future at any rate, Dr Ian Bogle and his team stated that they wished to feel their way forward, accommodating fundholders, but had to do so without offending the majority of general practitioners who oppose the concept and our hospital colleagues, who rightly feel threatened by it.¹ Their task is made more difficult as they are shackled by both the GMSC's and the BMA's policy opposing fundholding.

The fact that fundholding was not debated at the annual representative meeting suggests to me that the leadership feared that the current policy would be endorsed, making public the discomfiture of the negotiating team and the division within the profession. I expect the hope is that time and pragmatism will resolve the problem and that the policy will ultimately be changed, perhaps at the next annual representative meeting. This is a high risk strategy as the cracks are likely to be showing more next year than this. I believe that such fundamental difficulties are best faced early, however uncomfortable they are, as postponement usually makes the differences more entrenched.

The association missed an opportunity either to state that it now supports fundholding or to accept publicly that, though it continues to oppose the concept, it will work with the concept to ensure the minimum damage to patients' care. Had the debate been held and the present policy endorsed the signals would have been clear and the consequences would rest with the membership. The members of the association are democratic, and opponents of fundholding, such as myself, would accept a change of policy after a thorough debate. What is more difficult to accept is the leadership avowing one policy and practising another. The responsibility of leaders in an association such as the BMA is to carry out policy or to persuade the membership that the policy is inappropriate and to generate change.

The current situation pleases no one and makes the association look foolish and the leadership less than strong.

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1 The week in Nottingham: building bridges. *BMJ* 1992;305:193-4. (18 July.)

Induction of house officers

EDITOR,—Mollie McBride rightly sees a role for general practitioners in the education of house officers,¹ and this should extend beyond the vital induction course. The acknowledged success of vocational training in general practice has given many trainers skills that can helpfully be used by others. Some trainers now have spare capacity because of the recession in vocational training.

Each hospital employing house officers should have a preregistration tutor whose task is to supervise, facilitate, and develop all aspects of teaching for the new doctors. His or her priorities would be educational and the remit broadly based to include pastoral care and career advice for the holders of these stressful posts. The curriculum for the year has now been established by the General Medical Council. Consultants have their own priorities, which a preregistration tutor could collate, along with the existing teaching resources that abound in every hospital.

Those concerned with the preregistration year tend to despair at the monumental task of changing the manpower demands of the service to let a little education in. A more optimistic approach is to start the educational initiative now; the manpower changes will follow. General practice trainers could be key people in establishing a worthwhile educational structure to the year. They have the experience and personal contacts to do it and

would, I suspect, discover much common ground with the primary care doctors of the hospital service.

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EDITOR,—Our induction course has been radically changed for this month's intake of preregistration house officers and shares many of the ideas put forward by Rodney Gale and colleagues.¹ The gulf between final year medical student and house officer is huge. In many ways this transition period is poorly supervised. Our general induction took place on 31 July, and management agreed to pay the doctors for one extra day. The content of the day has changed: it no longer hinges on matters such as safety regulations and how to use the laboratories. The emphasis has shifted towards discussing the role of the preregistration house officer as a team member on the ward and in the hospital as a whole—for example, in relation to general practitioners. There is also a focus on pastoral matters.

The second part of the induction comprises six lunchtime meetings on consecutive Wednesdays. All the consultants with a preregistration house officer attached to their firm have agreed to that house officer attending each week for one hour, and the senior house officers have agreed to carry the preregistration house officer's bleeps. The topics for the lunchtime meetings were picked in a group discussion with junior doctors: bereavement counselling and dealing with the coroner; managing intravenous lines and Hickman lines and giving cytotoxic drugs; doctors and solicitors; doctors and defence organisations; managing pain; and stress. These subjects are poorly dealt with in undergraduate training and are particularly relevant in the first few weeks of the preregistration house officer's job.

The third part of our induction is a handbook for house officers set up in a similar way to that described by Gale and colleagues. The contents of the handbook and the lunchtime meetings will be reviewed annually, and the stimulus for change should come from the preregistration house officers.

Setting up these three aspects of induction has been stimulating both for us and for others. Groups such as consultants, the social work department, and liaison nurses have asked us to include particular information or clarify their roles. Senior house officers have asked if they might attend parts of the course or have a similar one organised for them. This is encouraging as it suggests a general realisation that in the past preregistration house officers have been poorly catered for and deserve better.

