members from the Royal College of General Practitioners are reminded that as the college represents only just over half of general practitioners its aspirations must be tempered by the lack of a mandate from its own discipline. The joint committee is therefore of increasing importance.

Independent fiscal powers for regional advisers hold, for them, obvious attractions. If change is necessary, however, one need look no further for a model than the reconstituted Scottish Council for Postgraduate Medical and Dental Education, where professional accountability and financial probity are assured and explicit.⁴

Finally, I wish to consider the "blatant attempt to bring the [Royal College of General Practitioners] into the forefront of education."¹ Members of other disciplines often perceive their colleges as having too much power: who will guard the guards themselves? When the Royal College of General Practitioners has achieved among general practitioners the membership levels of the ancient royal colleges its bid for total power might just be acceptable. In the meantime, most general practitioners will not allow it to have power without representation or to exert a Socratic authority on the basis of wishful thinking.

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Proposals will make the royal college all powerful

EDITOR,—The view that education was far too important a matter to be left to educationists was very much in the mind of at least one member of the General Medical Services Committee when the constitution of the Joint Committee on Postgraduate Training for General Practice was discussed during the 1970s. Jamie Bahrami's editorial does little to weaken this view, with its plea for the Royal College of General Practitioners "to discard the political shackles of the past and become Britain's supreme educational body in general practice."¹

This, together with Bahrami's suggestion that the regulations for vocational training should be rescinded, could result, as he says, in the abolition of the joint committee. It could also result in the college controlling entry to practice by insisting on membership of the college as a condition of being a principal (which might lead to the production of general practitioners with stereotyped attitudes). The college could also gain complete control over vocational training and reaccreditation. It would thus have enormous power, not to say absolute power, over the attitudes, the working life, and the livelihood of every present and future general practitioner. Is that what the college really wants for itself or its successors? Should the profession concede them that power?

The dictum "Power tends to corruption and absolute power corrupts absolutely" is highly relevant, and I wonder whether any future hierarchy of the college would be able to disprove it. That apart, it would be unfair in practical terms to expose the college to the perils of patronage. The continued existence and primacy of the Joint Committee on Postgraduate Training for General Practice, with a large proportion of its members nominated by the GMSC, which represents all general practitioners in the NHS, is essential.

There is another question which is not referred to in the editorial but arises from it: is vocational training worth the effort and the expense? When I retired 12 years ago nobody had taken the trouble to evaluate it. Has anybody now done so, or have I missed something?

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- 1 Bahrami J. General practice education and training. *BMJ* 1994;309:284-5. (30 July.)

Joint committee is effective

EDITOR,—Jamie Bahrami alleges that the Joint Committee on Postgraduate Training for General Practice is not effective and that its proposals for summative assessment are confused.¹ The committee is the only body recognised by the secretary of state for health for the purpose of issuing the certificates of completion of vocational training for general practice under the NHS Vocational Training Regulations. The committee has issued over 27 000 such certificates for the largest branch of the medical profession, and these are now used by more than half of all NHS general practitioners. The committee presides over a national system, which includes a visiting programme for Scotland, Wales, and Northern Ireland and all regions in England. Two features of this—namely, the requirement that general practitioner teachers should attend courses in education and that no trainer should be appointed for more than five years at a time (more commonly three)—have not yet been equalled by any other branch of medicine and have proved effective.

As for summative assessment, the committee widely promulgated its six point plan in May last year—namely, that all doctors who are to work unsupervised as principals in general practice in the NHS should have adequate factual knowledge, problem solving skills, clinical competence, consulting skills, the ability to do appropriate practical work, and the ability to satisfy a duly appointed trainer. This plan is sensible and not confusing and will, provided it receives support from the Department of Health, lead to summative assessment for vocational training being introduced in 1996 throughout Britain.

The joint committee is the only national body that brings together the educationalists from the Royal College of General Practitioners, the General Medical Services Committee, and the universities with both generalist and specialist representation. For nearly 20 years it has operated broadly by consensus and mutual cooperation—values that remain as important today as when it was established in 1976.

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Emergency transport for neonates after home deliveries

EDITOR,—After an elective home delivery of a low risk pregnancy, unexpected neonatal problems ensued and our neonatal flying squad was summoned for immediate help with resuscitation. Such an emergency service to home deliveries has not been planned or funded, and so the midwife was advised to call a standard emergency ambulance.

In view of the increasing trend towards home deliveries, supported by the Royal College of Midwives and the government, we wish to express our concerns over people's expectations of the

traditional neonatal flying squad after the discussion at the British Medical Association's annual representative meeting.¹ The term "flying squad" is a misnomer for a system established to transfer sick neonates from smaller district general hospitals to neonatal intensive care units. As the district general hospital always provides facilities for initial resuscitation and support, these flying squads have generally not been organised or resourced to provide an instant response assembling the experienced medical and nursing staff required; and an ambulance and crew, particularly out of hours, takes a median of 45 minutes at our unit,² the team having to be freed from other duties or, at night, attend from home.

