long, despite two thirds of visits being made within one hour and 80% within two hours. However, whether patients are satisfied or not is meaningless if what they were waiting for is not studied. Waiting two hours for an opinion on a nappy rash is an excellent service, whereas an hour's delay for chest pain is unacceptable. Higher expectations among patients will lead to greater dissatisfaction if services are not forthcoming, but are their expectations reasonable, and thus are the particular findings in this paper of great significance?

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Health education in general practice

Sir,

I was interested to read the article by Dr Pill and colleagues (February *Journal,* p.53) concerning the characteristics of attenders and non-attenders at health checks in general practice. I have studied some of these features in a case-finding programme at a health centre in a district of Toledo.

A random sample of 545 patients over seven years of age attending the health centre during 1987 were screened. Blood pressure was measured in those aged 35–64 years, obesity and alcohol consumption checked in those aged 15–64 years, smoking levels in those over 15 years old, drug abuse in those over 25 years old and dental health in those aged 7–14 years.

One or more problems were detected in 479 patients and they were invited to attend a consultation with a nurse, which focussed on health education. The following characteristics of the patients were noted: age, sex, profession,[1] type of home, size of family, number of cigarettes smoked per day, alcohol consumption per day, systolic and diastolic blood pressure, body mass index and presence of a chronic illness.[2,3]

Of the 479 patients 408 (85%) accepted the invitation and 71 (15%) did not. Those who rejected the invitation were significantly younger, were more likely to be inveterate smokers, smoked a greater number of cigarettes per day and had fewer chronic illnesses than those who accepted ($P<0.001$). There were no other differences.

As in Dr Pill's study, patients that attend more frequently, often those suffering more chronic illness, are more likely to attend for health education. In my study smoking seems to be a limiting factor for acceptance of preventive measures offered in primary care.

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Homoeopathic medicine

Sir,

I have read no comment or discussion on the article on homoeopathic medicine by Dr Swayne (March *Journal,* p.119). Are we all intellectually and ethically moribund, or merely lazy?

I believe medical schools should teach only that which is based on proven science or prolonged critical clinical appraisal. Admittedly this is difficult in the wide field of psychology but must be attempted.

Any cure-monger, be he qualified physician, homoeopathist, Christian Scientist, chiropractor, acupuncturist, mystic or frank charlatan, will have many satisfied patients, and achieve many 'cures' without the use of science. Of course he will also kill a few people and harm quite a lot.

The trouble is that many intelligent, observant practitioners of unscientific methods add much sound normal medicine to their quackeries. If they are good people, or even plausible rogues, many are inevitably attracted to their cult. An established cult resists rational and proper attacks with resolution and skill. It takes a long time to debunk it and it may arise again, like the phoenix from well-deserved ashes.

We should always know whether *scientia* or *caritas* is applicable to our therapeutic efforts. For example, should *caritas* apply to chiropractic and acupuncture when they lack scientific basis?

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Allergy controversy

Sir,

The media have accused the medical profession of being allergic to allergy, probably because of the lack of research into the mechanisms and presentations of allergy. There has been a great deal of conjecture about the incidence of allergy, the cause of allergy and the many bizarre symptoms and syndromes which are claimed to be of allergic origin.

It would be possible to demonstrate the incidence of allergy in the general population by conducting a survey to discover in what proportion of married couples both partners have an allergic diathesis. Married couples are randomly selected pairs and the incidence of allergy in such a series would enable a statistician to calculate the incidence of allergy in the population as a whole. For the survey to be meaningful it may be necessary to include as yet unproven manifestations of allergy. For example, is migraine a masked allergy to food?

The concept of a masked allergy as a valid mechanism of illness is thought by many to be unproven, so disagreements on the presentations of allergy can influence judgement on the incidence of allergy. On the other hand some doctors have suggested that allergy is now such a common cause of illness that all patients seen at hospital should be screened for masked allergy as an initial step in modern diagnosis. The College could give a lead in this field where clinical research is likely to anticipate laboratory validation by many years.

There is great need for research to clarify these controversial issues, cure the media of their inappropriate curiosity and offer a better approach to allergy for the benefit of our patients.

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Mystery symptom

Sir,

I would like to seek the advice of your readership over a symptom that has affected a number of patients, including myself. This is a sharp stabbing pain, not severe, centred over the spleen. It is not pleuritic, does not vary with respiration or posture and is not related to chest infections.

It comes in short episodes of seconds or minutes and only lasts a couple of days. It follows fairly severe viral illnesses such as influenza. I suspect that it is due to in-

creased activity of the reticuloendothelial system in the spleen either causing enlargement or possibly micro-infarcts.

