Channel 4 Television

Well-being, a series of 10 television programmes made with the advice and support of the College, is to be shown on Channel 4 at 22.30 to 23.15 hours on Fridays. The following titles are provisional at the time of our going to press.
12 November: A Weight Off Your Mind. *The problems of obesity*
19 November: Push Harder. *Maternity services and primary care*
26 November: Take It Easy. *Coping with stress*
3 December: Breaking Out. *Some non-drug approaches to mental ill-health*
10 December: Use It or Lose It. *Adding life to years*
17 December: Chips with Everything? *Food and health*
7 January: Name Your Poison. *Addictions (tobacco, alcohol and tranquillizers)*
14 January: The Medicine Chest. *Home remedies*
21 January: A Woman's Lot. *Some gynaecological problems*
28 January: The Second Sex. *Approaches to gynaecological care*

A paperback book, *Well-being* (Penguin Books), providing background material to the series, should be available in bookshops by mid-November. Each programme will also be supported by a brief 'fact sheet' available to the public from the television company.

Enuresis

Both praise and criticism are handed out to general practitioners in a small discussion paper recently published by the Family Service Unit. While it reminds us that urinary tract infections are five times more common in enuretics, the main purpose of the paper is to point up the failings and inconsistencies in central and local government policies. It gives recommendations aimed at making improved and more consistent help available for families with enuretic children. The point is well made, but much progress could be achieved not by a major input of resources, but just by working energetically and sensitively in an area where so many families are made so unhappy. Available (£1) from the FSU national office, 207 Old Marylebone Road, London NW1 5QP.

Health Education Council

Mr. Brian Bailey is joining the Health Education Council and will become Chairman for four years from 1 January 1983. He is currently Chairman of the South Western Regional Health Authority and a member of the Medical Research Council.

LETTERS

Healthier Children—Thinking Prevention

Sir,
It makes me sad to discover that a vast amount of time spent by nine eminent members of our profession, and the use of four tons of paper, should produce in "Healthier Children—Thinking Prevention" a document (with the College arms on its cover) which is seriously inconsistent within itself.

The crucial paragraph 7.25 refers to 20 "interventions . . . scientifically validated", which makes nonsense of much that follows. After such a superb, clear and attainable list, why is it suggested that we should ask if a child is dry at night when we are going to do nothing about the answer? Such inconsistencies cast doubt on the wisdom of the rest of the document, not least in the minds of those outside general practice, which is a great pity.

No, sir! Most of us should show that we can achieve 95 or even 90 per cent of what has been shown to be effective. We would then show that general practice is the right setting for promoting the health of children. We would gain most of the improvement in their health which is capable of being made by the intervention of medicine, as opposed to politics or social engineering. We might also gain self-respect or even hard cash! The minority who have the skill and inclination can show us in due course whether there are any other items which should be added to the list of 'interventions'.

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Ultrasound Therapy for Herpes Zoster Pain

Sir,
A few physiotherapists have been using ultrasound therapy (US) for herpetic pain for many years. Miss M. K. Patrick and Mrs E. M. Oakley introduced it to us, but we are not aware of any scientific publication of results.

We have treated 20 cases within three weeks of the onset of the rash. All have had considerable relief and most have been cleared of pain at the first application. The pain has returned with less intensity within a few hours. Subsequent US has been followed by longer relief and all have been free of the need for analgesics within 1 to 2½ weeks. US can be given when the rash is still active and can be given concurrently with idoxuridine (Herpid) paint. We have also treated eight cases between 1 and 15 months after the rash appeared; the same rapid relief of pain has occurred in all but one. This man has severe scarring; he has had great relief, but not as much as other patients. In a further eight long-standing cases—15 months or more after the rash appeared—most have benefited and have been able to stop or greatly reduce analgesics. Some, particularly those who have had injections to relieve their pain, have had little or no benefit. One, previously treated with paravertebral injections and acupuncture, had an increase of pain after US applications. On the other hand we have seen success after 14 years of pain. Residual paraesthesiae or sensitivity to cold is not always cleared. It is the pain and the need for analgesic and psychoactive drugs with their side-effects that have been rapidly eliminated.

US has been applied at 1 MHz, 0.25 W/sq cm at the rate of two minutes for every 12 sq cm. In extra-sensitive areas, pulsed US has been used. Occasionally it has been necessary to skirt the area with pulsed US before treating an extremely sensitive area. There is some evidence that 3 MHz is more successful. We have only recently bought this

machine and as yet our experience is not sufficient to form a judgement. Those who have machines with minimum delivery of 0.5 W/sq cm or more need to use pulsed US more frequently, but they are usually successful. In most cases treatment has been given daily, apart from weekends. Most patients require from six to 12 applications.

