defined period, so that they will avoid the insecurity of not knowing whether they will become a fully fledged specialist until they obtain a consultant appointment. This insecurity has bedevilled the British system. Finally, the 52% of female medical students in the first year will be able to look forward to a probability of becoming a specialist equal to that of male students. This large pool of talent needs to be used even handedly, especially as medical training is largely subsidised by British taxpayers.

Articles and letters of unhappiness from junior staff have been published periodically in the British medical press throughout my professional life. The equivalent unhappiness is rare in the American medical press.

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1 Roberts J. Specialists in the United States: what lessons? *BMJ* 1995;310:724-7. (18 March.)

Coping with psoriasis

EDITOR,—Susan Weingarten's account of the realities and humiliations of having psoriasis provide a useful insight for anyone who cares for patients with skin disease.¹ The particular aspects that Weingarten emphasises accord closely with the results of two recent national surveys that used a standard questionnaire, the psoriasis disability index. In 538 patients in the Netherlands one of the highest scoring questions related to having to wear different types or a different colour of clothes (H H Haisma *et al*, sixth international congress on dermatology and psychiatry, Amsterdam, 20-22 April 1995), and in Britain 70% of 369 patients stated that their psoriasis had interfered with sport, including swimming.² Other high scoring questions related to having to take more baths, problems at the hairdressers, and problems caused by the treatment itself. Two fifths of patients answered that over the past month they had either smoked more or drunk more alcohol because of their psoriasis—echoing Weingarten's mother's comments. It is important for dermatology staff to discuss these effects of psoriasis with their patients and hence to formulate practical strategies to alleviate these problems.

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Malaria prophylaxis

EDITOR,—I have concerns about the recommended wider use of mefloquine as prophylaxis for British travellers advocated in a recent *Fortnightly Review*.¹ I am currently responsible for and supervising some 250 mining engineers and their families based in west Africa who have been using mefloquine prophylaxis. Side effects have often occurred in this group with such a frequency that more than 162 people have developed problems, which include malaise, lethargy, headache, and dizziness. The symptoms have presented not only within the first few weeks but sometimes after 6-8 weeks of use.

Dehydration seems to increase the frequency of side effects and is a particular problem for subjects working out of doors (175 or 70% of the workforce).

Some wives (80 in all, representing 50%) are not taking mefloquine. Their religious beliefs prevent them from taking contraceptives; they would therefore be at risk of conceiving while taking the drug. Their alternative regimens complicate family prescribing. Medical authorities in these African countries have been reticent in introducing mefloquine to delay the onset of resistance to drugs, as seen in South East Asia.

We also exclude subjects who operate vehicles, aircraft, and machinery from using mefloquine, which again restricts its use in our practice. Advice given by the United Kingdom Civil Aviation Authority also restricts the use of mefloquine in pilots.² I therefore have reservations about the wider use of mefloquine because of its toxicity and think that its introduction may have the same consequence as the adoption of Fansidar as a prophylactic.

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2 United Kingdom Civil Aviation Authority. *Air information circular* 2/95. London: UKCAA, 1995. (Pink [Medical] 107, 12 June 1995.)

Vitamin E deficiency

EDITOR,—Minerva suggests that vitamin E is a vitamin without a deficiency disease.¹ This is incorrect. In both children and adults vitamin E deficiency has been shown to cause a progressive neurological syndrome, consisting of cerebellar ataxia, posterior column loss, and peripheral neuropathy.² Importantly, treatment with vitamin E may halt the progression of neurological symptoms. Doctors should be aware of this and should check vitamin E concentrations in patients who have this constellation of features without a known cause.

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2 Harding AE. Vitamin E and the nervous system. *Crit Rev Neurobiol* 1987;3:89.

Unified training grade

Purchasers cannot put the cart before the horse

EDITOR,—Trevor J Bayley suggests that, during their negotiations with trusts, purchasers of services should insist on an increase in the number of consultants in specialties in which the number of career registrars exceeds likely demand.¹ Without this, he states, the many efforts to improve specialist training in Britain will have been for naught.

Firstly, the function of purchasers is to assess their population's health needs and negotiate the delivery of relevant health care interventions from appropriate providers. As in other purchaser-provider relationships, the planning of staffing levels, medical or otherwise, is a matter not for the purchaser but for the provider of services.

Secondly, if expansion of a particular specialty is genuinely needed in any location then purchasers should be calling on trusts to develop those services independent of the number of career registrars. It would be wrong, however, for purchasers to seek, let alone insist on, new consultant appointments in specialties in which they are not needed. For Bayley to suggest that they should do so is simply special pleading. It would be a dereliction of their duty to secure the best balance of health services for their population if purchasing authorities

sought these new appointments simply to provide secure employment for people who found themselves in the unfortunate position of being career registrars without specialist registrar posts to move to.

