eye, continue to be a target in boxing and should we advise boxers with previous retinal detachments to give up boxing?

In a survey 58% of boxers were found to have sustained injuries that threatened their vision.² Few other situations exist in which there is such a strong relation between cause and effect. Though the link between smoking and heart disease is more tenuous, it does not prevent doctors from advising their patients against smoking. Why do we not advise against boxing?

There is as yet no evidence that a boxer with a previous retinal detachment is more likely to develop a new detachment than any other boxer. But this does not detract from the fact that boxing causes serious eye injuries. McLeod correctly points out that retinal detachment may present some months or years after an injury. It follows that prophylaxis should be given before an aspiring boxer receives his first blow. Who would be prepared to administer laser treatment to teenage boys when the procedure is not without complications?³

The question is not whether the British Boxing Board of Control has the "courage and clout" to stage a longitudinal survey but whether vitreo-retinal surgeons dare come off the fence and provide unequivocal advice to their patients: to refrain from boxing if the sport continues to permit injuries to the head. Whether their advice is heeded is then up to the individual person, who can choose between a risk of losing his sight and career, fame, and fortune. It is up to the law makers (and maybe society as a whole) to decide whether boxing is entertainment or grievous bodily harm.

By advocating a clinical trial of prophylactic laser treatment we would be condoning boxing in its present form. Are we seriously asking boxers to continue to injure each other in order to satisfy our curiosity as to whether laser photocoagulation might work?

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AUTHOR'S REPLY.—My colleagues from Liverpool are perfectly at liberty to join the BMA on the moral high ground. Though most of the public are against banning boxing, other colleagues and I are quite comfortable sitting astride the philosophical fence. Unencumbered by self righteousness, we can thus get on with the job of patching up damaged eyes and providing objective advice to the British Boxing Board of Control. At the same time, information on the risks of boxing is given to all patients, whether previously injured or not, and each boxer is urged to stop. I imagine that most doctors are reconciled to the fact that patients don't necessarily heed their advice.

The counterpunch to my editorial¹ delivered by the boxing board's chief medical officer² is as wide of the mark as his earlier assertion that ocular injuries from boxing are rare.³ The board's medical regulations are arbitrary and often unsustainable against boxers' actions for restraint of trade. Having agreed other criteria against which specialists can formulate advice on a boxer's eligibility for a professional licence, Whiteson is definitely hitting below the belt to claim that the regulations are "vigorously opposed" by those who seek to assist the board in its difficult deliberations. The challenge for the board is to establish a forum for expert debate,⁴ rather than have its chief medical officer resort to public criticism of its advisers

on radio and in the popular and medical press.

As to financing longitudinal surveys on ocular morbidity, the current arrangements for re-examining boxers must be tightened through the formulation of a comprehensive clinical protocol¹ and a review of the competence of examining physicians. This would provide the core of any study, and, as now, the fighter himself must foot the bill from his purse. At the end of the day the punter should pay.

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Accreditation after Goldstein

SIR,—Stephen Brearley highlights the fact that the accreditation system in the United Kingdom is designed to permit specialist control within the NHS.¹ This ignores the healthy private sector. Private medicine is seen as the exclusive province of NHS consultants who resent any intrusion from those who are not "properly accredited."

"Junior doctors" unable to achieve a consultant post are therefore denied access to the private sector either by the refusal of insurance companies to recognise them or by medical advisory committees of private sector hospitals, which control admitting rights. As a result they live in a limbo of insecurity, lurching from one locum job to another. In the past many were foreigners. Now an increasing number of home graduates are affected, and the degree of disillusionment, disappointment, and sheer misery has to be seen to be appreciated. In the past they were able either to seek employment abroad or go into general practice, but the increased requirements and restrictions in every branch of our profession has made even that an impossibility.

The argument that quality of care has to be maintained and that only the NHS can provide such standards is untenable, particularly in central London, where private general practitioners demand the very best care and are able to select a specialist at will.

If practitioners wish to become specialists they should be able to do so after a reasonable period of training culminating with the EEC form of accreditation. If they then wish to continue to work in the NHS it is up to them to pursue the requirements laid down by the NHS. They should not be denied the right to practice their trade freely in the private sector or even to compete for work in the new trust system where it involves the private sector. I for one would welcome an ongoing audit or assessment programme in both the NHS and the private sector as a means of judging the continuing ability of a specialist to practice, rather than the present archaic system of apprenticeship and patronage that has outlived its usefulness and should be relegated to history.

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- 1 Brearley S. Accreditation after Goldstein. *BMJ* 1992;304:518-9. (29 February.)

