substantially increase the cost per admission. In addition, we are responsible for transporting and escorting our patients for court appearances; this cost would otherwise be met by the Home Office. Should local purchasers be responsible for these costs in future?

We are convinced that the proper place for mentally disordered prisoners requiring hospital treatment is hospital. We have shown that the problems described by Needham-Bennett and Cumming are not insoluble; the solution is not legislative but financial. The delays inherent in the resolution of serious cases inflate our costs. We have expressed our concerns to the Home Office but have received only an acknowledgement. In the absence of any acceptance of joint responsibility by the Department of Health and the Home Office for funding services for mentally disordered remand prisoners, we believe that the current situation is a disaster that is already happening.

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Transverse myelitis unlikely to be due to measles, mumps, and rubella vaccine

EDITOR,—K A Joyce and J E Rees report on a 20 year old man who developed subacute transverse myelitis two to three weeks after immunisation with measles, mumps, and rubella vaccine.¹ Five days after vaccination he developed a feverish exanthematous disease, which fluctuated for two weeks and preceded the onset of the neurological symptoms. Postvaccination transverse myelitis was diagnosed when a significant rise in titres of rubella antibodies was observed. The authors suggest that antibody status should be checked before vaccination.

The course of events is incompatible with rubella related to the vaccine. Rubella-like disease related to vaccination develops nine days after vaccination at the earliest and does not last as long as two weeks. An increase in rubella IgM antibodies is possible after vaccination. Measurement of the titres cannot differentiate between wild virus and the attenuated vaccine strain. As the incubation period of wild rubella is 14-21 days² the patient may have had natural rubella.

Postvaccination transverse myelitis is diagnosed by exclusion, and serological tests should include tests for viruses such as echovirus and herpes simplex virus as well as coxsackievirus groups A

and B—particularly because the patient had a transient rash over his upper body.

Behringwerke has distributed about 8.8 million doses of monovalent rubella vaccine and measles, mumps, and rubella vaccine in the German market since 1980. No case of suspected transverse myelitis has become known to us. On the assumption that the yearly incidence of transverse myelitis in Germany is similar to that in Minnesota (approximately 7.4/100 000 people),³ postvaccination transverse myelitis after rubella vaccination is unlikely. Furthermore, the three other published cases of myelitis to which Joyce and Rees refer occurred after the administration of vaccines other than those currently used. There is insufficient evidence to indicate a causal relation between the currently used human diploid cell rubella vaccines and neuropathy.⁴

In conclusion, Joyce and Rees do not provide sufficient evidence to show that this case of transverse myelitis was caused by measles, mumps, and rubella vaccine. The need to check the patient's antibody status before vaccination cannot be deduced from this case report.

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General practitioners' depression

EDITOR,—The Personal View giving a general practitioner's account of her depression and her reflections on her work is honest and courageous.¹ I found it helpful and encouraging. I am a 37 year old full time female general practitioner who is married with two small children. While I view my job as secure and have no immediate plan to move, I find it depressing to think that I may be in the same place for 30 years. Five years is as much as I can cope with. For a while I felt guilty about this abandonment of the accepted norm for general practice—but no longer. The NHS is changing so rapidly that we must all embrace the possibility of career changes, as the new registrars in general practice seem to be doing.

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- 1 I should have been more selfish. *BMJ* 1995;311:957. (7 October.)

Notification of tuberculosis is compatible with venereal diseases regulations

EDITOR,—The Department of Health shares Alexander S Pym and colleagues' concern that undernotification of cases of tuberculosis, particularly in association with HIV infection, could have important public health consequences.¹ Undernotification causes difficulties for con-

sultants in communicable disease control when they carry out their responsibilities for local monitoring and control of tuberculosis and may result in contacts of infectious patients not being screened for the disease.

Concern about confidentiality has been given as one reason for failure to notify patients with HIV infection who have tuberculosis. Some clinicians are thought to be under a misapprehension that the NHS Venereal Diseases (1974) Regulations take legal precedence over the legislation on notification. This is not the case, nor is notification incompatible with the regulations, since the purpose is to identify and prevent further cases. The HIV status of the patient does not need to be stated on the notification form.

In response to concerns about possible under-notification of tuberculosis, last April I wrote to all consultants in genitourinary medicine, consultant physicians, and consultant paediatricians to remind them of their statutory duty to notify known or suspected cases of tuberculosis under the provisions of the Public Health (Control of Disease) Act 1984.

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- 1 Pym AS, Churchill DR, Coker RJ, Gleissberg V. Reasons for increased incidence of tuberculosis. *BMJ* 1995;311:570. (26 August.)

Problem based learning at medical school

Some people think it's thrilling . . .

EDITOR,—Having survived a traditional medical education in Britain, I have spent the past 14 months working at McMaster University, during which time I tutored a problem based learning group. I am glad to learn from John Bligh's editorial on problem based learning that the attitude of some universities to undergraduate medical study has changed greatly.¹ Continued learning should be an integral part of a professional career. Medical students in a traditional programme fill folders with lecture notes giving the currently accepted "facts," but this method of learning is unavailable after graduation. Doctors must develop a new learning strategy if learning is to continue in their postgraduate years, but, often, they stick to the strategies that they used as medical students.

Problem based learning allows students to develop a learning strategy that is effective throughout their professional life, but it is not practised in a vacuum. As in professional life, previous knowledge is not ignored but used by the tutorial group to formulate group and individual learning objectives. Once these have been agreed by the group the individual students are free to address those objectives in ways that are relevant to them. They may use books, computerised literature searches, or journals or spend time in a clinic talking to patients and family; many will also talk to relevant staff. This new knowledge is then brought back to the group.

Students recognise that their educational development is best served by cooperation within the group and by a free exchange of ideas and uncertainties. Removing formal examinations from the undergraduate course so that students see their peers as colleagues rather than competitors encourages this. A dual track system exists as examinations throughout the undergraduate course are usually considered important by proponents of the traditional approach. With the traditional approach students are tempted to spend more time on the part of the course that leads to examinations and to compete against each other rather than strive toward understanding.