although I have not had the time or skill to audit the quality of my care. My personal list is 2100 patients, and I look after about 100 patients who have misused drugs long term (about 60 of these receive regular prescriptions for various replacement drugs).

Practices with large numbers of patients who are long term drug users who are handled with skill, understanding, and firm discipline are a medical phenomenon. I believe that their experience should be canvassed nationally: they could contribute considerable knowledge to the debate on how primary care can take on the care of those who are chemically dependent.

Quality primary care for long term drug misusers is costly in surgery time and draining in personal energy but can be very worthwhile. I believe that questions concerning the financial resources for this work have not been adequately addressed. I strongly support the idea of establishing a forum for practices with 50 or more patients with serious problems of chemical dependence to exchange views and set up workable protocols to assess quality of care and for personal support. I would like to hear from anyone interested in exploring this further.

H M CAMPBELL

Freedom Health Centre,
Plymouth PL4 8RH

1 Cohen J, Schamroth A, Nazareth I, Johnson M, Graham S, Thomson D. Problem drug use in a central London general practice. *BMJ* 1992;304:1158-60. (2 May.)

Performance related pay for radiologists

EDITOR,—Jonathan Boyce and Tim Morris are incorrect in their belief that the performance of either a radiologist or a department of radiology can be assessed by throughput.¹ Currently, good practice in radiology is concerned with reducing radiation dosage and eliminating unnecessary radiography. Any discussion of performance related pay in radiology must surely take this into account, especially if the application of good practice means a reduction in departmental workload and income. To relate a radiologist's remuneration to his or her workload would be a retrograde and dangerous step.

DAVID GRIEVE

Wexham Park Hospital,
Wexham,
Slough,
Berkshire SL2 4HL

1 Boyce J, Morris T. Performance related pay for hospital doctors. *BMJ* 1992;305:131-2. (18 July.)

Unawareness of dystonia

EDITOR,—After the publication of a review of the dystonias¹ the Dystonia Society carried out a pilot scheme in the north west, sending a concise information sheet on dystonia to all 2154 general practitioners (with four million patients) in the area. The bottom part of the information sheet had a tear off portion whereby recipients could ask for a free copy of Marsden and Quinn's article and to buy or borrow a video on dystonia. Twenty two recipients asked for a copy of the article and seven asked to borrow the video, which suggests that unawareness of dystonia is a thing of the past.

The best estimate of the prevalence of dystonia is 391 cases per million; this suggests that there should be an average of 1.73 patients with dystonia per practice, or 1564 in the north west. Of the hospitals with dystonia clinics in the area, two of the most active are at Walton Hospital in Liverpool (one clinic a week) and the Royal Preston Hospital

(one clinic every two weeks). Both see about six new patients each month, which suggests that the prevalence estimate is fairly accurate.

Requests for information and inquiries to the society from patients and the public's interest in talks organised by, and specialist leaflets available from, the society suggest that many patients are still suffering and awaiting treatment from neurologists in special clinics who have knowledge about dystonia. Thus it is unfortunate that our pilot scheme engendered such a low response from general practitioners. The Dystonia Society would like to be able to devote all its attention to supporting patients and raising funds for its research rather than being centres for disseminating information to patients. It would be much better if general practitioners could supply such information.

A MARTIN

Dystonia Society North West Area,
Darwen,
Lancashire BB3 1RQ

1 Marsden CD, Quinn NP. The dystonias. *BMJ* 1992;304:139-44.

Asian doctors and the MRCGP examination

EDITOR,—It is no surprise to me that Richard Wakeford and colleagues did not find any systematic discrimination against doctors of Indian subcontinent ethnic origin ("Asian doctors") to explain their poor performance in the MRCGP examination.¹ The authors give some plausible explanations for the poor performance of Asian doctors: poor training or training that is not congruent with general practice in the United Kingdom, and the barrier of the English language.

As an Asian doctor myself, I believe that these explanations have a minor role. The common problem is the system of education and the principle of learning by rote, which is so much a part of teaching in the Indian subcontinent. Far greater importance is laid on collecting facts than on how to assemble knowledge and use it constructively. It requires a great deal of effort, time, conscious realisation, and guidance to absorb new methods of learning and put them into practice.

