most obese (4.1%), both considerably higher than the mean for those of average weight (2.7%). This finding raises the question of the effect of weight changes *within the average range* on mortality. Any weight changes recorded prospectively in individuals in our study did not change the weight status of any individual patient to such a degree that they should be classified in a different weight category. We therefore do not agree that with this compound patients will be paying a high price in terms of significant weight increases.

R LINDSAY

Helen Hayes Hospital,
New York 10993, USA

D MCKAY HART

Stobhill General Hospital,
Glasgow G21 3UW¹ McKay Hart D, Lindsay R, Purdie D. *Front Horm Res* 1978;5:174-91.² Sorlie P, Gordon T, Kannel WB. *JAMA* 1980; 243:1828-31.

Dorsal column stimulation in multiple sclerosis

SIR,—In connection with your recently published leading article on dorsal column stimulation in multiple sclerosis (31 May, p 1287), which lucidly discussed the various aspects of this intervention, I would like to bring to the attention of your readers a report published by Duquette *et al* on their experience with this technique.¹ In a thorough evaluation of dorsal column stimulation effects in nine multiple sclerosis patients they observed the following results: definite amelioration in one patient, minor amelioration in three, no change in three, and temporary deterioration in two, one patient suffering from an acute exacerbation. As in some other studies, beneficial results related mainly to sphincter, motor, and sensory functions; no change was noted in cerebellar function, and spasticity or paresis of the lower limbs was occasionally aggravated during treatment. In their discussion, the investigators hypothesised that the benefits of unspecific stimuli such as dorsal column stimulation may well be limited to functions controlled through the autonomous nervous system.

F LORTIE-MONETTE

Hull, Quebec J8Y 5Y4
Canada¹ Duquette P, Duquette J, Bouvier G. *Union méd Can* 1980;109:890-4.

Corrective shoes for surgery

SIR,—May I say how much I agree with your leading article comment (28 June, p 1556) on the uselessness of "corrective" shoes for children? What a pity your refreshing iconoclasm did not extend to the final sentence.

What evidence is there that: "It is the constrictive action of tight shoes in infancy that leads to most adult foot deformities?" Most infants and children I see wriggle out of shoes or kick them off if they are uncomfortable—and often even if they're comfortable. And most are barefoot during sleep, or wear lovingly knitted and easily stretchable booties. I find it hard to accept that intermittent constriction causes permanent deformity; the experience of centuries of foot-binding in China (which, to be effective, had to be continuous) makes this seem most unlikely.

But never mind, knocking down one myth

at a time is pretty good going and I am grateful to you.

A GRAHAM APLEY

London W1N 1HH

Student electives overseas

SIR,—The observations on student electives overseas by Ruth A Cruikshank and Dr D B Walsh (7 June, p 1359), prompted by the excellent series in the *BMJ* of articles about student electives, raises issues which could affect the way in which they are organised in future. Doing electives in distant countries is a growing phenomenon and certainly the cross-pollination of ideas and experiences should be strongly encouraged. Our own findings confirm the undoubted value of the elective period and during the past five years a constant 30% of our students have availed themselves of the opportunity of doing their electives abroad.¹

Electives require much administrative effort and we assist our own students and visitors with placements and official documentation. The proliferation of complex forms required by some institutions to evaluate the performance of visiting students and the apparently excessive weight given to the elective is a matter of concern to us. We question the wisdom of this since an elective, in order to fulfil its purpose, should allow the student a free choice with wide objectives in which the main component could be either increasing theoretical knowledge and practical experience, research, or widening social experiences.

It would be a pity if an important freedom in a generally rigid curriculum became strangled with red tape.

J P DE V VAN NIEKERK

Faculty of Medicine,
University of Cape Town,
Cape, South Africa¹ van Niekerk JP de V. *S Afr Med J* 1979;56:446-7.

Vocational training for general practice

SIR,—Reports in the medical press [and our report (2 August, p 369)—Ed, *BMJ*] from the National General Practitioner Trainee Conference in Exeter have revealed some disquieting facts which can only lead to the conclusion that Britain's GP trainers are taking the Government's money without delivering the goods. Britain's trainees, currently costing the Government £15 000 each per annum, may be the victims of one of the biggest spoofs in medical history.

Trainees are paid £2550 per year for teaching no less than two sessions (seven hours) per week. Yet a survey reveals that 92% of trainees receive less than four hours' training a week and 4% receive none at all. Many are left on call in their practices without back-up and are very obviously being used as unpaid partners. Large proportions of trainees appear dissatisfied in that they are unable to obtain hospital experience in essential areas such as paediatrics or obstetrics. Sixty-five per cent of trainees complain that they fail to get relevant GP teaching during their two-year hospital stints. These facts, combined with the increase in patients' complaints against trainees, are an incredible indictment of vocational training, a system which has become law without any scientific proof of benefit to our country.

At £15 000 per head per annum, if vocational training for general practice ceased tomorrow

would there be a significant deterioration in patient care?

ADRIAN ROGERS

Exeter, Devon

Changing to A4 folders

SIR,—Drs G N Marsh and J R Thornham in their article about conversion to A4 folders in general practice (19 July, p 215) unfortunately omitted to discuss the problem of reconverting A4 folders to the FP5/6 envelope when patients leave the practice. In this practice we have long been on the waiting list for A4 folders, and while wishing to follow their final advice and go ahead with an A4 system we feel that this would be impractical while the FPC refuse to handle records of A4 size. This problem must be common to many practices with a high patient turnover, and I would hope the BMA will bear this in mind when the General Medical Services Committee is negotiating for the wider provision of A4 folders.

J M HAYWARD

Health Centre,
Thatcham,
Newbury, Berks

Regional versus local consultant contracts

SIR,—Aneurin Bevan, when the Health Service was inaugurated, made sure that the consultants were employed by a regional authority and not locally. He realised the dangers of parochialism creeping into appointments, from his detailed knowledge of the Welsh mining valleys (incidentally, having worked there and in suburban London I realise that there is even more parochialism in London). Mr Patrick Jenkin's "desire for more autonomy at local level"¹ is exactly what is not needed here. In the same way that Sir Keith Joseph made grave and expensive errors in 1974, it looks as if Mr Jenkin is going to make gross errors in the second reorganisation.

The reasons against local employment of consultants in the Health Service are very cogent. Firstly, there is a serious danger of "favourite sons" being appointed on account of their local personal connections rather than their professional ability. This criticism is often made in educational appointments. Secondly, the consultants who find grossly inadequate services for the community they are looking after, if they are employed locally and make constructive criticisms, may well be frightened of either being dismissed from their jobs or having their jobs made unworkable by their local employers. This would often prevent them, in the public interest, emphasising the grossly inadequate local medical services—which applies particularly to the Cinderella specialties of psychiatry and geriatrics.

In the Health Service structure it would be still worse if consultants were to be employed locally by bodies which were not even democratically elected. At least if they were employed by local government there would be a possibility of changing the representation at the next election. In the new proposed District Authorities there would be no such opportunity.

The lack of interest shown by the consultant body as a whole in this matter suggests I may hold a minority view. Before reorganisation the hospital management committee wanted to dismiss me on account of criticism I was making about its grossly inadequate service;