The simple fact is that possession of a registrar post has never been a guarantee of progression to senior registrar and consultant employment. In the past many hundreds of doctors have reached a considerable degree of skill in their specialty (often holding higher degrees) at the registrar level but have been thwarted in their attempts to get senior registrar jobs purely for reasons of an imbalance of staff.

To state that without this special treatment of current career registrars the many efforts to improve specialist training in Britain would have been for naught is absurd. The improvements resulting from the implementation of a unified training grade and the increased emphasis on training that go with it will be of enormous benefit, whether or not all current career registrars find specialist registrar posts.

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1 Bayley TJ. Unified training grade. *BMJ* 1995;310:1020-1. (22 April.)

Expanding consultant numbers is not enough

EDITOR,—Trevor J Bayley suggests that the unified training grade will improve the lot of senior house officers and registrars.¹ What matters is not what they are called but whether they hold recognised posts in organised training schemes and can find jobs on accreditation.

I disagree with his statement that a simple, sudden expansion of the number of consultants can be the key to successful implementation of the system. In some specialties this may be feasible, but in surgery, at least, we face considerable problems. We could achieve a small expansion by promoting senior registrars and some highly experienced registrars, but what of the trainees of the future? Our latest trainees are expected to acquire the experience necessary to become consultants in roughly half the number of years that their predecessors served, while working fewer hours each week. The aim is laudable, but how is this to be achieved, especially with increasing demands for a consultant based rather than a consultant led service?

I suggest that trainees can reach the level of current NHS consultants so quickly only by means of increasing subspecialisation and a total reorganisation of our present system. Current trainees are scattered among large numbers of hospitals, each providing a broad based service to a relatively small population, thus diluting the trainees' experience. I believe that we should concentrate all emergency and major elective surgery in units serving much larger populations than the current district hospitals serve. All trainees would be based in these units, with their constant throughput of specialised cases and where periods on call would provide worthwhile experience. Patients with more routine problems could be managed more efficiently in the remaining hospitals in the absence of conflict with emergency services, and visiting trainees would again benefit from the greater concentration of routine cases in regular sessions. I see no reason why these principles should not apply to several other branches of hospital medicine.

Sadly, although our political leaders have in

theory endorsed the rationalisation of resource allocation, they have imposed a system in which every hospital believes that, to survive, it must continue to provide the fullest range of services regardless of their suitability. Let us hope that common sense will eventually prevail.

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Vocational training for GPs should be community based

EDITOR,—Trevor J Bayley's editorial on the unified training grade leaves the impression that, after nearly three years of lengthy debate, countless meetings, and working parties, we are still no nearer a solution than we were in 1992.¹ Although undoubtedly an expansion in the number of consultants is a prerequisite for the successful implementation of the grade, I believe that the main obstacle is our traditional habit of trying to introduce change without upsetting the status quo. For instance, the assumption that all those with a certificate of completion of specialist training will seek employment only in NHS hospitals or will want full time employment is open to debate. Furthermore, many of the expected difficulties would be overcome if we were to grasp the nettle of knowing staffing requirements in each specialty. The widely held view that this is impossible needs to be challenged.

The question of doctors who qualified overseas and want specialist training in Britain, though important, in reality is a red herring. It should be possible to create appropriate educational opportunities for such doctors without necessarily interfering with the implementation of the new grade. I also suspect that in many hard pressed specialties such doctors would be very welcome.

Bayley's comment about securing specific hospital posts for those in vocational training in general practice is important. Indeed, since the publication of the Calman report serious concerns have been expressed about the possible impact of the scheme on vocational training. A consensus is now emerging, however, that vocational training might become more community based, with a greater flexibility of educational opportunities than previously envisaged.²

It is now time to implement the scheme and modify it in the light of experience. After all, the European medical directive was agreed in 1975.

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2 Royal College of General Practitioners. *Education and training for general practice*. London: RCGP, 1994.

Deprivation payments to general practitioners

EDITOR,—The Department of Health has recently announced that in the 1995-6 financial year deprivation payments to general practitioners will be made using 1991 census data instead of 1981 census data.¹ To determine what impact this change will have on local practices, I used data from Merton, Sutton and Wandsworth Family Health Services Authority's age-sex register and census data to calculate both current (based on 1981 census data) and revised (based on 1991

Differences in deprivation payments based on 1991 census data and current deprivation payments based on 1981 census data for general practices in Merton, Sutton, and Wandsworth Family Health Services Authority (only patients living in the authority included in calculations)

Difference (£)	No of practices	Difference (£)	No of practices
≤ -32 500	1	To 2500	94
To -27 500	1	To 7500	13
To -22 500	0	To 12 500	2
To -17 500	1	To 17 500	4
To -12 500	3	To 22 500	1
To -7500	1	> 22 500	1
To -2500	9		

census data) deprivation payments to the 131 practices within the authority. Eighty nine per cent (601 330/672 872) of the people registered with these 131 practices lived in Merton, Sutton, and Wandsworth; no data were available on the 11% of patients registered with these practices who lived outside the authority.

