LETTERS

General Practitioner Obstetrics

Sir,
The College has been working for several months with the Royal College of Obstetricians and Gynaecologists to produce a report on training for obstetrics and gynaecology for general practitioners. The discussion document on pages 116-122 is now available for all members to see, and I should be glad to have any written comments here by 1 May 1982.

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Trainees and the College

Sir,
The results of the survey of general practice trainees in Devon and Cornwall reported in the November *Journal* (p. 697) by Dr T. N. Griffiths must not be disregarded. They indicate that most of those questioned see the College as little more than an examining board, whose obstacles must be overcome before a career in general practice can develop. I suspect that these views are not restricted to the West Country.

We must recognize that few trainees know much about the activities of the College and that most see us as an exclusive body concerned only with matters relating to established general practitioners. There is, therefore, now an urgent need for us to indicate clearly to those preparing themselves for future work in general practice, that we are concerned about the difficulties they face in their training and in settling into new practices. It is essential that we identify those training for general practice in their hospital and trainee years, and that we invite them to join us in all that we are doing. In this way, acquiring the MRCGP should become but incidental to the more important and active part that we encourage them to take in our local activities.

Identifying vocational trainees, and especially those in their hospital years, is a difficult task, but, with our faculty organization, it is easier for us than most other bodies. I suggest that each faculty board nominate three or four of its members to be responsible for linking with the vocational trainees in the faculty area and for encouraging them to become involved in local groups and meetings. Those given this task would be able to speak at trainee day-release courses about the work of the College and could also arrange for locally based College examiners to discuss with them the College exam and how best to prepare for it. The most suitable members for undertaking this task would be those who have completed their own vocational training three or four years previously, for it is sometimes difficult for these younger members to find roles for themselves in the faculty.

I believe that if we can involve trainee general practitioners in College activities, then they are more likely to understand our aims and to work towards them, even after they have gained a full membership.

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National Trainee Conference

Sir,
I would like to add a comment to the report on the National Trainee Conference at Sheffield (October *Journal*, pp. 634-636).

Before the GMSC document on trainee representation was sent out to LMCs, the GMSC withdrew the recommendation that the trainee subcommittee be the agency for setting up future national conferences.

It will now fall on individuals in chosen regions to arrange the trainee conferences. I hope that these individuals will seek, and receive, support from national bodies such as the College, the BMA and the GMSC, and that they will also find help at a regional level.

I agree, Conference is the logical place for the national trainee representative of each body to report formally on the year's activities. Some trainee representation has failed in the past because of difficulties in disseminating information to individual trainees and in channelling complaints on a national basis. Hopefully, the new representation of the GMSC trainee subcommittee will be more truly democratic and allow easier contact between individual trainees and the representative national bodies.

I am not so sure that Conference is the right place to elect national trainee representatives, as the report suggested. National representatives are better elected via the usual committee procedures, after the committee has observed the performance of its individual members.

I know the College is concerned about trainee representation, and I hope that use will now be made of some of the framework of course and regional representation.

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Annual Symposium

Sir,
May I, through your columns, congratulate the organizers and the College on the Annual Symposium "The Disabled: Who Are They?" That such a subject was chosen is good in itself, but so many such symposia have paid mere lip service to this International Year of Disabled People. It is a tribute to the organizers, speakers and participating audience that this Symposium provided a practical, scientific and human guide to the understanding and care of those of us who are disabled.

I might say, too, that it restored for many of us faith in the ideal of the constructive, caring nature of the medical and para-medical professions.

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Sore Throats

Sir,
The exchange of views about sore throats in the October *Journal* (p. 627) once again shows that statistical significance does not necessarily equal clinical significance. Dr Whitfield has replied to Dr Fairbrother in statistical terms but I suspect that his argument may not convince everyone of his clinical point of view.

I have conducted a small study which illustrates my point by suggesting the opposite conclusion to Whit-

field's on statistical grounds, while I nevertheless agree with Whitfield's clinical conclusion. Adult patients in two Southampton general practices were eligible for entry if their sore throat was abnormal on examination and had lasted no more than seven days. Throat examinations were recorded, throat swabs were taken for streptococcal culture, and patients were supplied with a ten-day symptom diary card. Thereafter, patients were allocated to one of three double-blind regimens—penicillin V, cephradine, or placebo, to be taken orally four times daily for seven days. Patients returned on the tenth day for repeat throat culture and handed in their symptom diaries. Results were obtained from 200 patients. Analysis of the symptom diaries showed no difference between the two groups of patients taking antibiotics but both groups reported quicker recovery than the placebo group. By the third day 45 per cent of patients taking antibiotics reported no sore throat compared with 25 per cent of the placebo group. By the seventh day the corresponding percentages were 84 per cent of the treatment group and 79 per cent of the placebo group. Of the 200 patients, 36 (18 per cent) gave a positive culture for beta haemolytic streptococci (Group A) at entry to the trial.

