problem children as a patient, perhaps presenting with hyperactivity, inability to sleep, or plain bloody-mindedness. The headquarters are at 1 South Audley Street, London W1 (telephone: 01-499 1188).

F G HERMAN

Bickley, Kent

"Curing" minor illness in general practice

SIR,—Dr G N Marsh's article (12 November, p 1267) leaves me confused as to his aims.

If he is attempting to reduce the work of the primary health care team, then why has "the health visitor's role . . . increased dramatically" and the "nurse care of minor illness" been "fortified"? It appears that the patient merely consults a different person. I would be interested to see the change in number of contacts between patients and health care team between January 1976 and January 1978. If his object was to reduce the cost of prescribing, then this is easily accomplished by saying "no." (Eventually of course patient-doctor consultation rate would fall to the acceptable zero!)

I fail to see how a "return to the old virtues of self-reliance and independence" can result in the doctor seeing "more serious illnesses and more patients" (*italics added*). I do see, quite often, self-reliance producing more serious illnesses.

I hope that the end result of the new approach to primary health care will not be a system of specialist nurses being administered by doctors.

PETER CATLIN

Yorkley, Glos

Primary care in Kenya

SIR,—As I have been involved in primary medical care in Kenya for just under 15 years now, perhaps I might clarify some points in the article by Dr T D V Swinscow (21 May, p 1337), which has just reached us.

Initially medical assistants were purpose-trained by the colonial government, which was unwilling to send nursing sisters into the bush. This training was stopped before independence, when it was hoped that enough doctors would work in rural areas. When free outpatient treatment was introduced in 1965 more clinical workers were urgently required and an upgrading course for enrolled nurses was started.

A new three-year registered clinical officer course for school-leavers with good school certificate passes was started in 1969 in Machakos and moved to Nakuru in 1972. This school has had an intake of 558 students, of whom 256 have qualified, 251 are in training, and 51 have left training for various reasons. The only further training our graduates can get are clinical officer specialist courses in ENT, eyes, anaesthetics, or paediatrics. They can become doctors only if they get relevant "A"-level passes and complete a normal university course and this is very frustrating for them. They can never run non-Government clinics unless they work with a qualified doctor.

Additionally, our volunteer medical workers include doctors from Holland, Peace Corps workers from USA, and a variety of others from other sources. Missionary hospitals do not account for 40% of the medical work in Kenya and the Flying Doctor Service mainly

helps with surgery in the remote areas. The article could, so far as I am aware, be read to apply to Tanzania simply by substituting the home of their training school at Moshi for Nakuru.

We would be delighted to have help in upgrading some of our excellent clinical officers and would be happy to have a visit from any of your readers who find themselves in Nakuru, but at the moment we are a little doubtful about the accuracy of other *BMJ* comment.

J M GRAY

Medical Training Centre Extension,
Nakuru, Kenya

Changing the FRCS exam

SIR,—I write to support Mr Peter F Jones's excellent letter regarding the proposed changes in the Edinburgh FRCS examination (29 October, p 1145). I can, however, assure him that although a good deal of pressure for these changes may be coming from some specialties, this certainly does not apply to urology. A small working party of Fellows engaged in the practice of urology met earlier this year to discuss the proposals and rejected them entirely in so far as the training requirements of urological surgeons were concerned. At present no candidate for a senior registrar post in urology would be accepted without possession of a fellowship as evidence of his basic general surgical training, and the proposed expanded part 1 FRCS would not be an adequate substitute at this stage. Furthermore, the introduction of a so-called "specialist" FRCS diploma, implying yet a further examination at two or more years after attaining the status of senior registrar, seemed to us totally unrealistic and undesirable. The present system of accreditation run by the Joint Committees for Higher Surgical Training would appear to provide the best basis for assessing and maintaining the standards of higher training in the surgical specialties and should be encouraged.

I do not wish to recount all our other objections but would reassure any potential consultant urologists of the future that it is not (yet) the wish of their seniors to put a further examination in the route to their chosen career.

A G GRAHAM

Department of Urology,
Western Infirmary,
Glasgow

Training in accident and emergency medicine

SIR,—Now that yet another investigation into accident and emergency departments has started (5 November, p 1235) it is to be hoped that the conclusions reached will be practical and acceptable to the profession as a whole. In the past there has been a lot of talk about the staffing of accident and emergency departments. Only the most prejudiced individuals would probably now argue with the concept of sensibly sized departments run by consultants with suitable training in the specialty. Through the Joint Committees on Higher Medical and Surgical Training the establishment of senior registrar posts to provide this training is now well advanced. At a lower level the finding of senior house officers will be made easier by the rationalisation of the number of such depart-

ments and the inclusion of such posts in various rotations, including vocational training for general practice.