In 1994-5, the 131 practices received a total of £411 874 in deprivation payments for patients living in Merton, Sutton, and Wandsworth. If Jarman scores derived from the 1991 census had been used to allocate payments, they would have received £402 410 in deprivation payments, £9464 (2.3%) less than now. Ninety four (72%) practices would have received from between £2500 more to £2500 less than now in deprivation payments (table). However, differences for some practices were large; one practice would have received £22 961 more and another practice £33 051 less in deprivation payments if these payments had been made on the basis of 1991 census data.

This study has shown that, for many practices, changes between the 1981 and 1991 censuses will not alter greatly the amount they receive in deprivation payments, but for some practices the differences will be large. In part, the larger differences occur because of the "all or nothing" method of allocating payments; a small change in the Jarman score for an electoral ward between the two censuses—for example, a change in the score from 29 to 31—leads to large changes in the deprivation payments allocated to practices with patients in that ward. To prevent such anomalies, the Department of Health should consider altering the method of allocating deprivation payments. For example, the current system could be replaced by a more graduated system of payments.² There is also evidence that patients are more representative of their enumeration district than their electoral ward,³ and a system of deprivation payments based on enumeration districts may therefore be fairer than one based on electoral wards.

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Hospital doctors' work

EDITOR,—Peter Jackson emphasises that doctors should be well supported by managers, who must share responsibility for patient care and medical training.¹ Results of a survey which we conducted on British trained preregistration house officers in West Midlands in 1993 lend further weight to Jackson's comments. Of 196 respondents (an 84% response rate) only 36% of preregistration house officers reported that they felt supported by managers.

Before a universal move to shift systems can be recommended, we must look at the consequences of these work patterns. Our work, based on small

numbers, suggests that a partial shift system may be worse for preregistration house officers' physical health (as shown by stress) than is a full shift system, but a partial shift system may lead to better job satisfaction among senior house officers than a rota system.

The Doctors Tale also reported that doctors are unclear of what is expected of them, that they perform tasks which could be undertaken by other staff, and that junior doctors frequently work unsupervised.² Again our results support this: 94% stated that their skills were underutilised, and many commented on the number of "menial tasks" required of them. Additionally, feedback from consultants was for the most part minimal; 28% reported no feedback, indicating a poor level of supervision.

Suggestions about improving postgraduate training are welcome, but our work shows the need to ensure that undergraduate training is also adequate. Nearly three quarters of respondents felt ill prepared for their role as a preregistration house officer, with lack of training in practical procedures being the major bone of contention. This dissatisfaction with training in practical procedures persisted through to senior house officer level. Similar numbers felt ill prepared for working within the NHS; most wanted training in self management techniques such as time management.

Finally, *The Doctors Tale* makes reference to the need for part time training. Our work suggests that only 40% of preregistration house officers are aware of the possibility of part time training and that it is mostly women who would take advantage of the scheme. Undoubtedly this type of training must be better advertised.

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1 Jackson P. Hospital doctors' work. *BMJ* 1995;310:952-3. (15 April.)

2 Audit Commission. *The doctors tale: the work of hospital doctors in England and Wales*. London: HMSO, 1995.

BMJ on the internet

Will be useful for isolated general practitioners

EDITOR,—The release of the *BMJ* on the internet is a landmark development.¹ It is a particularly heartening example of the idealism of wanting to share knowledge being more powerful than the need to maximise the commercial return.

As an educator who helps general practitioners, I am only too aware of the professional isolation that so easily engulfs my general practitioner colleagues, and as an Australian I am aware of the geographical isolation that presents such a challenge for many of our rural general practitioners. Access to the most relevant current medical information through the internet is an important weapon in fighting this isolation. Already doctors in isolated areas are beginning to acquire access to the internet as a means of communicating with each other, and the *BMJ*'s page will be a powerful additional motivation for more doctors to do so.

I encourage the *BMJ* to continue experimenting with the best use of this new medium. I am particularly impressed with the use of hypertext in the article on medical informatics. Although I am sure that the computer screen will never replace the written page (I for one will continue to read the hard copy of the *BMJ*), the internet can offer something unique. Immediate and direct communication with the authors of articles and an easy