

Table 1. Trainees' responses to questions about training and experience in child health surveillance.

Stages of examination	Percentage of positive responses (n = 74)		
	Training adequate	Experience	Feel confident
Neonate	91	89	89
6 weeks	80	82	88
6-9 months	57	61	55
2 years	45	50	39
Pre-school	31	32	30

Table 2. Trainees' responses to questions about training and experience in minor surgery.

Minor surgical procedures	Percentage of positive responses (n = 74)		
	Training adequate	Experience	Feel confident
Injections:			
Joint	57	58	50
Varicose veins	10	8	7
Haemorrhoids	4	3	3
Aspirations:			
Joints and bursae	55	66	55
Ganglia	18	18	15
Removal of toenails	57	57	49
Incisions:			
Abscesses	80	80	82
Thrombosed piles	20	18	19
Cautery and cryocautery	42	46	43
Ligation of varicose veins	10	5	3

would be eligible for inclusion in minor surgery lists. Once these trainees become general practitioner principals, will they operate, and risk possible medico-legal complications, or will they refer all minor surgery to outpatient departments?

A worrying feature of our survey was that some trainees reported confidence in carrying out a number of procedures while confirming that they had not received sufficient training or experience in these. As Irvine and colleagues stated (letters, October *Journal*, p.434) it is vital that doctors completing vocational training for general practice have achieved a satisfactory standard of competence and performance as judged by external, set standards.

Additional surgical training is obviously required, but at what stage in a prospective general practitioner's career should this occur? Castle in his survey of

established general practitioners reported that 36% obtained the necessary skills in general practice and 41% cited house officer posts. Wherever it is felt such skills can be acquired it is vital, as Kearley states, that priority objectives for vocational training are clarified and that trainees have the opportunity to achieve them.

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General practice training in the hospital

Sir,

We were interested in the editorial by Dr Styles on general practice training in the hospital (October *Journal*, p.401) as until recently we have all been intensively involved in the north Devon vocational training scheme.

Consultants have been closely linked with the scheme ever since its start, in the 1970s. They have been well represented on the vocational training scheme committee and in this committee they have proved of great help in our deliberations. Over the past three years or so, the consultants and senior house officers in the scheme have had joint meetings with the trainers. About 18 months ago we acted as facilitators for the consultants looking at video recordings of their teaching sessions with their senior house officers.

Here in north Devon consultation between the various teachers does take place and is beginning to broaden.

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Sir,

Dr Style's editorial (October *Journal*, p.401) covers most of the fundamental points related to training for general prac-

itioner trainees in the hospital years. However, some points need amplification.

Many trainees in hospital posts neglect their educational commitment owing to regard for fellow juniors who would need to work extra hours to cover the absent senior house officer. Training is not free; time and government money is needed for the teacher and the taught. Time for education is in direct conflict with service elements and government finance is not specifically 'ring-fenced' for extended educational need. I fear that as health authorities up and down the country try to balance the books, accept the changes of the new contract and cope with hospitals that have opted-out, the educational component of hospital posts will suffer even more.

New contracts need to be written which encourage all consultants to teach their juniors and all juniors to have protected teaching time. Without this safeguard we are at risk of reaping the poor rewards of inadequate investment in training.

Meanwhile, trainees need to make the best of a bad job, attempt to protect their learning time and organize it to extract the most from each post. To this end, a trainee in Gloucestershire has constructed a curriculum guide for hospital trainees (available on request from Syntex Pharmaceuticals Ltd, St Ives Road, Maidenhead, Berks SL6 1RD). The number of curriculum guides and the fact that they continue to be produced by teachers and are now produced by trainees indicates that they are highly desirable and practical organizers of teaching time.

While I share Dr Style's view that the greatest scope for progress is at a local level, I feel that trainees need authority given to them from above, by liberal interpretation of the vocational training act, to support their needs in these difficult times.

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Sir,

I would like to point out an omission in William Styles' editorial (October *Journal*, p.401) and Karen Kearley's article (October *Journal*, p.409) on the hospital component of general practice training. Greater reference should have been made to accident and emergency medicine as a six month component of vocational training schemes.

It is accepted by the royal colleges that if the Royal College of Surgeons gives educational approval to posts in accident and emergency medicine, then the Royal

College of Physicians and the Royal College of General Practitioners automatically give their recognition.