Secondly, the profound effects of the social, psychological, and cultural changes related to immigration should not be ignored. Asian doctors have to face the rigours of this transition together with the tremendous stress experienced while preparing for the postgraduate medical examination.

I hope that in any future investigation of poor performance case by case (as Wakeford and colleagues suggest) the above mentioned factors are seriously considered. It would be helpful if the royal colleges provided counselling and ran short induction courses and training workshops on examination techniques. These, I think, would greatly improve the performance of Asian doctors.

DARYLL J J BRITTO

Royal Shrewsbury Hospital—Shelton,
Shrewsbury SY3 8DN

1 Wakeford R, Farooqi A, Rashid A, Southgate L. Does the MRCGP examination discriminate against Asian doctors? *BMJ* 1992;305:92-4. (11 July.)

EDITOR,—Richard Wakeford and colleagues highlight the problem of about a fifth of general practitioners in the United Kingdom—those from ethnic minorities, mainly Asian—and the failure of the Royal College of General Practitioners to redress their plight from the beginning.¹ The college has mentioned wherever possible that the chance of passing the MRCGP examination is poor if you are an overseas doctor, but it has not

attempted to introduce graded educational programmes to help these doctors succeed in the examination: many would welcome a programmed distance learning course.

Training practices where overseas doctors often train should be inspected more frequently and the content of their training programme scrutinised. Even now in West Yorkshire overseas doctors and British born Asian graduates of British universities are trained in poor quality training practices, where they are no more than an additional pair of hands. Few good inner city practices run by overseas doctors are considered for training purposes, though the facilities and management protocols are far superior to those of many training practices.

As an undergraduate tutor in general practice and an overseas doctor, I do not think that Asian doctors fail on account of their clinical knowledge. They fail because of the multiple choice questionnaire and the language and, most of all, because they have to assimilate and "think British" along the lines of most of the examiners, who are middle to upper middle class with totally different socio-cultural values from those of the patients of most Asian doctors in inner cities. Wakeford and colleagues' paper may help a little to remedy this or at least make some people think and not alienate one fifth of the profession.

RAJ MENON

Arthrington Medical Centre,
Leeds LS10 2JJ

1 Wakeford R, Farooqi A, Rashid A, Southgate L. Does the MRCGP examination discriminate against Asian doctors? *BMJ* 1992;305:92-4. (11 July.)

Life as a junior hospital doctor's spouse

EDITOR,—Lorna Montgomerie urges junior doctors' wives to inject their lives with good cheer and a positive approach topped up with a dose of laughter.¹ Taking her advice, I have formulated an alternative 10 point survival plan.

(1) "Get to know your spouse well before you get married"—it will help you recognise him when he does actually come home.

(2) "Treat time together as precious"—particularly those tender moments when he falls asleep in your arms 10 minutes after arriving home and you've got four days' talking to do.

(3) "Don't ever keep meals waiting"—even better, don't even bother to learn to cook.

(4) Congratulate yourself on having chosen a superhuman husband who can survive on two hours' sleep a night. He must really be something special, mustn't he?

(5) Laugh your socks off when you catch a government spokesperson on Radio 4 assuring the nation that no doctor works more than 72 hours a week.

(6) Have great fun sabotaging your husband's plans to spend his precious free weekend working on research papers.

(7) Delight in being able to eat your "TV Christmas Lunch For One" in peace and quiet.

(8) Happily plan for the future when you can be together more: who knows, trips to the moon might be available on senior citizens' passes by then.

(9) Enjoy being able to decorate your (many) houses to your own taste—he'll never be there to enjoy them anyway.

(10) Be immensely grateful that your husband made it to the birth of your child.

Positive enough? I'm trying.

TIPHANIE MELLOR

Terrick,
Buckinghamshire HP17 0TJ

1 Montgomerie L. Life as a junior hospital doctor's spouse. *BMJ* 1992;305:120. (11 July.)