The real problem for the future will be in finding staff to provide intermediate cover between the senior house officers and the consultants. Only a minority of departments will ever have the facilities to justify the presence of senior registrars. Unfortunately too many people look to the staffing concepts in other specialties to solve the problems of the accident and emergency department and wish to appoint more and more registrars. Few such registrars could have a long-term career in accident and emergency medicine.

Accident and emergency medicine has two major differences from most other specialties. Firstly, the varying work load is spread over a large part of the day and does not conform to normal working hours, which means that intermediate-grade staff should always be present in the department, rather than on call. Secondly, there is a very limited need for the on-going care of inpatients, so that the employment of doctors on a limited sessional basis is practical. Rather than discussing registrars, the employment on long-term contracts of doctors on a multisession basis (say, minimum of five sessions per doctor) to work in the department throughout most of the 24-hour period should be considered. These doctors would have the interest and experience to advise the more junior doctors and take part in postgraduate activities and yet have job security which could be adapted to their personal and domestic requirements. Such a grade does not exist, as the hospital practitioner grade is too restricted, while clinical assistants do not have long-term contracts recognising their increasing expertise.

S M LORD

Accident and Emergency
Department,
Walton Hospital,
Liverpool

The medical manpower debate

SIR,—I write concerning Scrutator's comments on the recent debate in Council on medical manpower (22 October, p 1095). Dr David Guèret Wardle's remark was incorrect and I do not know the source of his information. In 1977, this medical school made the transition from two six-monthly graduations per annum to one annual graduation. This transition necessitated finding house jobs in August/September 1977 for about 100 new graduates plus 50 others who needed a second preregistration post, having graduated in November 1976 (a total of over 150). There was never any question that there would be enough house jobs for them all "in UCH or associated hospitals," and all concerned knew this. Some found posts on their own initiative. An assurance was given that suitable house jobs would be found elsewhere for the remainder.

When the lists for "UCH and associated hospitals" were published early in July about 30 new graduates were still in need of a post for August 1977; of these, 23 had posts for February 1978. Within the next two weeks suitable posts were found for 20 new graduates and by the beginning of August we had placed all those who were available for interview and whose choice of job was not restricted by tight geographical constraints.

It is unfortunate that inaccurate information

should receive publicity, particularly since other teaching hospitals in London will be making the transition in 1978 and 1979. I hope you will help in correcting the record through the columns of your journal.

LYAL WATSON
Postgraduate Sub-Dean,
University College Hospital Medical School
London WC1

* * We sent a copy of this letter to Dr Guèret Wardle, whose reply is printed below—ED, BMJ.

SIR,—I have checked again the factual basis of my observations to the recent Council meeting regarding preregistration jobs at University College Hospital. Some of those who finally had to look for jobs outside UCH and linked hospitals feel that they must have misunderstood what was said to them before this year's graduates qualified. Genuine misunderstandings like this can arise from time to time, but it does not detract from the central argument. It appears that there used to be sufficient posts for all those who did not wish voluntarily to seek jobs elsewhere to do their preregistration jobs within UCH or linked hospitals. Now that is no longer true—not through any fault of UCH, but because with one annual graduation and an increase in the total number graduating over the years there are more people needing jobs.

I must apologise if my comments have given offence to UCH. They were not meant in any way to be a criticism of that institution but to illustrate a much wider problem. There are an increasing number of medical graduates qualifying each year throughout the country at a time when the NHS budget is to remain largely static. As we heard the chairman, Dr J C Cameron, say at the same Council meeting, for the first time there were very nearly not enough preregistration posts available over the country as a whole. Government has no statutory obligation to provide jobs, other than preregistration posts, for doctors in training. With even more doctors qualifying next year it is pertinent to ask three questions:

(1) How many more preregistration posts are to be created next year and where will they be?

(2) How many more posts other than preregistration posts are to be created so that those doctors who have become fully registered can continue in training next year?

(3) What plans are there to prevent an unbalanced career structure from becoming even more unbalanced? There are already too many in the training grades for the number of available career posts.

D GUÈRET WARDLE

BMA House,
London WC1

Functional budgeting

SIR,—Although the BMA's advice to consultants on functional budgeting (12 November, p 1299) is, for the most part, concerned with unimportant detail, the paragraph labelled (e) seems, if I understand it correctly, to raise an important new issue.

