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.

BRIAN D KEIGHLEY
General practitioner

The Clinic,
Balfon,
Stirlingshire G63 0TS

- 1 Bahrami J. General practice education and training. *BMJ* 1994;309:284-5. (30 July.)
- 2 National Association of Health Authorities and Trusts. *Partners in learning: developing postgraduate training and continuing education for general practice*. London: NAHAT, 1994.
- 3 Royal College of General Practitioners. *General practice education and training. Proposed college policy statement*. London: RCGP, 1994.
- 4 Scottish Office Home and Health Department. *Postgraduate medical and dental education in Scotland. Report of the advisory group, chairman Dr Kenneth C Calman*. Edinburgh: SOHHD, 1991.

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?

B D MORGAN WILLIAMS

Stratford on Avon CV37 7EB

- 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.

DENIS PEREIRA GRAY
Chairman

Joint Committee on Postgraduate Training for General Practice,
London SW7 1PU

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

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.

CAROL SULLIVAN
Senior registrar
ANDY LESLIE
Transport coordinator
TERENCE STEPHENSON
Consultant paediatrician

City Hospital,
Nottingham NG5 1PB

- 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