LETTERS TO THE EDITOR

RABIES

Sir,
As an army medical officer and a microbiologist I have long been interested in, and indeed fascinated by, the important problems raised by that universal disease of great antiquity, rabies; consequently I read the information and timely paper by Dr Dunlop (May *Journal,* p.293-296) with great interest.

With respect, however, I should like to comment on his reference to Korean haemorrhagic fever which he claims has not spread further than Korea and far eastern Russia, and suggest that in fact this viral haemorrhagic fever, which impinged itself so strongly on the minds of my military medicine and army health collegues when it hit our troops and other United Nations contingents so dramatically during the Korean War, is now believed to be more widespread than at first thought and may be seen in infected foci this side of the Ural mountains.

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RAISED BLOOD PRESSURE AND PSORIASIS

Sir,
Dr Burley (April *Journal,* p.236) has raised an interesting and valid point in connection with the study of an association between psoriasis and hypertension (December *Journal,* p.713). In this study the male sample of a general practice shows a significant degree of association between these two diseases and Dr Burley asks whether treatment by beta-blocking agents or topical steroids could have affected results.

Beta-blocking agents were taken by two male patients in the study, but in each case psoriasis had been diagnosed several years before the drugs were given. Topical steroids had been used at some time by 12 in the hypertensive group and eight in the normotensive, but only one hypertensive and two normotensives had received topical steroids within the past two years. It is therefore most unlikely that steroids were in use at the time of the study other than in these three cases. The amount of topical steroid prescribed was small in all cases (less than 30 grams per year) with the exception of one normotensive patient who received up to 100 grams per year.

As an interesting corollary to the above study, Dr Charles McDonald, of Brown University, Providence at the 1977 Annual Meeting of the American College of Physicians reported that in a retrospective enquiry into 324 cases of psoriasis, occlusive vascular disease was twice as common as in controls. He found that psoriatic males were more prone to arterial disease whereas psoriatic females under 50 years of age were more prone to venous occlusion. The twofold predisposition to vascular disease and the variation between the sexes has close similarities with the findings reported in the Exeter Hypertensive and Psoriasis Study.

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TRAINING GENERAL PRACTITIONERS

Sir,
As one who chose to enter a vocational training scheme before going into general practice, I should be more than pleased to have my choice vindicated by statistical proof that structured training is superior to unstructured training. Indeed, I am convinced that this is so.

However, I cannot accept that the article on this subject (June *Journal,* p.360) proves its point. The fact that question papers A and B were used in the form of a cross-over trial when one group under study was in a position to discuss both papers before the second part of the trial while the second group was not (indeed, the authors stress the point of their geographical scatter) would be enough to cast doubt upon the figures. When the authors also admit that one member of the vocational trainee group received special tuition because of his poor performance in the first examination, and that this member showed the greatest improvement in the second examination and hence must have had a key influence upon the significance of the trial, then all credibility is lost.

I should also like to enquire whether the trainee group had the opportunity to practise examinations of this type as part of their training. If, as I suspect, this was the case, then the 'significant' difference may not represent knowledge, but technique.

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INDEPENDENT CONTRACTOR STATUS

Sir,
Dr Robson's thoughtful letter (June *Journal,* p.373) regarding the 'pros and cons' of the independent contractor status *vis à vis* a salaried service shows clearly the superficial attractions of the latter. However, I do not believe that we should consent to becoming salaried NHS employees just now.

Dr Robson states that we should not have to provide our own equipment. This is true, but if we did not, we should find ourselves in a long queue for the 1984 allocations (State of the Economy permitting)! Those of us involved in other aspects of NHS administration know the exasperation of waiting for an ever-receding goal. As independent contractors, we can provide the premises and equipment we prefer, without waiting, and if it is sub-standard we have only ourselves to blame.

In times of economic stress, we have seen (RAWP and all that) that the result of attempts to equalize resources leads to a general levelling down of standards (DHSS, 1976). I have little doubt that a change to a salaried service would in time lead to a levelling down of standards in primary care as money becomes tight.

Those who have worked in area health clinics as well as in general practice will know that in the former one is restricted by policies laid down from above. Freedom to treat is therefore not always what one would choose, given full clinical freedom. The greatest (and last?) bastion of clinical freedom, in spite of all the fuss about overprescribing, is the independent contractor status, whether of general practitioners or consultants in private medicine.

In conclusion, I believe that the most damning accusation against the independent contractor status is that it has permitted an unacceptable variation in