The mean duration of sore throat after entry was shorter for the antibiotic group by 1.0 days for those with a negative initial culture and by 1.2 days for those with a positive initial culture. For all patients the total mean duration of sore throat was 7.6 days from reported time of onset (standard deviation 3.2 days) and 4.6 days from time of entry to the trial.

My conclusions were that statistically significant numbers of patients with sore throats gained some early symptomatic benefit from antibiotic therapy, although this advantage was lost by the seventh day; however, the general use of throat cultures did not help to identify patients with different outcomes. Dr Whitfield's results suggested similar findings in that patients taking penicillin had slightly earlier relief of symptoms, but here there was no statistically significant difference between this treatment and placebo groups overall (Whitfield and Hughes, 1981).

I would agree with Dr Whitfield by saying that neither trial suggests a large enough clinical advantage for antibiotics to recommend their routine use for every patient with an abnormal looking sore throat. Placebo controlled trials of antibiotics in minor respiratory illness generally show that either no advantage (e.g. Stott and West, 1976), or at best slight advantage, (Taylor *et al.*, 1977) is gained by taking antibiotics.

Many remain unconvinced by such evidence. An antibiotic prescribing policy is often defended by the claim that withholding penicillin will increase the rate of unscheduled follow-up. A retrospective study by Howie and Hutchinson (1978) did not support this argument, but confirmation of their findings by prospective studies might persuade more doctors to prescribe fewer antibiotics. A different basis for our clinical judgment was also suggested by Howie (1976) when he showed that our conduct in the consulting room is often influenced by non physical factors. If pressing social factors increase our antibiotic prescribing, this suggests either that we believe the antibiotics are effective or, at least, that we are unable to persuade our patients that they don't work very well.

I conclude that properly controlled studies so far conducted do not show a degree of clinical effectiveness in the antibiotic treatment of abnormal sore throat sufficient to match the expectation of a cure by many of our patients. If we help our patients learn more about the natural history of such self-limiting conditions, for example by providing simple reference booklets (Morrell, 1980), we will be in a better position to help our patients decide on the pros and cons of antibiotic therapy. Such an approach is worth further study.

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Teaching General Practice in the Third World

Sir,
I read with interest Professor Metcalfe and Dr Varnam's account of teaching general practitioners in Sri Lanka (October *Journal,* pp. 605-610).

The writers quite rightly bring up the question of the recipients' wants and needs and seem to answer them in saying that, "The problem of winning respect and support of colleagues in other specialties and of methods of internal organization are similar to those faced by British general practitioners of 25 years ago".

If these were the wants and perceived needs in Sri Lanka, then I suggest that English general practitioners should steer well away from the country and any other with similar concepts about the improvement of general practice, for two reasons. Firstly, in dealing with the problem of lack of respect and support by colleagues, an important issue is the context of improving health care, by implication for all, in Sri Lanka. Secondly, are the strategies and skills which have been developed successfully in English general practice transferable to a developing country?

The first of my questions implies a discussion on values and how a problem becomes important, and cannot, I think, be usefully discussed here. The second question is one which needs careful thought.

The strategies and skills developed in British general practice have tended to concentrate on epidemiological developments in small defined groups, on sophisticated doctor-patient skills, and on highly competent investigation-supported clinical ability. Until recently, British general practice has neglected the development of delegated clinical skills to less sophisticated health workers, and the development of preventive strategies. These two issues, along with public health administration, another cornerstone of primary health care in the developing world, are probably among the most important parts of the primary health care doctors' work in the developing world, and it is difficult to see what British general practice can offer in these respects.

In case it should be argued that a ratio of one general practitioner to 30,000 population obviates the need to delegate clinical duties, I should suspect that considerable urban-rural variation exists in Sri Lanka in terms of doctor-patient ratios. The latter may be very favourable in Colombo, but much