In our experience many midwives wrongly believe that a call for help with a home birth will produce an instant response by a neonatal team from the local hospital. Many hospitals will not provide a neonatal flying squad at all, and even those larger units that do are unlikely to provide a 24 hour emergency service. If midwives are unaware of the limited facilities available parents are probably deciding on the place of delivery without the full facts, unaware of the skill required in the event of problems and the inevitable time taken by a neonatal flying squad to arrive to give this support.

If the public wants a full neonatal emergency support service major changes will be needed in the organisation of transport for neonates: a trained team with no other commitments would need to be on permanent standby together with an ambulance and crew, and different equipment would be needed to ensure access to all types of accommodation. The financial and staffing implications of such a service are vast, and community units, as the purchasers, would have to pay for this. Without such a strategy litigation is almost inevitable and will probably cost as much.

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- 1 The BMA's annual representative meeting. *BMJ* 1994;309:200-5. (16 July.)
- 2 Leslie AJ, Stephenson TJ. Audit of neonatal intensive care transport. *Arch Dis Child* 1994;71:F61-6.

Long term use of hypnotics and anxiolytics

May not result in increased tolerance

EDITOR,—Both Neil Wright and colleagues¹ and John W G Tiller² question whether long term use of benzodiazepines is as bad as the media stereotype suggests. We provide evidence that long term prescription of this class of drugs does not necessarily result in increasing tolerance.

Altogether 191 (3.9%) patients receiving computerised repeat prescriptions of hypnotic and anxiolytic drugs (*British National Formulary* class 4.1) were identified from a general practice with a list of 4857 patients in Haddington, Lothian region, in 1992. Primary care case notes for 181 of these patients were available for review. The mean age of these patients was 69 (range 4-93). They had received long term treatment (defined as a two month supply of tablets at least three times each year) for a mean of 5.6 years (range 1-41), but the first prescription had been a mean of 20 years before (range 2-41), indicating that many patients had received the drugs intermittently. Seventy patients had been changed from their original hypnotic or anxiolytic to another drug in the same class.

There was little evidence of increasing tolerance

as escalation of the dose was rare, having occurred in only 15 cases. In contrast, the dose had been reduced in 30 cases, and the remaining 136 patients had taken the same dose since the initial prescription. All doses conformed with the *British National Formulary's* guidelines.

The reasons for starting the treatment were recorded in 57 cases: insomnia (17), neurological disease (for example, epilepsy) (16), anxiety state (13), bereavement (4), alcohol withdrawal (3), and others (4). Long term administration was inappropriate for some of these indications, notably bereavement and alcohol withdrawal, and may reflect problems with dependence. Hospital doctors were recorded as having initiated the prescription in only six cases. Wright and colleagues report that 45 (73%) of the patients in their study taking daytime benzodiazepines (anxiolytics) had had documented contact with a psychiatrist.¹ In contrast, only 29 (16%) of the patients in our study, who were receiving hypnotics or anxiolytics, or both, had seen a psychiatrist. Twenty eight were receiving concurrent psychotropic drugs: antidepressants (24), antipsychotics (6), and lithium carbonate (3). Thus patients who receive hypnotics long term may be less likely to have seen a psychiatrist than those who receive anxiolytics, and their routine referral to psychiatrists could cause a substantial increase in psychiatric workload.

Medical practitioners are generally advised not to prescribe benzodiazepines long term.² As Tiller argues,² however, doctors should remember the potential negative effects of not prescribing such drugs. Some patients are severely disabled by anxiety and insomnia and may treat themselves with potentially more harmful agents, including alcohol. The usual rationale for avoiding long term prescription is to avoid the risk of tolerance, necessitating steadily increasing doses, and dependence, manifest by discontinuation phenomena. However, the dose had been increased in only 8% of the patients in our study, and no more than 30-40% of long term users suffer withdrawal reactions.³ Medical conservatism may be as potent as media alarmism in denying some patients symptomatic relief with anxiolytics and hypnotics.

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Night time users ignored

EDITOR,—There is nothing new about Neil Wright and colleagues' finding that 0.5% of one general practice population were long term daytime users of benzodiazepines and that almost half expressed a desire to keep taking the drugs.¹ The authors' conclusions (and those of John W G Tiller in his accompanying editorial²) were that prescribing of these drugs has declined and that the stereotype of dependent patients wishing to come off the drugs is false.

Daytime use of benzodiazepines is only half the story; more than half of long term users in general practice take the drugs at night,³ and it is among these patients that reducing prescribing is hardest.⁴ In 1988 colleagues and I published the results of a similar study to that of Wright and colleagues,⁵ and, though we did not give separate figures for daytime use, they can be derived from the figures for patients taking diazepam and lorazepam. The calculated prevalence was 0.67% (95% confidence interval 0.43% to 0.98%). This confidence interval

overlaps with that for Wright and colleagues' data, which, though not given in their paper, can be calculated as 0.38% to 0.62%. With regard to the views of long term users, at least four surveys since 1987 have reported that more than half of such users wanted to continue taking the drugs and did not see them as harmful.

