altogether to pay the bankers' order. During the last subscription year over 600 cheques had to be sent from the College refunding dual payments of subscriptions.

(4) Secondly, we have had considerable problems in the Finance Department of the College in identifying the member's name in the case of some bankers' orders. For example, Dr White, in the partnership of Drs Brown and Green and White: the payment we receive from his bank says it is from " the account of Brown and partners ". The time taken to identify the member's name in such a case can be considerable, and the problem is worse when a member changes partners or banks, so that the source of payment has to be re-identified.

(5) To help overcome our difficulties the 1973 Annual General Meeting agreed to the adoption of the direct debit system for payment of annual subscriptions by those members who were willing to do so. So far over 80 per cent of all the fellows, members, and associates who pay an annual subscription have agreed to pay by this method. In the direct debit system, instead of the member authorising the bank to send the subscription to the College, the member authorises his bank to accept the College's request for payment. The major difference is that we now know for certain who has paid. Furthermore, our bank (Messrs. Coutts & Co.) accepts the responsibility for collecting all the direct debit on the due day.

There are several advantages to the College. The very large sum of money involved is received within a very few days of 1 July, and a large proportion can be put to productive use. Our accounting system is greatly simplified. Payments received via bankers' order came in any jumbled alphabetical order and arrived over a period of days and even weeks. By direct debit we receive from our bank an alphabetical list of members who have paid their subscription.

(6) Only one snag—we hope—remains to be overcome. Because of inflation it is now necessary to increase the rate of the annual subscription at relatively frequent intervals instead of every five years or so as in the past. Using our present direct-debit system would mean that every member who agrees to pay his subscription this way would have to fill in a fresh direct debit instruction every time there was a change in the rate. With the variable direct debit system the member authorises his bank to pay such an annual subscription as shall have been duly approved at an Annual General Meeting of the College. If and when the subscription rate is altered, the member need take no action.

What protection will the ordinary member have if he agrees to pay his subscription by variable direct debit? Firstly, he will receive notice of the intended alteration to the subscription rates. Secondly, he can of course attend the AGM—or brief his colleagues who are attending. Thirdly, notice of any such change will appear in the College *Journal*. He will receive a letter from the College Finance Department informing him in good time of such changes as affect his subscription.

(7) The more members who agree to adopt variable direct debit, the greater will be the saving to the College in the administration of our subscription department. This saving is passed on to the fellows, members, and associates, in that the subscription can be kept at a lower rate, perhaps by as much as £2 per member per year.

STUART CARNE
Honorary Treasurer of the College

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CHILDHOOD LEUKAEMIA IN GENERAL PRACTICE

Sir,

An article in your April *Journal* caused considerable comment at a departmental meeting. I am writing this letter of criticism so that future writers will not fall into the same trap as did Dr Mark McCarthy, writing his article on the care of *Childhood Leukaemia in General Practice*.

The major criticism I have of his method is the bias in selecting interviewees. Only 73 per cent of the involved practitioners were interviewed, and inevitably we must question the representation of these doctors. Response from parents was higher at 85 per cent, but the number of refusals from parents whose children were treated at district hospitals was significantly greater than those from parents whose children were treated by special centres (9 against 2 respectively; $p = 0{\cdot}023$ by Fisher's exact test). Although this bias does not appear to be important to the remainder of this article, it shows an ability to accept sloppy methods by the author. Inevitably we must ask ourselves where else such biases might occur without our being told.

Presenting symptoms, as recalled *two years later*, are discussed and it is claimed that " specific haematological symptoms had become more frequent " by the stage of referral to hospital. Even if the data were reliable, the table produced does not show such a change in symptoms to be statistically significant ($x^2_2 = 2{\cdot}07$). This is not to say that delay in general practice does not occur—nearly a third of interviewed parents claimed that it did. However, such delay has not been shown to be related to symptomatic development of the disease by Dr MacCarthy's study, even though he later claims that survival correlates significantly with delay both on the general practitioner's and on the parents' part. Unfortunately we are not let into the secret of how such a claim came to be made!

