ship that has grown up between the family practitioner committees and practices. On-the-spot advice concerning practical working problems in primary care, the necessity to form forward plans, and the evolution of changes in patient care will all suffer by the absence of practising doctors. One doctor representative on the committee is totally inadequate.

There are many other worrying proposals for general practice. 'We have lost our existing contract, together with the independent contractor status; our charter has been torn up; our freedom of referral has gone; the partnership with family practitioner committees has been destroyed; and local medical committees have been emasculated' has been one response to the proposals, with which we agreed (Dr C. Zuckerman speaking at the GMSC).[17]

What is there to be constructive about? At least for the present the NHS is to be 'available to all, regardless of income, and to be financed mainly out of general taxation'.[2] An increase in information technology, audit and cost-consciousness is to be welcomed, as long as it is used for the benefit of patient care, and not for cutting costs as the sole objective. Patients should have the best care available.

What are the aims of these proposals?[6] The title of the white paper, *Working for patients,* is in our view a complete misnomer. These proposals aim to cost-limit the NHS, especially general practice. The services available to the patient will be reduced. Direct government control will be imposed, with general practitioners being left to explain and implement the government's decision to limit health spending. The government's proposals are an attempt to buy time, and be seen to be active, before the next election, and to prepare the way for privatization, if the Conservatives are successful at the next election. Two-tier health care will then have arrived in this country, with treatment becoming a function of ability to pay, and not of patient need. Why else would the government put such a poorly researched, evaluated and negotiated set of proposals before the country?[18]

The white paper states 'The general practitioners' advice will therefore be crucial ...' Unless these proposals are properly researched, evaluated and then negotiated with the doctors, we cannot support them. If the government does impose the proposals, a major tragedy will befall the NHS.

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Oilseed rape and asthma

Sir,

Like other general practitioners and chest physicians, I have noted the rise and plateauing out of the incidence of asthma. In my own area of practice, I have watched an increasing number of fields changing from grassy green to yellow owing to the planting of oilseed rape. The rape oil plant (*Brassica napus*) contains glucosinolates which by enzymatic processes give rise to volatile isothiocyanates (mustard oils). These are well recognized bronchial irritants.

I have obtained figures for the acreage of oilseed rape grown in the Essex region of Greater London (Ministry of Agriculture, Fisheries and Food) and also figures for asthma admissions at the King George Hospital, Ilford (Redbridge Health Authority). Curiously enough these figures parallel each other (Figure 1).

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Why do trainees take the MRCGP examination?

Sir,

In view of the current discussions about the role of the MRCGP examination, the results of an anonymous questionnaire study of the perceptions of a sample of general practitioner trainees of the role of the membership examination may be of

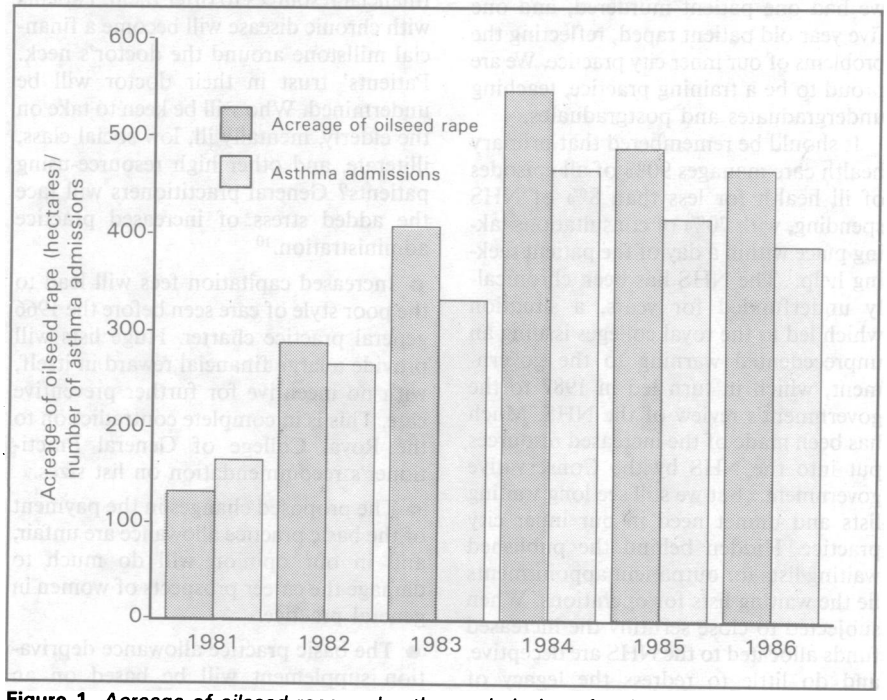

Figure 1. *Acreage of oilseed rape and asthma admissions for the period 1981–86.*

Table 1. Reasons for taking the MRCGP examination among 280 general practitioner trainees.

