Undergraduate and postgraduate clinical training

SIR,—The recent letter from Professor Derek R Wood and Sir Douglas Ranger (12 August, p 498) has drawn timely attention to the highly unsatisfactory situation regarding Health Service planning in relation to the essential needs for clinical undergraduate and postgraduate medical and dental education in our university teaching hospitals.

These difficulties have developed from the reorganisation of the NHS, which not only abolished the existing boards of governors of teaching hospitals but placed the university teaching hospitals in area health authorities (teaching) (AHA(T)s), which are at a sub-regional health authority level. This new arrangement for managing and funding university teaching hospitals removed the governing bodies which knew and understood the twin needs of the NHS and of the universities for clinical medical education and training of future doctors and dentists and which had served so well the complementary interests of the NHS and the universities.

In an era of financial stringency it is entirely proper that a careful assessment of national NHS facilities should be made in relation to the money available to pay for these facilities. The Resources Allocation Working Party (RAWP) undertook this task and proposed adjustments in resources designed to mitigate in stages serious deficiencies in certain NHS regions at the expense of other regions. RAWP recognised that some special provision for university teaching hospitals, embedded in the AHA(T)s, was needed and proposed a special increment for teaching (SIFT) to provide the adjustment.

Professor Wood and Sir Douglas emphasise the urgency of the situation, for any changes made now to our clinical training facilities in the university teaching hospitals will have very serious long-term, damaging effects, which will be compounded by the agreed increasing throughput of medical students (rising from 2300 in 1965 to 4100 in the early 1980s). These very damaging effects would take years to rectify if plant and facilities at our 29 university teaching hospitals are allowed to decay, if wards continue to be closed, and if there is a continuing non-appointment of new consultants to vacancies caused by consultant retirements.

I am certain that there is much good will to be tapped to reverse this dangerous trend. There is an urgent need for a national medical education committee to bring together representatives of all the interested bodies so that the overlapping interests of the NHS and university medical education may be considered nationally, the problems identified, and solutions proposed. Such a national medical education committee should be set up at once. It must not be a "talking shop." It should have the means of acting quickly and effectively to harness and to develop the interests of the NHS and the university teaching hospitals.

Dr Robert Lowe has written three articles in the *Times Higher Education Supplement* of 16, 23, and 30 June 1978, in which he sets out with great clarity the problems facing medical education, explains the impact of RAWP, SIFT, etc., and proposes the solution referred to above—namely, a national medical education committee. His three articles form such an excellent summary of the situation and its dangers that I hope they might be reprinted.

This would not only recognise the immense service Dr Lowe has given to medical education but would make more available to doctors an authoritative summary of the dilemma in medical education.

Let us join with Professor Wood, Sir Douglas Ranger, and Dr Lowe in pressing for a national medical education committee to be set up at once, as the urgency is dire.

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Distribution of registrars

SIR,—In your account of the meeting of the Joint Consultants Committee held on 25 July (12 August, p 512) you report that Professor I Rannie, chairman of the clinical side of the Central Manpower Committee, stated that the DHSS had said that "one part of the profession was dragging its feet" in respect of the implementation of the redistribution of senior registrars and registrars. Leaving aside the dubious theoretical basis underlying this scheme, it is not surprising that it is meeting with some opposition in view of the defects in the figures on which this redistribution exercise is based.

The redistribution is planned to start this year and continue until 1980, but the figures on which it is based are the 1976 figures for the distribution of senior registrars and registrars. The figures provided by the Statistics and Research Division of the DHSS for the numbers of such staff in 1977 show important differences from those used by the DHSS in making their calculations. To take one example, according to the DHSS document (Appendix B to MM 1978/5 B/M41/104) there are seven senior registrars in general surgery in the Trent Region, and on this basis it is recommended that the region should "receive" one senior registrar in general surgery. According to the Statistics and Research Division, however, in 1977 there were in the Trent Region 11 senior registrars in general surgery, suggesting that instead of "receiving" an additional post they should be surrendering more than one. It may well be that the 1978 figures, which will be available shortly, will show further important changes of this sort.

Furthermore, the calculations take no account of university staff holding honorary contracts with the NHS, the most important category being that of lecturer with honorary senior registrar appointment. It is true that some of these staff are largely engaged in research work, but many hold positions very similar in the content of their work to that of a senior registrar, as witnessed by the fact that many of these posts are recognised by the Joint Committee for Higher Surgical Training as providing approved training in clinical surgery. The distribution of these posts throughout the country is not uniform, but despite repeated requests the DHSS refuses to take them into account, defending this position (MM 1978/5 B/M41/104) in two contradictory ways: (a) that the figures would be difficult to obtain; (b) that even if they were taken into account they would make no significant difference.