In October 1987 the Royal College of Surgeons of England produced their guidelines for pre-fellowship surgical training posts in accident and emergency medicine.¹ Since the majority of accident and emergency posts have the same work practice and educational content, irrespective of the future career that the incumbent wishes to pursue, these guidelines are applicable to all accident and emergency posts.

Because of the changes now taking place in general practice, the surgical experience to be gained in accident and emergency medicine makes it even more relevant for vocational trainees than perhaps it was in the past.

It must be remembered that there will not be time for education if departments are inadequately staffed, and the guidelines of the Royal College of Surgeons¹ make it quite clear that 'there should be approximately one trainee for every five thousand new patients per annum'.

Finally, the guidelines emphasize that time must be set aside for didactic education, as opposed to 'learning on the job'.

In summary, the training to be had in accident and emergency medicine, where we are specialists in the immediacy of a work practice of managing acute problems is very relevant to general practice; great thought has also been given to the training of accident and emergency trainees.

In addition the academic committee of the British Association of Accident and Emergency Medicine is producing a paper entitled *Teaching standards in accident and emergency departments* which will further delineate standards that must be attained.

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Reference

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Testing asymptomatic patients for *Chlamydia trachomatis*

Sir,

We support the view that the consequences of the chlamydia epidemic can only be reduced by testing asymptomatic

women in general practice, coupled with changes in sexual behaviour. However, the analysis presented in a recent paper (*April Journal*, p.142) has two significant flaws.

The authors state that the chlamydia culture method used was assumed to have a sensitivity of 75% and a specificity of 100%. Many general practices will not have access to chlamydia culture, and will have to rely on enzyme-linked immunosorbent assay (ELISA) methods, which have less than 100% specificity. A specificity of 95% may sound reasonable, but the implications of such a test when applied to a population with a 5% prevalence of chlamydia are that 5% of samples will yield true positive results, and 5% will yield false positives. The significance of a positive result could be evaluated by the toss of a coin. This sort of consideration is important before widespread screening programmes are contemplated.

Furthermore, the partner was also treated, but no contact tracing was performed. This is inadequate. The epidemic of chlamydial infection exists because young people do not confine their sexual activity to long-term faithful sexual partners. Treating only the most obvious partner may not prevent reinfection of the index patient, and will certainly have no impact on the overall epidemic of chlamydia. The epidemiological model used in this paper is too simplistic.

Many doctors will recognize that the correct procedure to follow in patients suspected of having chlamydial infection is referral to a sexually transmitted disease clinic.¹

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References

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Sir,

I write to express my concern at the prospect of widespread screening for endocervical *Chlamydia trachomatis* among asymptomatic sexually active young women. I accept that there is a case to be made for such a programme. *C trachomatis* is a major cause of pelvic inflammatory disease in the industrialized countries¹ and cheap effective interventional treatment is possible within a latent interval.² Professor Buhaug and his col-

leagues (*April Journal*, p. 142) conclude that such a programme in sexually active young women could be cost effective.

My concern arises from the fact that the psychological effects on women who have been screened have not been studied. It has been shown that healthy adults who have been screened for cardiovascular risk markers experience an increased incidence of psychological distress.³ It is likely that screening for a sexually transmitted disease would have an even more distressing effect on the participants. Before we are tempted to embark on yet another screening programme I believe we should find out more about women's attitudes to being screened for sexually transmitted disease and about the effect such a programme might have on the mental welfare of its participants and their families.

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Detection and management of urinary tract infection

Sir,

I would like to comment on the articles on the detection and management of urinary tract infection in general practice (*October Journal*, p.399, 403, 406).

First, I found it surprising that neither of the two original papers made any reference to the paper by myself and colleagues¹ which looked at the use of screening tests for the detection of bacteriuria in elderly subjects and which gave results quite similar to those found by Hiscoke and colleagues.

Secondly, I am concerned that in both original papers the laboratory diagnosis of bacteriuria was based upon the results of a single voided urine sample. As alluded to by Dr Brooks, it has been found that greater than 10⁸ organisms per litre in a sample of urine predicts the presence of significant bacteriuria with an accuracy of 80% while greater than 10⁸ organisms per litre of the same organism in two voided urine samples increases the accuracy to 95%.² Therefore, as a minimum require-