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

standards of primary care, but this is something which must be regulated by the profession itself, and a start towards it has already been made through compulsory vocational training.

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Reference

Department of Health and Social Security (1976). *Sharing Resources for Health in England.* Report of the Resource Allocation Working Party. London: DHSS.

Sir,

Reading Dr Robson's letter (June *Journal,* p.372) reminded me of the topsy-turvy world of Lewis Carroll, if that is not too flattering a description of the sort of tendentious arguments and selective statistics used, for example, by the Radical Statistics Health Group, with support from the National Union of Public Employees, in their pamphlet *In Defence of the NHS* (1978).

Dr Robson apparently despises butchers and grocers and he dislikes the market place.

He seems ready to blame the independent contractor status for the failings he sees in the NHS.

He is concerned about the increasing inroads being made into doctors' political and clinical autonomy, yet under the umbrella of 'democracy' he suggests that doctors should seek alliances with other health workers and their trade unions, for he believes that trade union organization can protect doctors' interests.

It is, however, difficult to see how this can be so, since trade union power ultimately rests on the ability to injure the employer directly, or in monopoly or nationalized industries indirectly, by injuring the consumer. Doctors will not injure patients, hence their reluctance to strike. The only weapon doctors have, therefore, is resignation to an alternative service; something similar perhaps to that of France or New Zealand. There we find independent contractors operating in the market place, with the government ensuring adequate care for those in financial need.

After 30 years of largely fruitless dealings with successive governments, we have learnt the sad and unpalatable lesson that proper remuneration, and hence the financial power to do the job properly, is not likely to come through our present system, nor through a salaried service, a closed contract, discussion with a Review Body, liaison with trade unions, nor even through independent contractors without *some* stimulus from the market place applied to patients and doctors alike.

C. H. MAYCOCK

The Court
Neopardy
Nr Crediton
Devon.

Reference

Radical Statistics Health Group (1978). *In Defence of the NHS.* London: RSHG.

TRAINERS' COURSES

Sir,

As the course organizer responsible for the Thames Valley Faculty Trainers' Courses referred to by Dr Wayne Smith (March *Journal,* p.184) and Dr Peter Kersley (June *Journal,* p.373), I would like to describe how the 1977 Course was designed and evaluated by its members.

In the Oxford Region trainers regularly participate in a local trainers' group and attend a teachers' course, not necessarily the Regional Course, once every three years. The aim of the Regional Course, which is residential and lasts five days, is to contribute to the work of the trainers both in their teaching practices and in these local groups, and the objectives were chosen in the light of the needs of these groups and of some of the problems in teaching practices commonly reported by trainees, which have recently been discussed by Dr John Hasler (June *Journal,* p.352).

The Course was designed to introduce the tasks of educational assessment and curriculum design, the preparation and conduct of tutorials, the witnessing and analysis of consultations, and the design and review of records. It was felt that all of these could be continued in the local trainers' groups and would also help with some of the difficulties in achieving them in practice by using the intensity of the residential week to increase our understanding of the problems of working in groups, our difficulties with giving and receiving honest criticism, and our problems with interpersonal relationships, particularly with our trainees. This can be disturbing for the members of the Course and it was the responsibility of the course organizers to maintain the balance of the Course and to respond to the wishes and needs of its members.

The Course was attended by 43 trainers, 11 trainees, and Dr Ben Pomryn, Consultant Psychiatrist, who helped us with the process of the Course. We worked for most of the week in small groups of trainers and trainees. The session in the previous year's Course, referred to by Dr Peter Kersley, when the trainees were observed in their own group, was recognized as being mistakenly divisive and was not repeated.

The Course was evaluated by a questionnaire sent to members two months after it had finished in which they were asked to rate the degree of relevance and degree of achievement of our objectives. They were also asked the extent to which they agreed or disagreed with various statements about the Course. The conclusions were that while all the objectives of the Course were seen as very relevant, the degree of achievement was greater in consultation analysis, working in groups, and interpersonal relationships than in educational assessment and curriculum design, though these were also considered to have been achieved. The members also felt strongly that the Course had helped to motivate them to improve their teaching and had been a valuable stimulus to their teachers' group; this has also been endorsed by the course organizers of these local groups.

However, they felt that the experience of the Course had been disturbing for some of the members and the question remains whether this was due to the discomfort of finding out more about ourselves and producing a creative dissatisfaction, or whether it detracted from the other tasks we intended to achieve.

Dr Wayne Smith suggested that the course organizers were not experienced enough to handle some of the reactions that arose on the Course and a small majority of the other members agreed with him. While four out of five of us had indeed attended the Nuffield Course beforehand, we may still be short of this experience, but if, as we believe, some of the unresolved problems in our teaching practices and trainers' groups are due to our difficulties with interpersonal relationships and giving and receiving honest criticism, then we cannot take the comfortable option of ignoring them but must continue to work together to resolve them.

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WHAT KIND OF COLLEGE?

Sir,

Both the William Pickles Lecture by Dr Freeling (June *Journal,* p.329), and the