In the light of such extensive earlier work, conclusions such as "exhortations [to reduce prescribing of benzodiazepines] have worked" and "a community survey in this week's journal does not confirm earlier notions of long term use of benzodiazepines"² seem uninformed.

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- 1 Wright N, Caplan R, Payne S. Community survey of long term daytime use of benzodiazepines. *BMJ* 1994;309:27-8. (2 July.)
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Enterovirus hypothesis for motor neurone disease

EDITOR,—A longstanding hypothesis based on indirect and epidemiological evidence proposes that motor neurone disease is a late consequence of subclinical infection with poliovirus. C J Woodall and colleagues provide supportive evidence for this "enterovirus hypothesis," reporting the finding of conserved enterovirus sequences in the spinal cords of nine of 13 patients with motor neurone disease when they used conventional polymerase chain reaction and hybridisation; they conclude that these sequences were related to Coxsackie B virus rather than poliovirus.¹ The enterovirus hypothesis has also been proposed for idiopathic inflammatory myopathy, and Behan and Behan, from the same group as Woodall and colleagues, have reported finding enterovirus in 56% of cases of idiopathic inflammatory myopathy (27/48).²

In conjunction with our study of the prevalence of enteroviruses in idiopathic inflammatory myopathy³ we investigated 28 patients with sporadic motor neurone disease and seven matched controls, using quality RNA extracted from either frozen or paraffin sections from the spinal cord, brain stem, and motor cortex. In contrast to the results of Woodall and colleagues, we found that none of the patients or the controls were positive for enterovirus sequences in a sensitive, nested polymerase chain reaction assay.³ The duration of disease, degree of autolysis of tissue, and time for which the tissue had been stored in paraffin were all excluded as factors that may predispose to negative results.

We have previously discussed³ the difference and consequences of the locations of primers between our enterovirus assay³ and that established by Gow *et al*⁴ and now applied to motor neurone disease.¹ In brief, both assays use primers that recognise sequences of the conserved 5' untranslated region of the enterovirus genome and, indeed, show a marginal overlap of 61 bases. Although a deletion downstream of our primer EV2³ could conceivably explain the anomaly between the results of these two studies, the consequence of such a deletion or specific mutation would most probably be to inhibit viral growth and perhaps attenuate neurovirulence as has been described for mutations and deletions in the 5' untranslated region of the poliovirus genome (for

example, Sabin strains). Nevertheless, Woodall and colleagues could easily confirm such an alteration in the 5' untranslated region of the enterovirus genome in their patients positive for enterovirus by using anchor polymerase chain reaction.

With regard to persistent enteroviral infections and idiopathic inflammatory myopathy, three recent studies⁵ in addition to our own³ have found no evidence of enterovirus RNA in muscle tissue despite each assay differing in its polymerase chain reaction format or primer combinations within the 5' untranslated region of the enterovirus genome; having verified broad specificity for enteroviruses including Coxsackie B viruses; and showing adequate sensitivity, which in our assay was 40-400 copies (12.5-125 ag) of synthetic Coxsackie B virus RNA transcripts in 1 µg of cellular RNA. Moreover, in one of these studies an unspecified number of patients with motor neurone disease were included in the control group of 16 subjects and no enterovirus infection was detected by polymerase chain reaction.⁵

The enterovirus hypothesis for the pathogenesis of both motor neurone disease and idiopathic inflammatory myopathy seems unlikely, given that most polymerase chain reaction results are negative, unless there has been appreciable alteration of the 5' untranslated region of the enterovirus genome.

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- 1 Woodall CJ, Riding MH, Graham DI, Clements GB. Sequences specific for enterovirus detected in spinal cord from patients with motor neurone disease. *BMJ* 1994;308:1541-3. (11 June.)
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Decompression sickness

Role of patent foramen ovale is limited

EDITOR,—Wilmshurst *et al* have reported an association between patent foramen ovale and some forms of decompression sickness.¹ Our initial experience of performing contrast echocardiography in divers with decompression sickness, which we reported in a letter rather than a peer reviewed paper because we studied our subjects in an uncontrolled and non-blinded manner, failed to confirm this.² J J W Sykes states that the link between a shunt and decompression sickness is controversial, giving a reference to our letter.³ Peter Wilmshurst, who criticises our findings,⁴ will recall that at the conclusion of our letter we suggested that more work was needed before recommendations for divers with shunts were implemented.²

One of the divers we studied with contrast echocardiography (no intracardiac shunt was detected despite multiple injections of contrast both with and without provocative manoeuvres) was subsequently investigated by Wilmshurst: a large shunt was seen (P Wilmshurst, personal communication). This simply illustrates the limitations of contrast echocardiography, not that