LETTERS

Out-of-hours Experience for General Practitioner Trainees

Sir,

Your editorial (July *Journal*, p. 395) expresses a concern for adequate training which I share. I was horrified to learn that some trainees whose trainers use a deputizing service had no experience of out of hours calls at all.

Might I point out that at present trainees cannot work for a British Medical Association deputizing company. A minimum of six months experience in general practice is mandatory and furthermore although some have been employed as deputies, payed employment for trainees outside their practice is not encouraged. Many would be extremely unhappy to see a trainee working unsupervised as a deputy even during his second six months as a trainee.

Would it not be more reasonable to consider the appointment of deputy trainers to supervise training in deputizing and also the setting up of special training posts within deputizing? Deputizing provides an ideal opportunity where experience rapidly can be gained. One night in deputizing would give a trainee as much experience of emergency care as he might gain in some practices in one year.

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Acknowledgement

I would like to thank Air Call and Plymouth Professional Advisory Committee for permission to submit this personal opinion for publication.

Attracting Trainees to the College

Sir,

The College wishes to attract more members. It would welcome an increasing number of doctors identifying themselves with its ideals and objectives.

New entrants to general practice will make up the majority of candidates. As trainees they can be associates for £22.50. However, in my own faculty only three trainees are associates. I suspect that ignorance of this opportunity is widespread, which is regrettable, as many of their trainers are College members.

Trainers and course organizers should invite each trainee to become an associate. The College should be presented as an organization that is worthy of support. Its democratic structure should be stressed: if the young doctor disagrees with any policy, he will have a wide audience, and the opportunity to initiate change. In East Anglia we have seen a new member of the faculty board make a proposal that eventually led to a change in the national constitution.

At a more personal level, the trainee should learn of the facilities and services that the College makes available to associates and members alike. There should be a perceived advantage in associateship. There is scope for an office at Princes Gate catering for the particular needs of trainees and new principals.

As associates, trainees receive copies of the *Journal*. They learn of the internal functioning of the College, and its many debates. Faculty newsletters give details of local activities. At the end of their training I hope that they would wish to remain involved in the work of the College, either as associates or as members, with the clear concept of the College as more than a source of diplomas.

Members who are trainers should feel strongly enough to pay the annual subscription fee on behalf of their trainees. Could there be a better demonstration of personal interest in the trainee, and of the College reaching out its hand? Perhaps the Membership Division could devise some form of joint trainer/trainee membership.

These ideas were formulated in a working paper produced by the East Anglia Faculty Board for the Communications Division.

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Polymyalgia Rheumatica

Sir,

I was interested to read the paper by Dr R. M. Turner (March *Journal*, p. 167) and also Dr D. J. Paynton's letter (June *Journal*, p. 389).

I have a personal series of 22 cases of polymyalgia rheumatica and/or giant cell arteritis. My list size is just over 3,100 but 28 per cent of these are aged over 65 years. This may be one reason for the comparatively large number of patients with these conditions in my practice. I also believe that the condition is being under-diagnosed because of a natural reluctance to prescribe steroids.

Dr Paynton asks two questions and I should like to respond to those by saying that I do not think that we are seeing a different condition. I think that there are some individuals whose erythrocyte sedimentation rate (ESR) never rises very high and yet who may have quite severe and disabling illness, and also some individuals who seem to have a very prolonged illness despite never having very elevated ESRs. For example one of my patients is a man whose illness was first diagnosed at the age of 62 years. His ESR has never risen above 20 mm in the first hour. Three years ago we managed to stop his steroids but had to restart them again earlier this year. I also have a woman patient whose illness was first diagnosed at the age of 55 years when her ESR was 45 in the first hour but who had marked wasting of the proximal muscle groups and muscle tenderness. All investigations, including muscle biopsy and anti-nuclear factor, were negative, and she responded dramatically to prednisolone. Four years later on she still takes 9 mg a day as well as non-steroidal anti-inflammatory drugs.

I have reached the conclusion that the people who tend to do relatively badly are men and those who first develop the illness before they are 65 years old. The height of the ESR does not appear to be especially important as a prognostic indicator.

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Research: The Role of the General Practitioner

Sir,

I quote from your editorial (August *Journal*, p. 469). 'Researchers in general practice should work towards a common vocabulary.' In the next sentence but one you write 'There is a universal need for transcultural and translingual expressions applicable in the dialogue between individual researchers'.

Is further comment necessary?

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