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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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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Reference

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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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Reference

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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

our practice we are more fortunate in already receiving reports from the school medical service when girls are immunized against rubella at entry to secondary school.

Using our age–sex register our practice nurses checked the notes of all girls aged 12 and 13 years for a record of rubella immunization. A definite record was found in 130 out of 145 cases (90%), indicating that in Devon the school medical service is efficient at both carrying out rubella immunization and informing general practitioners.

We subsequently wrote to the parents of the 15 girls with no positive record of immunization. Three presented for immunization, three claimed to have been immunized, and nine (60%) did not reply — their notes have been annotated for action at the next consultation.

From our experience we would agree with the recommendation that the general practitioner be informed of all immunizations by other agencies. We suggest that all records are examined when female patients are aged 12 or 13 years and the notes annotated if no record of rubella immunization is found. However, writing to patients seems to be a waste of time. In addition all young women should be screened for immune status, usually at first presentation for contraception, and the result should be displayed prominently on the summary card.

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Coxsackie B viruses and the post-viral syndrome

Sir,

I was interested to read the paper on Coxsackie B viruses by Calder and colleagues (January *Journal,* p.11). An outbreak of myalgic encephalomyelitis began in Brechin in July 1983. Seventy patients in a population of 10 000 have had raised neutralizing antibody titres to Coxsackie B viruses (512 and over). The age range of the 70 patients was 15–73 years and 29 were male and 41 female. Titres to all five serotypes were found but B4 was the commonest — 44 patients had a titre of 512 and over to B4.

The frequency of symptoms has been similar to that recorded by Dr Calder and a similar proportion of people have been unwell for over one year. A noteworthy feature was the periodic nature of the symptoms particularly after the patient had been unwell for a few months. Symptom-free days were followed by a recurrence of symptoms when active work and activities were performed. Over a period of some months the symptom-free period gradually became longer.

A self help group, started in Brechin in November 1986, had 140 members within eight weeks and it is now incorporated within a Tayside region group with branches in Dundee, Perth and Angus. This group liaises with the national myalgic encephalomyelitis self help group.

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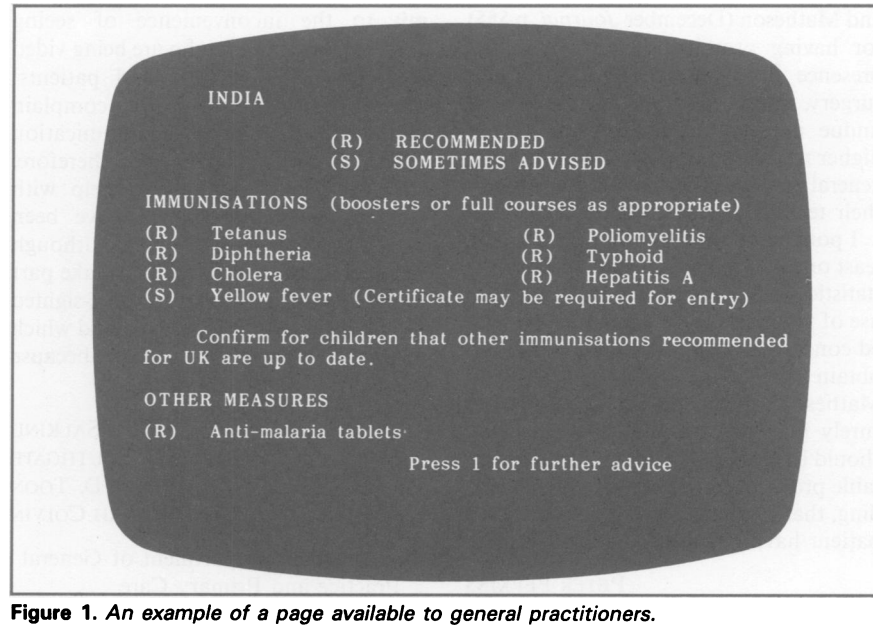

Figure 1. *An example of a page available to general practitioners.*

Computerized advice on malaria prevention and immunizations

Sir,

Dr Campbell suggests (February *Journal,* p.70) that there is a need for continually updated information about suitable antimalarial drugs for travellers and that this could be provided via general practitioners' computers. This service has recently been made available on a data base compiled by the Communicable Diseases (Scotland) Unit and installed by the Scottish Poisons Bureau Information Service on their mainframe computer. An example of one of the pages available is shown in Figure 1. General practitioners who have access to a terminal or computer with a modem (such as that which links with Prestel) can register to use the service by contacting the Communicable Diseases (Scotland) Unit (telephone 041-946 7120).

The service covers recommended immunizations and malaria prophylaxis and is updated directly from the Communicable Diseases (Scotland) Unit on the basis of advice from various sources including the World Health Organization, the Department of Health and Social Security, the Malaria Reference Laboratory, embassies and drug companies. Information about the administration and availability of both commonly used and the more unusual vaccines is also provided. Direct feedback is encouraged so that the information can be improved and answer the most frequent questions. A modified version of the data base will be made available soon to other interested parties such as airlines, travel agencies and businesses.

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Video recording in general practice

Sir,

Dr Roberts expressed surprise that a significant proportion of patients might be reluctant to have their consultation video recorded (March *Journal,* p.134), yet he admitted later in his letter that he too was anxious during his first experience of being recorded. He also criticized Servant