meets most of the criticisms of the consultant merit award system, and incidentally we feel that if consultants are involved in helping to assess general practitioners' awards, general practitioners should also be involved in assessment of consultants' merit awards.

We therefore suggest replacing the vocational training, seniority, group practice and postgraduate training allowances with this new renewable performance-sensitive payment.

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A Double Blind Randomized Control Trial of Diazepam

Sir,

We read the *Journal* regularly with great interest as the articles published are often of good quality and useful to us in our work as general practitioners.

It was therefore with great surprise and regret that we read this article by L. Condren and colleagues (October *Journal,* p.635). This work is of such poor quality that we were surprised that your *Journal* should publish it. We would like to point out some of the most obvious mistakes.

In the introductory passage the authors say that there is no conclusive proof that diazepam is better than placebo. They even suggest that diazepam is poorly documented. We have been in touch with Roche, the manufacturer of Valium (diazepam), who say that there are approximately 15,000–20,000 original articles published about diazepam. In this case, far from being poorly documented, diazepam is probably one of the best documented drugs on the market.

We are very critical of the design of the study. Only 20 out of the 150 doctors that were contacted replied, giving a drop-out of 86 per cent! Of the brave few (20) who were left only *eight* replied with filled in protocols. Furthermore, 47 per cent of the protocols from the eight doctors were incomplete. These figures are of course totally inadequate if the article is to have any pretext to scientific validity. The authors even state that one of the reasons for the large drop-out may be difficulties in getting the patient's informed consent. It seems reasonably safe to assume that the patients with the more serious symptoms would be more hesitant before taking placebo instead of diazepam than the average patient. One could assume that among these patients a relatively larger number would benefit from adequate therapy. This is of course a major objection to the whole study and its result.

The authors have not explained to our satisfaction how the scoring of the symptoms was performed. It appears that it was the treating physician who scored his own patients. In our opinion the scoring should have been performed by an impartial person, preferably a psychologist.

We quite realize and sympathize with the fact that to organize and execute scientific studies in general practice is not without its problems. To call this project a double-blind randomized control study is however an absurdity. This description is reserved for, or should be reserved for, scientifically designed studies executed with enough resources to give an acceptable result. It is of course useful and interesting to learn about the opinions of colleagues. These opinions should not however be given the halo of 'medical science' by using a pseudo-statistical cloak and publishing them in respectable journals.

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The Assessment and Teaching of Factual Knowledge

Sir,

Dr A. H. E. Williams is to be congratulated on devising an assessment programme by which trainee practitioners can evaluate their progress in comparison with a standard set by trainers (January *Journal,* p.41).

What struck me with amazement was that of the 14 areas of medicine tested, no assessment was made of knowledge in geriatric medicine. It might be argued that 'medicine' and 'human development' would encompass some aspects of this vast and growing subject. However that would not satisfy me, nor a growing number of colleagues that I meet.

The lack of a structured education in this subject, the teaching of it in hospital units devoted to rehabilitation rather than preventive medicine and the natural evolution of diseases of ageing may be responsible. But the College working party of which I was a member produced a document that is structured to allow an assessment to be made.[1] We may recall that it was not until 1980 that the MRCGP examination contained a question specifically about the elderly, and this revealed such shortcomings in the minds of candidates that it has presumably been felt best to leave that difficult area alone, although I have noted as an observer a doubling of the rate of questions asked at the oral table.

One notes, ironically, that College Council cannot yet cope with the idea of a Diploma of Geriatric Medicine, although this assessment, at least as far as hospital doctors are concerned, seems inevitable. Looking again through Dr Williams' list, it is possible that questions could have been asked concerning the elderly in every category except paediatrics and obstetrics. However, when Stuart Carne said some years ago that the quality of a practice could be found in the way it cared for children, he may already have been out of date. Today, it must lie at the other end of the age scale.

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Reference

1. Training general practitioners in geriatric medicine. *J R Coll Gen Pract* 1978; **28:** 355-359.

Victualler's Thumbnail—a Condition of Subungual Osmotrauma

Sir,

In describing this condition (February *Journal,* p.118) I am sure that Stephen Head has done us all a great service. However I am rather concerned that he may be adding yet another item to the long list of great medical misnomers. In much the same way that we now know the gastro-colic reflex to have nothing to do with either the stomach or the colon (and neither is it a reflex) this condition has nothing to do with osmosis. We are all taught in 2nd MB physiology that osmosis requires the presence of a semi-permeable membrane, so that this is a simple example of rehydration by diffusion.

May I suggest, therefore, that the original title be kept as simply 'Victualler's Thumbnail' or even, perhaps, 'Head's peculiar lacticoma'!

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