Being a rather non-specific and fleeting symptom is has probably been ignored, but some patients are quite anxious about it and may be sent for unnecessary chest x-rays.

I have asked colleagues and searched the textbooks but there is no mention of this symptom following viral infection. Could I ask whether anyone else has noticed this or if it has been reported?

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General practitioner's attitudes to homosexuals

Sir,

The ability to form and maintain close relationships, and to have those relationships supported by the wider community, is a fundamental prerequisite for physical and mental health. For lesbians and gay men the current climate of fear surrounding their chosen relationships, which is being supported by prominent members of our society, may be seriously damaging their health.

Indeed, a recent article in the *British Medical Journal*[1] includes brief reference to one statistic which we feel necessitates further discussion — that one in 10 of general practitioners questioned definitely favoured the re-introduction of legal penalties for sexual relations between male homosexuals, with a further one in 15 saying that they were uncertain on this matter. This, then, indicates the negative attitudes experienced by gay men when seeking health care. As a group of lesbian health workers, we are only too well aware that lesbians also experience this same attitude towards their lifestyle. Until now this 'homophobia' towards lesbians has largely gone unwritten and unspoken in public circles. People are still reluctant to even acknowledge the possibility of two women having an intense and sexual relationship. But 'clause 28' of the local government act changes that. As is by now well known, the clause will prohibit the intentional promotion of homosexuality by local authorities.

As lesbian health workers we see much evidence of the ill effects of homophobia on many of the lesbians and gay men who constitute 10% of our clients. Some local authorities have been providing support through counselling and recreational facilities which have helped to alleviate some of the isolation and distress caused by a hostile society. These initiatives have gone some way towards providing positive images of lesbians and gay men.

In the light of this forthcoming legislation we are requesting that all health workers, regardless of their own sexuality, or their role in caring for patients, should re-evaluate their thoughts and feelings about these sex relationships and should affirm the value of family relationships within the lesbian and gay community. Finally we are asking health workers to take whatever action they feel is appropriate to maintain and improve the service they offer to what is, after all, 10% of the population.

'EDWINA'

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Reference

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Training in the North East Thames region

Sir,

The most dramatic recent news was the decision of the Joint Committee on Postgraduate Training for General Practice (JCPTGP) to withdraw approval from the training schemes in the North East Thames region. This unprecedented move by a committee which has in the past been the subject of criticism for too much rhetoric and too little action has caused alarm in all corners of the UK.

I am sure there are many voices in defence of the North East Thames region. I have great sympathy with their plight as it seems harsh to condemn a whole region on the basis of a visit to a few training practices. There will also be those who will see the North East Thames region as the sacrificial lamb to silence the critics of the JCPTGP. There will also be many who will wonder about other practices and schemes which may be worse than those in North East Thames. Worse still, there are rumours of legal action, and claims that the JCPTGP has stepped beyond the limits of its power.

Despite all this, we must accept that to improve the standard of training and safeguard the interests of our trainees we have to conform to some agreed national guidelines, especially when they are as basic as those concerning medical records. This does not mean that every scheme will have to be the same, but certainly, variety can no longer be an excuse for unsatisfactory standards of training. Therefore, the JCPTGP should be applauded for its action which was bold, courageous and long overdue.

Furthermore, as a consequence of this action, JCPTGP inspection visits, an expensive and time consuming exercise, will now be seen as a far more effective educational/regulatory activity than hitherto. There may also be a lesson in all this for the specialty posts. Could all the training posts in hospitals pass the acid test of suitability if they were to be subjected to a similar monitoring exercise as that of the JCPTGP?

No matter what happens next, vocational training has taken a major leap forward.

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Sir,

I am a recently-appointed trainer in the North East Thames region, and a new member of the College. There are over 250 trainers in the North East Thames region, who have now been deemed to be unsatisfactory on the basis of 'random' visits within the region. I not only regard this as personally insulting, but also fail to see its logic. If one of the other royal colleges withdraws recognition for a training post at a particular hospital, they do not subsequently withdraw recognition from the whole region. Similarly, a trainee is now seen as unworthy of taking the MRCGP examination because they have trained in the North East Thames region — again, condemnation of every training practice.

In any region there will be trainers who are not up to standard. There may be a higher percentage of such trainers in the North East Thames region, but to label all the region's trainers as 'bad' is no way to provide leadership. While the College can be publicly seen as trying to act as a policing authority for general practitioners, power politics of this type will damage those least able to defend themselves; in this case, current and prospective trainees in North East Thames.

If there is a behind-the-scenes power struggle between the College and the General Medical Services Committee, I would suggest it be kept behind the scenes or opened out into a public debate within the profession, so that damaging effects, which may last years, are avoided.

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