Despite the claimed difficulty in obtaining these figures the Statistics and Research Division in fact gives figures for some regions

from which the numbers of those holding honorary contracts can be calculated. For instance, to take again the Trent Region, in 1977 the total number of whole-time equivalent senior registrars in general surgery (NHS staff plus those with honorary contracts) was 14.2. Can it really be true that the inclusion into the calculations of this further 3.2 WTE (representing a 25% increase over the NHS staff) would make no significant difference?

In the light of the foregoing it is, I submit, not surprising that some people are expressing disquiet at the proposed redistribution. A redistribution may be indicated, but it is certain that any such exercise, to be acceptable, must be based on demonstrably correct figures which take into account all relevant staff, whoever pays their salary.

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Survey of notifications of tuberculosis in England and Wales

SIR,—Tuberculosis remains the second commonest notifiable disease after measles. Information about the type of disease being notified and its bacteriological characteristics is important in planning future tuberculosis control. A survey to obtain such information is being carried out in England and Wales for six months from the beginning of October 1978 by the Medical Research Council Tuberculosis and Chest Diseases Unit. The survey has the enthusiastic support of the Joint Tuberculosis Committee, the Research Committee of the British Thoracic Association, the DHSS, and the Welsh Office.

It is particularly important that all doctors who diagnose tuberculosis, both respiratory and non-respiratory, ensure that all their cases are always notified according to the normal public health regulations. We appreciate that physicians and surgeons in a wide variety of specialties occasionally encounter tuberculosis and that it is particularly these cases which may escape notification unless special care is taken. The value of this survey would undoubtedly be enhanced if all cases are, in fact, notified.

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Efficacy of rubella vaccination

SIR,—It is always a matter of concern when a drug or vaccine apparently fails to exert its expected therapeutic or prophylactic effect, and possible explanations for the failure (Dr W J C Roberts, 5 August, p 433) deserve serious consideration. Since live attenuated rubella vaccines do not elicit haemagglutination inhibiting (HAI) antibodies in more than 90-98% of seronegative vaccinees the remaining percentage of subjects will lack detectable HAI antibody after vaccination.¹ Over 100 serologically monitored clinical trials of Wistar RA 27/3 strain live attenuated rubella vaccine (Almevax) in over 20 countries and involving vaccination by the subcutaneous route of well over 10 000 seronegative subjects have shown that over 96% were rendered seropositive by subcutaneous vaccination. The seroconversion

rate and mean antibody response remained consistently high for all batches of vaccine used. Sugishita *et al*² have shown that some subjects in whom vaccination apparently fails to elicit an antibody response are protected by low levels of antibody which can be detected by the highly sensitive radioimmunoassay technique.¹ Similarly, subjects who have themselves suffered from congenital rubella and are found to be seronegative for rubella HAI antibody are known to respond poorly to the administration of vaccine.³

Although a standard single dose of Almevax given subcutaneously under optimum conditions contains over 300 times the immunising dose of virus,⁴ live vaccines may still be inactivated by adverse temperature conditions during storage and transportation or by exposure to heat, sunlight, spirit, or other disinfectants following reconstitution.

The techniques employed in rubella HAI antibody titrations vary between laboratories, resulting in different sensitivities.^{5,6} For example, some laboratories find kaolin preferable for removing non-specific inhibitors, although removal of rubella-specific IgG by this method has been reported.⁷ Thus in one laboratory the same low HAI antibody titre may be regarded as evidence of protection and in another an indication for vaccination. The percentage of subjects with low antibody titres in whom vaccination elicits a fourfold or greater antibody response is lower than in seronegative vaccinees.⁸

These considerations may help to unravel the reasons why three of Dr Roberts's 12 subjects have apparently failed to respond to vaccination. Previous experience suggests that the explanation is most likely to lie in the serological testing.

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¹ Freestone, D S, *British Journal of Preventive and Social Medicine*, 1974, **28**, 258.

² Sugishita, C, *et al*, *Clinical and Experimental Immunology*, 1978, **31**, 50.

³ Cooper, L Z, *et al*, *American Journal of Diseases of Children*, 1971, **122**, 397.

⁴ Zealley, H, Morrison, A M, and Freestone, D S, *Journal of Biological Standardisation*, 1974, **2**, 111.

⁵ Schmidt, N J, and Lennette, E H, *Applied Microbiology*, 1970, **19**, 491.

⁶ Liebhauer, H, *Journal of Immunology*, 1970, **104**, 818.

⁷ Cabasso, V J, *et al*, *Applied Microbiology*, 1969, **18**, 410.

⁸ Rowlands, D F, and Freestone, D S, *Journal of Hygiene*, 1971, **69**, 579.

Rubella susceptibility in women

SIR,—The recent correspondence (8 July, p 127; 5 August, p 433; 12 August, p 504) about rubella susceptibility in women of childbearing age emphasised the need for a greater effort to check immune status in such subjects.