We feel that US provides a very effective and rapid relief of herpetic pain—much more so than any medication, particularly in early cases.

A. S. GARRETT
General practitioner
MARY GARRETT
Physiotherapist

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MRCGP Exam: Passing and Failing

Sir,
Consider a group of established principals who have failed the MRCGP examination and who, therefore, according to the stated aims of the College for that exam (RCGP, 1981), lack the ability to accept unsupervised responsibility for the care of patients in general medical practice (a worrying state of affairs for all involved: candidates, colleagues, College and patients alike). Then encourage them to attend a course designed to help them prepare to resit the exam (Scobie and Dymond, 1982). If it were then clearly demonstrated that those who had attended the course performed significantly better at resit than comparable 'failers' who had not attended, would the College, the organizers of the course, the candidates, and their patients be pleased or not? If these 'failers' really were incapable doctors in July, how are they suddenly capable in December, after a mere five-day course? If these 'failers' were simply bad at exams (advertisement for MRCGP course, August *Journal,* page 518)—and the course remedied that—then did their original failure really carry the significance that the College attaches to it? Scobie and Dymond conclude: "It is likely that the success of the course will be measured in terms of the examination results of those course members who sit it again." Because something is measurable is not a reason for measuring it. Because exam results and marks are convenient currency is not a reason for trading in them.

The College exam has dug itself into a deep hole, getting deeper. If it really achieves its stated aims, then apparently 40 per cent of British family doctors are incompetent. If it does not, then what is its function?

NICHOLAS BRADLEY

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Exeter.

References

Royal College of General Practitioners (1981). Obtaining and maintaining membership: a Council discussion paper. *Journal of the Royal College of General Practitioners,* **31**, 521–524.

Scobie, J. S. & Dymond, J. (1982). Towards the MRCGP. *Journal of the Royal College of General Practitioners,* **32**, 516–518.

Editing and Accuracy

Sir,
The level of care shown in the use of the words 'Britain', 'UK' and 'English' in Dr Hull's paper on low back pain (June *Journal,* pages 352–356) and in Dr Milne's paper on econazole (ditto, 360–364) gives rise to doubts on the accuracy of their medical content.

W. M. MACFARLANE

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Women Doctors

Sir,
Having been asked recently to comment on the opportunities for women doctors in general practice and having read many articles and letters in the past about this evergreen subject, one is aware that problems do still exist, particularly with the increasing number of women qualifying who choose to enter general practice, and the advent of mandatory vocational training. I would be grateful for any information relating to difficulties encountered in finding suitable employment, and the sort of problems that might occur during a later working relationship. It would also be interesting to know what particular qualities are considered important, as well as skills and attitudes when choosing a new partner. "Does sex really matter in the surgery?"

MARGOT RICHARDS

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The Word 'Trainee'

Sir,
The current Oxford Illustrated Dictionary contains the following entries: "Trainee. One who is being trained (for an occupation)." "Trainer. (esp) One who trains persons or animals for athletic performance, as race, boxing-match, etc." The emphasis of these descriptions is on instruction for a limited range of skills. This is not what is happening in general practice, or at least it is not what should be happening.

In a learned profession the learning process is known as education. The present terms used for the two participants are therefore grossly inaccurate, quite apart from the appallingly derogatory context in which the word 'trainee' is often used. It should be quite clear that a young doctor at this stage is already a highly intelligent, educated professional person who is a colleague, and does not deserve to be treated with such contumely.

Having spent several years expressing these views to apparently deaf ears, I find it both refreshing and gratifying that such a distinguished colleague as Dr Elliott-Binns (August *Journal,* p. 504) is in complete accord with me.

Is there any good reason why a trainer should not be called a 'teacher' or 'tutor' (of general practice), and a trainee a 'registrar' (of general practice), or even a 'resident' (in general practice) as in Canada?

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Sir,
Dr Elliott-Binns suggests that we abandon the word 'trainee' (August *Journal,* p. 504). He concludes, however, that there is no really suitable word to take its place.

Before *Journal* readers leap to invent new words, they should remember the views of trainees themselves. The issue of an alternative title was considered at the 1981 Trainee Conference in Sheffield. The trainees decided they were happy being called 'doctors'. After that any further discussion seems superfluous!

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