SIR,—Stephen Brearley correctly identifies the problems with the present accreditation system but hesitates to prescribe the necessary cathartic.¹ The recent court ruling is a timely warning to the medical profession to reconsider the principles

underlying accreditation and not merely tinker with existing procedures.

The medical profession regulates its own standards of practice under an established compact with society, an arrangement beneficial to both. Higher specialist training is but a facet of this self regulation. The purpose of regulation is to ensure that specialist doctors in independent practice have attained the standards of knowledge, skill, and judgment necessary to deliver safe and effective medical care. The body responsible for ensuring this should have no consideration other than that of competence when deciding whether a doctor should be accredited. In particular, attempts to regulate the number of specialists by restricting accreditation to a set quota is not only against natural justice but tantamount to running a closed shop.

With private practice becoming increasingly lucrative for specialist doctors such restrictive practices will be resented not only by those who fall outside the quota but by paying customers who are denied a choice of specialists. If the profession does not remedy this serious deficiency it is only a matter of time before society, be it through legislation, judicial review, or an inquiry by the Monopolies and Restrictive Trade Practices Commission, forces it on us. Brewers, miners, and engine drivers have felt the heat of public wrath before, and middle class professions are not immune to it.

It is perplexing that, in these days when central planning has fallen into disrepute, professional organisations still consider themselves competent to predict the number of specialists needed in the future. Such crystal ball gazing is unlikely to be useful given that technological advances can unpredictably alter the practice of medicine and render such manpower planning worthless.

The argument that the present system of tailoring training posts to the expected number of jobs will prevent disappointment to highly trained specialists unable to secure suitable employment smacks of big brother trying to direct people's lives. Such highly qualified people do not need to be nannied. High earning members of society such as doctors who seek to escape uncertainties regarding career or employment by forming what seems to be a cartel, do so at the risk of compromising the historic compact between medicine and society.

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Accreditation is linked to other issues

SIR,—Stephen Brearley is right in his call for reform of the procedures of the higher medical committees.¹ For too long the process of accreditation has been riddled with anomalies and secrecy. As he states, the first steps must include the creation of clear and consistently applied criteria for accrediting specialists in the United Kingdom and the end of the closed reference system. These changes are necessary as a direct consequence of the judgment given in the Goldstein case.

In the second part of his article, where he tackles the issues of manpower, training, and our relation to mainland Europe, however, the old attitudes and complacency of the British medical establishment are all too apparent. The idea that a British accreditation system totally separate from that of other countries in the European Community is needed and the implication that British consultants, by definition, must be superior to continental specialists do not stand up to examination. I believe that the debate that must inevitably follow the Goldstein case should result in wider reform of the training of specialists in the United Kingdom

and that we have as much to learn from Europe as vice versa.

The Hospital Doctors' Association has campaigned for two years for a single training grade for all branches of specialist medicine, in which the trainee would spend a shorter time and be more closely supervised than at present. This idea is now being examined by the Royal College of Obstetricians and Gynaecologists and piloted by the Royal College of Surgeons. I believe that Brearley is mistaken in seeking to extend the numbering system currently operated by the Royal College of Surgeons. It cannot be right to have two people in essentially the same job on the same rota, with one preselected for promotion and accreditation and the other denied this. Such a system will eventually fall foul of the courts in the United Kingdom or Brussels in the same way that the practices of the Joint Committee on Higher Medical Training have done already.

We must stop separating the issues of manpower, training, accreditation, and hours of work. They are all intimately linked. We need wholehearted reform of our practices of work and training, and the Hospital Doctors' Association has called for the royal colleges, the General Medical Council, the Department of Health, and the representative associations of the profession to meet and take up the challenge.

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Visiting registrars

SIR,—I congratulate Stephen Brearley on his editorial on accreditation.¹ A system riddled with anomalies was bound to have its days numbered. He goes on to say, however, that accreditation is a purely British phenomenon and designed to fulfil a uniquely British need. Does he mean the use of overseas doctors (alias the politically correct "visiting registrar") in district general hospitals, where the bulk of NHS work is done?

He recommends using visiting registrars for unrecognised senior registrar posts. Is this because they lack the necessary intelligence or because they do not deserve better? Once more the visiting registrar becomes the stop gap for unrecognised locum senior registrar posts. Justice is long overdue here too.

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Renal protective effect of enalapril in diabetic nephropathy

SIR,—We feel that Staffan Björck and colleagues¹ are not justified in concluding that enalapril reduces the rate of decline in kidney function in diabetic nephropathy more than metoprolol, given a similar antihypertensive effect. The accompanying editorial by Carl Erik Mogensen² points to some disagreement between their results and those of similar studies.^{3,4} Their results therefore need detailed scrutiny.