In stating that "it is the duty of the consultant medical staff concerned to maintain proper standards by restricting the service offered" the advice seems to suppose that one can simultaneously maintain standards and restrict the service offered. But surely this is a

contradiction in terms. To restrict the service is to lower the standard, since it is an essential and integral element of high professional standards that services are not withheld from some patients merely so that others can be offered services not available to all. Good professional practice demands a sense of proportion and co-operation in pursuing the most equitable distribution of available resources.

ALWYN SMITH

Department of Community Medicine,
University of Manchester

Assessment for invalidity pensions

SIR,—I am concerned about the assessment of patients for the new non-contributory invalidity pension for married women. We all know patients in our practices who qualify for this money, but it appears that many women, particularly those who play well the role of invalid, are claiming but in no way fulfilling the criteria needed. General practitioners have to relate to such patients and in some cases have developed a balanced rapport over many years. If we turn the applicant down, then she can have a sight of the assessment report, possibly to the detriment of the doctor-patient relationship.

It would be better if independent assessments were, in these cases, made by doctors outside the practice and not by the patient's own general practitioner.

I G MOWAT

Peterborough

Confidentiality

SIR,—I have recently been requested to complete a form "advised by the Association of British Adopting and Fostering Agencies, 1972" and forward this to Miss So-and-So at the local Family Community Services. Admittedly the envelope is marked "confidential." The form, however, requests intimate details of, among other things the examinee's urogenital system and causes as to why "he or she" is not pregnant or cannot be made pregnant.

I refuse to send such a form to any Tom, Dick, or Fanny and have sent it to a "professional" person who would act as referee and who, the introductory letter states, would ask for further information were it required. I fail to see why the forms cannot be returned direct to this referee and I feel that all the Family Community Services require to know is whether the applicant is "fit" or "unfit" to adopt a child. It is fairly common knowledge that Family and Community Services files have been, or could have been, examined by lay councillors.

C LIPP

Sheffield

Requirements for temporary registration

SIR,—The General Medical Council has recently received a number of applications for admission to the TRAB tests and for temporary registration from doctors who qualified overseas but who have travelled to the United Kingdom before acquiring the necessary professional experience.

Before overseas-qualified doctors are admitted to the TRAB tests or granted temporary registration the council requires them to have

completed *overseas* an approved internship of 12 months' duration or equivalent appointments. For this purpose the compulsory year's rotating housemanship introduced by most Indian universities since 1963 is accepted by the council as conferring only half the necessary experience.

In order to avoid disappointment by doctors who arrive in this country without the necessary experience the council wishes it to be known that it will not entertain applications for temporary registration in order that such doctors may hold one or more preregistration posts in the United Kingdom.

M R DRAPER

Registrar,
General Medical Council

London W1

Points from Letters

Varus and valgus

Dr A P MILLAR (Benson, Oxford) writes: If anybody is interested in words at this time when undergraduates are failing examinations in basic English the terms "varus" and "valgus" may be of interest. They have an orthopaedic slant, so to speak, valgus meaning a joint in the lower limb with its distal segment angulated away from the midline and varus meaning angulated towards the midline. The interest lies in the fact that the words had exactly the opposite meaning in Roman times. Smith's *Smaller Latin-English Dictionary* defines valgus as "bow-legged" and varus as "knock-kneed." . . . I once asked somebody who was a classical scholar to investigate this change of meaning and as far as I recall he found that the meaning changed about the beginning of the last century, but it would be interesting to know how and why the meaning of these two words should have been turned inside out and accepted throughout the world in their new sense.

Oust the louse

Dr H DE GLANVILLE (Nairobi) writes: Why does Miss M Tamblin (12 November, p 1292) suggest that it is important not to enter a chlorinated swimming bath for a week after malathion treatment of the head for lice when, if the advice in your leading article (22 October, p 1043) is followed, the malathion is shampooed out of the hair after 12 hours, lice and nits by then being dead?

Increases in plasma prostaglandin after vaginal examination and amniotomy

Dr R A WIKNER (North Herts Hospital, Hitchin, Herts) writes: . . . In their article on this subject (5 November, p 1183) Dr M D Mitchell and his colleagues fail to mention the number of women involved in their study, which makes their subsequent statistical analysis meaningless.

Of molluscs and men

Dr J J C CORMACK (Edinburgh) writes: Your contributor to "Words" (12 November, p 1271) asks, "Where . . . are the cockles of the heart . . . ?" Could it be that there is some connection between cockles and muscles?