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1 Gale R, Jackson G, Nicholls M. How to run an induction meeting for house officers. *BMJ* 1992;304:1619-20. (20 June.)

Primary health care teams

EDITOR,—I am surprised that, in his article on primary health care teams, John Hasler fails to refer to a salient report.¹ By the late 1970s the teams were disintegrating, so the Department of Health and Social Security set up a joint working group on the primary health care team under the chairmanship of Dr Wilfred Harding.² The

group's remit was "to examine problems associated with the establishment and operation of primary health care teams and to recommend solutions."

The working group made 50 recommendations; recommendation 22 stated "that in the longer term health authorities should make sufficient resources available to enable these nurses [practice nurses] to be employed within the normal NHS structure in a fully integrated nursing service without prejudice to existing arrangements where these are working satisfactorily." Unfortunately, this integration never occurred so that now practice nurses screen well patients and the district nursing service is overloaded with looking after ill patients. Indeed, Hasler points out that the new contract has stimulated further increases in the number of practice nurses to undertake health checks and work in special clinics for which there is payment.

Hasler regrets that the attached members of the team are employed by an external body and are not responsible for contracting with the general practitioners. Surely a lesson was learnt in the '70s when in the Court report health visitors were criticised for having relaxed their surveillance on children's health by reducing their visits to children under 5 from 93% in 1964 to 67% in 1974.³ This was partly responsible for the reduction in the primary immunisation rate and the recurrence of epidemics of whooping cough. It became clear that the health authorities were more concerned with the health issues in the population at large than the general practitioners looking for help in their practice work and delegating responsibility to health service nurses on that basis. It is doubtful if that mistake would be made again.

Hasler claims that the potential for new ways of delivering primary care have never been greater. It looks as though he is referring to the care of the fit population because he does not refer to the care of seriously ill or chronically ill patients at home. The new contract does not seem to have improved this aspect of care—indeed, home care may have declined because of the concentration of remunerated work in surgery premises.

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Role of Western public health in the "new world order"

EDITOR,—The Commonwealth of Independent States and eastern Europe are regressing rapidly with respect to leading health indicators.¹⁻³ Public health infrastructure is in decay; health care relies excessively on the hospital as a provider of primary services.³ Life expectancy in Eurasia is five years shorter at birth and two years shorter at age 65 than in the United States.³ Infant mortality is 25.1/1000 live births compared with 10.4/1000 in the US, and maternal mortality is six times that in the US. The overall age adjusted death rate in Eurasia is 1160 deaths/100 000 compared with 821/100 000 in the US.³ In addition, the environment in the Commonwealth of Independent States is emerging as one of globally unprecedented disaster, the health effects of which are only starting to be assessed. This is occurring during the greatest period of economic transition and social dislocation to which a civilian population has been subjected, other than in wartime, this century.

Major Eurasian health problems are preventable or remediable.⁴ Western primary care, public health, and epidemiological centres should become

involved with counterparts in the Commonwealth of Independent States to formulate culturally specific primary care and public health curriculums. Curriculums should focus on primary prevention of disease and health promotion, which have been addressed largely in rhetorical terms for most of Soviet history.

The health care system in the Commonwealth of Independent States must shift from service delivery centred on hospitals and clinics to community based primary prevention. Model curriculums should be developed to provide skills to institute health promotion and disease prevention programmes for at least three main populations in the Commonwealth of Independent States: the Europeanised, Islamic Central Asian, and Far Eastern. Most health indicators deteriorate as one moves east and south from Moscow to Central Asia and the Yakuts region.

Without projecting a Western or any specific national model on these populations,³ instruction for aspiring health professionals and those in mid-career can cover topics such as public health concepts and methods; administration of preventive services; family and community health; managing information; formulating policy; and major topics such as maternal and child health, prenatal and perinatal care, reproductive and women's health, immunisation, control of communicable diseases, preventing HIV infection and AIDS and other sexually transmitted diseases, injury, and preventing chronic diseases.

By building in capacity for professional training of health care providers the infrastructure of public health in the Commonwealth of Independent States would be strengthened. The population would benefit from this modest international help through improved delivery of public health services by better trained, more highly skilled practitioners. An epidemiological impact may be observed in reduced morbidity and mortality. There is an important role for Western public health in the emergence of a stable, peaceful, and healthy "new world order."