I was intrigued to note that the unspecified majority of doctors were satisfied with hospital communications. This contradicts much of the current literature on this subject, and if true, could indicate either that the quality of communication

varies directly with the seriousness of the disease, or that the general practitioner felt the communications to be adequate simply because he considered the disease to be one more suitable for hospital management than his own care.

The second major criticism of this paper then, is the lack of data and statistical analysis. The author makes a large number of statements, few of which are quantified. For instance, Dr MacCarthy tells us that " 50 per cent of general practitioners considered that they gave medical attention more often than usual to other members of the child's family ". If this is true, it is surely important. Where are the figures? How nice it would be if the author could show this remark to be valid, and how much better if he could compare such a pattern of use with that of families of children suffering a non-fatal disease like asthma or epilepsy.

Some very strange throw-away remarks are also made without further substantiation. Take the following for example: " no general practitioner had himself contacted the school medical officer " —why should he?; " bone marrow biopsy . . . is no more difficult than a lumbar puncture, *and may be as life-saving* "—are such investigations *ever* life-saving?

Management of leukaemia in a child must be one of the more difficult tasks a general practitioner may face in his career, albeit that the odds of meeting such a child in that whole time are seven to three against. Dr MacCarthy's simplistic and non-analytic article tells us nothing that could be useful in such a circumstance.

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THE ETHICS OF QUESTIONING RELATIVES AFTER BEREAVEMENT

Sir,

I would like to comment on Dr McCarthy's article (April *Journal*).

I note that Dr McCarthy interviewed 64 mothers of leukaemic children, *approximately 27 of whom had died* two to three years after initial diagnosis. The author's justification for such questioning about an event, which probably ranked as one of the most painful of their lives, are memories that fall into three categories: firstly, the recall of the child's symptoms before consulting the general practitioner; secondly, details of any subsequent interactions with the health team; lastly, an assessment of satisfaction or otherwise with the general practitioner's preliminary treatment of the child.

Recall of the child's symptoms after two–three years seem hardly likely to be accurate: the maximum recall period permitted for symptoms is generally taken as 14–21 days. However, Dr McCarthy informs us that recall was clear (how do we know?) *precisely because* each occurrence surrounding this situation was still so painfully present to the mothers.

The second category of information sought, relating to subsequent interaction with the health team, is surely best gathered from those insolved: the general practitioner, and health visitor. The facts obtained may, however, relate to the last category of satisfaction with the general practitioner's care. If this is to be the justifying item of the interview, one would wish to know rather more about the author's methods. The information presented here does not seem in any way to justify such an appalling intrusion into a deeply painful event of people's lives.

I feel that this type of work has deep ethical implications to which the author seems insensitive. This article gives no indication of a possible work of merit which would justify the exercise.

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REFERENCE

McCarthy, M. (1975). *Journal of the Royal College of General Practitioners*, **25**, 286–92.

VOCATIONAL TRAINING PROGRAMMES

Sir,

Dr Lawrence Mackie in the June *Journal* is rightly concerned about the feeling that all young doctors intent upon general practice as a career should enter a three-year structured vocational training programme or ' package-deal ' after the preregistration year. As he says, many young doctors are anxious to undertake various hospital jobs of their own choosing in different parts of the country or abroad before 12 months in a teaching practice as a separate appointment. Married women may have no alternative but to do it this way.

In this region we are planning for about two fifths of doctors in training for general practice to construct their own training either fully or partially. We have a small number of two-year programmes and a reasonable number of extra teaching practices over and above the requirements of the three-year scheme for this very purpose.

What is important is that these trainees (and their teachers) be fully integrated into the regional educational organisation. Let us stop thinking of them as second-class citizens.

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REFERENCE

Mackie, L. (1975). *Journal of the Royal College of General Practitioners*, **25**, 440.