	Percentage of respondents regarding reason as			
	Very important	Fairly important	Of some importance	Of little or no importance
To help in getting a job	33	38	25	4
As a personal hurdle or discipline	32	35	21	12
Belief that the MRCGP may become a requirement for entry to general practice[a]	23	29	29	20
To enable one to become a trainer later on	20	36	24	21
To allow participation in the College and its activities	6	16	37	41
To provide feedback for comparison with peers	3	19	36	41
As one is a trainee, one might as well take the exam	2	14	34	50

[a]A contemporary misconception.

interest. Four hundred trainees, most recently notified by local medical committees to the Joint Committee on Higher Professional Training, were approached in late 1985; they included no Scottish trainees. A 70% response rate was achieved, of which 89% were from England and Wales, and 11% from Northern Ireland. Thirty nine per cent of the 280 respondents were women and 61% men. The questionnaire covered plans to take the MRCGP examination, the personal importance of a number of possible reasons for taking it, the ideal role of the examination, and certain background questions.

Seventy six per cent of respondents definitely planned to take the examination, a further 16% said probably, 7% possibly and only 1% definitely not. As regards planning a career in general practice, 77% of respondents were committed to this, 18% fairly committed, 3% said that they would do this only if family commitments permitted, and 2% did not plan to make a career in general practice. The reasons for taking the examination are shown in Table 1. The two most important reasons were to help in getting a job, and as a personal hurdle or discipline.

The role for the examination considered by the trainees to be most important was to ensure a basic level of competence before supervision ceased (66% very important or fairly important). The idea of the examination being an educational assessment for the individual (feedback, no pass/fail), or a tool for the health service (quality control for vocational training) came approximately equal second (56% and 53%, respectively).

Five statistically significant cross tabulations of variables illuminate these data. First, and as expected, there was a strong relationship between respondents' plans to take the MRCGP examination and their commitment to a career in general practice ($P<0.001$). The other four matters relate to the sex of the trainee. Women, significantly more than men ($P<0.05$), felt that an important reason for taking the examination was to help in getting a job. At the same confidence level, women more than men regarded the possibility of the MRCGP becoming a requirement for entry to the specialty as being an important reason for taking the examination. However, enabling them to become a trainer later on was less important for women than for men. As regards the role of the MRCGP, women more than men thought that it should be to ensure a basic level of competence before supervision ceases. Finally, the women were less committed ($P<0.01$) than the men to a career in general practice — commitment was reported by 69% of women as opposed to 83% of men. Thus, women appear to be differently motivated towards the examination than men: the data are consistent with their seeing advantages in 'collecting' the MRCGP with a view to entering (or re-entering) general practice after having a family.

The sample included no trainees in Scotland. It may be that they would have different attitudes and intentions from their colleagues south of the border or across the water. However, in view of the

total agreement between the trainees in Northern Ireland and those in England and Wales this possibility can probably be discounted.

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Management of chronic (post-viral) fatigue syndrome

Sir,

The contribution of Wessely and colleagues (January *Journal,* p.26) to the management of chronic (post-viral) fatigue syndrome, while disclaiming any *'a priori* assumption as to aetiology' of the condition, concentrates largely upon the psychological condition of the patient. No consensus exists as to the aetio-pathology of the condition, and many suggestions (for example candida infection) are based more on emotion than demonstrable evidence. It is illogical, however, to outline one facet of treatment without some concept of the underlying pathology.

There is real evidence that the post-viral fatigue syndrome, with its highly diverse symptomatology, is organically based. Careful examination with a 64 tuning fork almost always shows diminished vibration sense when tested against a standard; abdominal reflexes are not uncommonly absent; internal rectus muscle paralysis may occur and a unilateral extensor plantar response has been seen.

Since a great many viruses have been blamed, it would seem that a primary lowered immunity allows opportunistic infection(s) with special proclivity for the lymph glands and nervous system (both cerebral, spinal and autonomic). Evidence of an organic basis for the disease in muscle has been provided by a study of single fibre myography in 40 patients with myalgic encephalomyelitis,[1] and by Friman and colleagues who concluded that there was defective muscle fibre membrane conduction.[2] Recent work at Oxford using nuclear magnetic resonance has shown that the biochemistry of muscle is profoundly disturbed in post-viral fatigue syndrome.[3,4] In addition, the immune system has been shown to be at fault.[5]

In the nervous system itself every case of post-viral fatigue syndrome or myalgic encephalomyelitis (a distinction recently emphasized by Ramsay 1988,[6] though difficult to sustain in practice) is found to have organic destruction of the nervous system. Of course organic disease is accompanied by some psychological overlay though this should not be sought out and treated as a disease *sui generis.*[7,8] Tests enable distinction between destruction of brain tissue by multiple sclerosis and destruction from another cause. Cases of post-viral fatigue syndrome always fall within the latter category. Nuclear magnetic resonance has shown small lesions over the high convexity of the brain and also a snowstorm effect. Some of these oedematous lesions involve the Wernicke and Broca areas and the brain stem. Much more needs to be done along these lines bearing in mind, however, that examination by nuclear magnetic resonance is a considerably blunter weapon than was originally thought and depends greatly upon skill in interpretation.

Wessely and colleagues should evaluate evidence of the nature of the disease, even though there seems little effective physical therapy at the moment, before going overboard on the psychological approach. Incidentally, about 80% of families (first degree relatives) studied by the Naomi Bramson Medical Research Trust show more than one case in the family. The interpretation of this is unclear; it could be exposure to the same bad environment laden with viruses, preservatives, fungicides, water pollution or stress, all of which may well lower immunity. Therapy should clearly be directed to rectifying this lowered immunity.

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