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Compulsory admission of dangerous psychopaths

EDITOR,—Jeremy W Coid and Christopher Cordess's editorial on the compulsory admission of dangerous psychopaths reinforces the need for us to rethink the old fashioned concept of psychopathy before we go on to compound the errors of the past.¹ Two basic issues must be addressed. The first is whether personality disorder can be recognised as a category of illness. If we accept Jaspers's description of it as a variant of human life, far removed from the average and somehow undesired by the affected person or his environment,² we are left with the conclusion that it fails to meet modern criteria for a disease state. The evidence that it is composed of separate symptom

clusters, objective signs, course, and outcome is far from convincing. Although we can now measure it reliably in different cultures,³ its validity as a disease entity has not been established. Until it is psychiatrists must be careful not to overstep the bounds of their profession.

Until this issue has been clarified talk of effective treatment programmes is premature, especially as the results of various interventions remain controversial. The advice offered in the editorial should be accepted with considerable caution. The authors' suggestion that an alternative to detention in hospital when no effective treatment can be given could consist of using determinate sentences for treatment defies logic. Psychiatrists and academics should concentrate their efforts on well designed research studies. Too much has already been done by proxy or inference. The association of personality disorder with mental illness is well known, and the fact that mental illness can be effectively treated does not lead to the conclusion that we can substantially alter the characteristics of the disordered personality.

Coid and Cordess are right to emphasise the confusion generated by punitive responses when things go wrong. It is necessary to tackle these issues, but our approach to personality disorder should parallel the basic principles of getting dressed in the morning: put the undergarments on first and the trousers later. Wearing underpants on the outside may be fashionable for a time but in the longer term is likely to attract pillory. It may even lead to psychiatrists being diagnosed by their medical colleagues as deviant by virtue of their being a variant of the average.

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Sex neutral vocabulary may be unhelpful

EDITOR,—The *BMJ* has published several articles on sexism in medical writing in recent years¹⁻³; I wish to comment from another point of view.

As a member of a research team looking at the relation of occupation with health in women I am trying to find relevant literature dealing with this subject. I have encountered difficulties because of inverted sexism in medical writing. The sex of the participants in medical studies is seldom indicated in the titles or abstracts of articles. Neutral words (humans, patients, workers, volunteers, cases, physicians, hypertensives) are used, thus making reports on women and possible gender differences difficult to find. When reading the articles I find that these neutral words are used to indicate male subjects⁴ or a combination of male and female subjects,⁵ but in one case the 40 "subjects" mentioned in the abstract turned out to be 40 female subjects.⁶ There are even articles in which sex neutral words are used throughout, making it impossible to tell the sex of the study participants at all.^{7,8} One may guess that "workers exposed to low doses of toluene" are indeed men,⁹ but what about "occupational exposure to styrene" where "workers" and "sex matched controls" were studied with respect to neuropsychological functions¹⁰? Exposure to solvents may well affect men and women differently owing to differences in fat content in the body.

I agree that sexist language is irritating, but sex is of interest in many contexts and should be stated

as early as possible, preferably in the title, in medical articles. Thus I recommend changing sexist vocabulary not into neutral vocabulary but into correct language—for example, "500 patients with hypertension" to "500 males with hypertension" (they almost always are male). The word "man" is best avoided as it is used to indicate both male subjects and a combination of male and female subjects in titles such as "Hypertension in man." Don't make it even more difficult to find relevant literature on women's health by neutralising sex specific words—use the correct ones even if it adds a few letters to the title.

Another and much more serious and irritating example of sexism is that so few of the volunteers, humans, subjects, hypertensives, workers, or whatever turn out to be women in medical science.

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Electrostatic discharges in radiographs

EDITOR,—D G Dunlop reports electrostatic discharges in radiographs and wonders whether the effect is mediated by photons or electrons.¹ The x ray image is usually produced in a radiograph by x ray photons (high energy photons) interacting with the intensifying screens in the film cassette and producing large numbers of light photons (low energy photons). These light photons interact with bromide ions in the silver-bromide crystals in the film emulsion to generate free electrons. The free electrons convert silver ions to metallic silver, forming a latent image, and this is converted to a permanent image by development.² An electrostatic discharge is a discharge of free electrons which generates metallic silver and a latent image directly, without the involvement of photons. Automated daylight loading systems do reduce the amount of manual film handling but contain multiple moving parts on which static electricity can build up, especially if the humidity is low.

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