The question at issue is whether Björck *et al* did in fact achieve an equivalent antihypertensive effect with the enalapril and metoprolol based regimens. They emphasised the similarity in mean arterial pressure but ignored important differences in supine blood pressure. In absolute terms supine

diastolic pressure was 6 mm Hg higher ($p<0.005$) with metoprolol, and the antihypertensive effect from baseline values was substantially smaller (11/1 mm Hg metoprolol; 17/12 mm Hg enalapril). One might argue about the relative importance of diastolic, systolic, or mean arterial pressure, but what is clear is that a mean difference in diastolic pressure of 6 mm Hg cannot be dismissed. For example, such a difference is associated with a 40% reduction in the incidence of stroke in intervention and epidemiological studies.⁵ It is quite conceivable that the blood pressure differences observed could be responsible for the apparent benefit of enalapril on renal function.

There is no doubt that angiotensin converting enzyme inhibitors reduce proteinuria, a response observed also in non-diabetic nephropathy even when renal function tends to decline more rapidly than with other treatment.⁶ However, the association between proteinuria and progression to end stage renal failure hinges predominantly on the relation observed in untreated patients,⁷ which may not hold in the treated state. The hypothesis that angiotensin converting enzyme inhibitors are renoprotective is likely to be answered convincingly only by much larger studies than that of Björck *et al*, and preferably by studies measuring real rather than surrogate endpoints.

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SIR,—Staffan Björck and colleagues claim to have shown a specific beneficial effect, independent of blood pressure, of enalapril on the decline of glomerular filtration rate in diabetic nephropathy.¹ We would like to draw attention to several problems with this study that lead us to question the validity of the conclusions.

In both the interim report of their study and in the final paper Björck *et al* reported significantly lower supine diastolic blood pressure values in the enalapril group than in the metoprolol group.^{1,2} Since even small differences in blood pressure above the normotensive range may have a substantial effect on the progression of diabetic nephropathy³ the effect of enalapril cannot be attributed to an action of the drug independent of blood pressure.

Differences in the decline of glomerular filtration rate between the groups were only significant when the measurements of the rate before randomisation of patients were included in the evaluation; differences were not significantly different during the drug treatment period (table III).¹

Deterioration of renal function over time was analysed by linear regression. This method of analysis can be used only if the decline of renal function is linear—but this was not the case in the

enalapril group. After six months of treatment glomerular filtration rate deteriorated significantly in only the enalapril group, as stated in the interim report and in the final report (fig 3).¹ Since the decline of glomerular filtration rate in the enalapril group was not linear no linear regression analysis can be calculated for this group. A transient drop in glomerular filtration rate when enalapril was started may have artificially "reduced" the slope of the decline of glomerular filtration rate in a linear regression analysis. Unfortunately the authors do not give the final values for the glomerular filtration rate in each group and they do not state whether the rate was different between the groups at the end of the study. Most probably it was not.

Patients receiving drugs whose renal function deteriorated rapidly should have been excluded in both treatment groups (patient No 23) and not only in the enalapril group (patient No 21).

Patients with a follow up of only six months should have been excluded as this follow up period allowed glomerular filtration rate to be measured only once during drug treatment. The lack of further measurements renders any regression analysis of the decline of glomerular filtration rate under the influence of the investigated drugs impossible.

In conclusion, the study does not provide convincing evidence for a specific beneficial effect of enalapril on the decline of glomerular filtration rate in diabetic nephropathy.

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AUTHOR'S REPLY,—It was a new finding in our study that the enalapril group tended to have a lower blood pressure than the metoprolol group in the supine position and that the reverse occurred in the standing position. This phenomenon cannot be handled by an increased sample size. The mean of the supine and the standing blood pressure is the only measure that can be used for the evaluation because of this unexpected difference in antihypertensive action. If we had used more aggressive antihypertensive treatment to reduce supine blood pressure more in the metoprolol treated patients the two groups certainly would not have been comparable, with a much lower standing blood pressure in the metoprolol treated patients. The difference of 1 mm Hg that we obtained in mean arterial blood pressure between the two groups is very small.

Even without a control group the result of enalapril treatment can be seen to be very good and is the best reported in this type of patient. After the initial half year the fall in glomerular filtration rate was only 0.4 (6.9) ml/min/year. For the six patients followed for three years the corresponding figure was 0.4 (1.4) ml/min/year, which is remarkable in patients with diabetic nephropathy and a 50% reduction in renal function. The figure is the same as the normal, age dependent fall in glomerular filtration rate.¹

Another conclusion from our data is that studies of angiotensin converting enzyme inhibitors should focus on the renal effects after renal function has been allowed to stabilise for some months. Therefore, even though ours is one of the larger prospective studies in diabetic nephropathy, new studies comparing other types of antihypertensive