ing of these courses. Although they were concerned with education for primary care, Section 63 funds were not made available and they were financed through a sponsoring drug company and course fees. Some nurses appeared to be paying their own fees, while others had their fees paid for by their general practitioner employer. General practitioners were able to claim reimbursement only for subsistence and travel expenses of their practice nurses attending these courses. The financing of courses for practice nurses certainly needs to be looked at. It is evident that there are indeed similarities between the historical development of general practitioners and practice nurses.[2] The problems relating to nurse training are particularly the method of employment of practice nurses, the lack of funds available for training, and the lack of knowledge about practice nurses of the nursing profession's leaders.

A particularly exciting development for the future has been the setting up after the first course of an ongoing peer group composed of local practice nurses.

Although the role of the practice nurse may be much disputed by some,[3] it is clear that changes in attitude towards both nurses and their role in screening in general practice must take place. Compulsory higher training of practice nurses will help this, and we believe that the area of preventive medicine is a useful place to start.

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2. Bolden KJ, Bolden S. The practice nurse: is history repeating itself? *Br Med J* 1986; **293:** 19-20.
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When is a trainee fit to be let loose on patients?

Sir,

A recent judgement by a medical service committee, and endorsed by the Camden and Islington Family Practitioner Committee, is extremely relevant to vocational training and I believe ought to be seriously discussed by the profession.

The hearing in question[1] arose from an incident during my traineeship in 1984, when I was involved together with my trainer in treating a young man for what we had diagnosed to be an upper respiratory tract infection. His rapid deterioration led to admission to hospital where he died shortly afterwards, the cause of death being certified as pneumocystic pneumonia due to acquired immune deficiency syndrome.

Although the service committee refused to uphold the complaints about our failure to recognize AIDS and to diagnose the pneumonia, its report contained several criticisms about purely clinical matters such as the detection of signs and symptoms, their interpretation and the clinical decisions arrived at. For example:

- 'On the question of the diagnosis of pneumonia, although the precise strain was rare, there were sufficient signals from the patient and his family over a short space of time to indicate that something was wrong; neither doctor was alerted by this.'

- 'The Committee were concerned that in his examination of the patient's throat [the trainee] had failed to notice the lesion which was later identified as a Kaposi's sarcoma on the patient's hard palate.'

- 'They accepted the descriptions given by the complainant and her witnesses, which clearly illustrated a seriously ill young man, and were puzzled by the conflicting picture presented by the respondent's trainee.'

- 'The Committee considered that Dr X, the respondent's trainee, had not taken a proper history of the patient ... probably as a result of his inexperience as a GP.'

These statements, especially the last one, are difficult to reconcile with the facts known to the committee about my previous hospital training. Questioning a trainee's clinical competence in such a way suggests that previous experience counts for very little, and that a trainee needs to be very closely monitored until he can be considered competent to take a proper history from a physically ill patient. The implications for future vocational training are bewildering.

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The complaints system in British general practice

Sir,

It sometimes requires an outsider to point out home truths. We should be indebted to Professor Max Kamien for his personal view of British general practice (January *Journal,* p.36). I was particularly interested in his comments about the complaints system and the way this influences patterns of referral to hospital.

His comments agree with much anecdotal evidence. Even though the chances of a complaint leading to a family practitioner committee hearing are one in 350 000 consultations, the answer to the problem is not to expunge the fear as Professor Kamien suggests but rather to recognize its effect.

A solution would be to change the complaints procedure. At the moment there is little scope for patients to air minor grievances which gives the impression that the complaints system is weighted against them. Many serious complaints are fuelled by multiple small resentments. At the same time there is evidence that doctors fear the present system and alter their behaviour accordingly. The professional consequences of even a single successful complaint can be disastrous. It is interesting to speculate on the cost to the National Health Service of doctors referring patients to hospital for the sole purpose of fulfilling their terms of service to the letter.

In the meantime, we have to live with an insensitive and inflexible complaints system that seems increasingly capricious and political[1] and is satisfactory to neither patients nor doctors. We are doing no one a service, least of all our patients, if we continue to deny the effect this has on practice.

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Rubella immunization — what happens in our practice

Sir,

I was interested to read of the experience of rubella immunization in Brent and Harrow as reported by Drs Price, Wallace and Wilton (February *Journal,* p.82). In