The study¹ we carried out in general practice showed that it was perfectly feasible to offer women attending a contraceptive clinic the chance to have their antibody levels measured before they embarked on pregnancy. It was easy to incorporate this in the normal routine of the clinic, and recall of those considered non-immune for vaccination added little to the work load. We hope to publish in the very near future a paper showing the effectiveness of vaccination as shown by the post-vaccination titres. Checking for rubella immunity at the first antenatal visit is too late to offer any active protection for that pregnancy and it is of use

only as a guide to the possible consequences and course of action should the mother come into contact with rubella during the subsequent months.

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CAREY BOWKER

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¹ Gringras, M, *et al*, *British Medical Journal*, 1977, **2**, 245.

Rubella immunisation

SIR,—Just recently there has been a considerable increase in referrals for termination of pregnancy associated with a high incidence of rubella in the community. This is particularly distressing in view of an active policy of rubella immunisation immediately post partum which has been pursued locally for two years. A great deal of mental distress for pregnant women is produced by the problem of contact with rubella and possible damage to the embryo. All those responsible for health in the community should ensure that everything possible is done to reduce the hazards from rubella in early pregnancy.

Women who are rubella seronegative after obstetric confinement should be offered immunisation within 48 hours of confinement with the advice that they should not become pregnant in the following three months. Other measures should also be considered:

(1) Women contemplating a pregnancy should find out whether they are seropositive before becoming pregnant, and they should be immunised if they are seronegative and should not become pregnant for three months.

(2) All personnel coming into day-to-day contact with women patients—that is, doctors, nurses, receptionists, secretaries—should find out whether they are seropositive.

(3) Patients being investigated for infertility should be screened for rubella immunity and if seronegative they should be offered immunisation.

Only by being more aggressive towards the rubella problem with pregnancy can we hope to reduce the great anxiety that many women suffer in early pregnancy.

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Rubella embryopathy

SIR,—We are happy to see that Mr J R Duncan and Mr A Kenney reiterate (12 August, p 504) our suggestion that women should be stimulated to demand rubella screening before contemplating pregnancy (24 June, p 1695), but we do not think that this will be achieved by placing posters in general practitioners' surgeries or gynaecological outpatient departments—healthy young women usually have better things to do than visit their doctors.

A few wise words from Doris Archer of the eponymous radio programme or from the dreaded but respected hostess of the Rover's Return, Coronation Street, would carry more weight than all the posters in the Chinese People's Republic.

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Relative chloroquine resistance of *Plasmodium falciparum* in Zambia

SIR,—The report by Professor A A Khan and Dr M J Maguire (24 June, p 1669) of the demonstration of relative chloroquine-resistance in *Plasmodium falciparum* is, of course, of great interest to African malaria-watchers, but there are some rather odd inconsistencies about it.

Firstly, the month legends in the figure seem all awry, with "May" under the later June dates, "June" under early July dates, and "July" nowhere.

Secondly, the figure shows the child to have been malaria-positive on the day of admission (4 May), a finding not mentioned in the case report, and whereas the case report refers to a finding of malarial parasites on 20 June the figure shows a negative blood slide on that date.

Thirdly, the text says that the child received 130 mg/kg chloroquine over the 13 days 25 June to 7 July, a dose which obviously calls for a minimum of 10 mg/kg/day. Yet the text speaks of doses varying from 5 to 10 mg/kg and the figure suggests that 5 mg/kg was given for all but one or two of the 13 days, which in no way could cumulate to the 1.3 g stated.

Fourthly, it seems most odd that although the final allegedly curative doxycycline/chloroquine course ended on 24 July, the next reported observation of the blood film was on 24 August, a month later. One would think this must be an error for 24 July, but it appears twice; if it is not, what was the state of the child's blood in the intervening month?

Fifthly, or perhaps as 2(a), while the text states definitely that the child's blood was positive after the 20 June chloroquine course, the figure records $\pm$, whatever that means.

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* * * The author sent a copy of this letter to Dr Maguire, whose reply is printed below.—
ED, BMJ.

SIR,—To answer Dr de Glanville's points, the month legends are all awry, as he suggests. May refers to the first number, 4, which was the day of admission. On that day, as shown in the graph, the blood slide was positive. The graph should then have been broken and the subsequent days given as 20 June–25 July.

I agree that we did not mention in the text that the child had malaria on admission, nor did we summarise the repeat courses of chloroquine and blood slides between 4 May and 20 June. This was felt not to be relevant to our main point, that of apparent chloroquine resistance, and as we were writing only a short report we did not want to clutter it up with irrelevant detail. We did not state that her blood slide was positive on 20 June. The course of chloroquine was given on clinical grounds before we had the blood slide result. On 25 June she had two blood slides, one of which was positive and one negative. It was this that determined us to give a trial of chloroquine treatment with Haskin's tests and repeated blood slides. As Dr de Glanville states, the dosage of chloroquine on 25 June and 7 July does not correspond very well with that shown on the graph. However, the total dose in the period was 1.3 g—that is, 130 mg/kg.