transition from municipal clinic work, with patients with TB and AIDS in South Africa, to 'normal' GP work in Britain has felt more like a complete clinical and psychological rehabilitation than an update of my knowledge and skills.

The extent of the damage I had sustained during prolonged work in public-sector primary care only came home to me fully when I spoke on AIDS to my fellow registrars at our weekly half-day release course. I was surprised to learn that I had become bruised, disillusioned and weary – burned-out – by working with predominantly young South Africans who should have been able to look forward to rewarding lives but, because they were denied antiretroviral drugs, faced early death heralded by TB, shingles or meningitis. It has taken me most of the year to recover and once again feel the professional fulfilment and personal satisfaction that general practice brings.

I also had the opportunity to drive through glorious countryside, visiting remarkable patients in their homes and learning something of English country life. Despite decided differences between public-sector clinic work in Cape Town and rural general practice in England, the fundamentals of family medicine apply as much in Cheshire as they do in South Africa; namely, close attention to the patient's expectations and needs. Above all, I have been gratified to learn that one can teach an old dog one or two new tricks.

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