bosis later in her life with perhaps fatal embolism on that occasion.

Jarvinen and Asp¹ found that the post-thrombotic state developed with unexpected rapidity—after one to three years 87% of patients already had symptoms and/or signs of venous insufficiency and after eight years at the latest all patients had such symptoms and/or signs. Bauer² found that 80% of patients with a venous ulcer had had a deep vein thrombosis. In the varicose vein clinic in this hospital, where approximately 2000 patients are seen each year, we have found that over 50% of the female patients with a postphlebotic limb give a history of ante- or post-partum deep vein thrombosis and in some cases it had occurred after several deliveries.

While the 30 deaths from pulmonary embolism per million deliveries are of extreme importance in the maternal mortality figures they do not give any picture of the hundreds of women with the postphlebotic limb for the remainder of their lives.

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¹ Jarvinen, P, et al. *Annales Chirurgiae et Gynaecologiae Fenniae*, 1975, 64, 96.

² Bauer, G. *Acta Chirurgica Scandinavica*, 1942, suppl 74, p 86.

Treatment of Wilson's disease

SIR,—We have read with interest the letter from Dr D P Vaughan and Mr R Kaderbhai (29 November, p 519) in which they suggested that metronidazole should be tried in the treatment of penicillamine-intolerant patients with Wilson's disease in preference to triethylene tetramine dihydrochloride. All suggestions for new orally active chelating agents are valuable and deserve investigation, but we have learned from experience that many chelating agents which bind copper in vitro do not act as cupruric agents when given to patients with Wilson's disease. A chelating agent which will bind copper in vivo and result in its precipitation in the tissues is theoretically dangerous since the possibility exists that the copper will eventually be freed from the ligand, resulting in a massive increase in "free copper" at some vulnerable site in the body.

Over the years we have investigated a number of compounds which may have this action—for instance, sodium diethyl dithiocarbamate, a very powerful copper-binding agent, when given to rats results in a fall in the urinary excretion of copper. Similar findings have been made for aminotriazole and benzotriazole; it was therefore with some doubts that we set up the following study to test the cupruric activity of metronidazole. Two patients who had presented with hepatic Wilson's disease and who had each been taking penicillamine for two years volunteered to test the compound. The test

procedure was as follows. No drugs were given for 72 hours, a 15½-hour overnight urine sample was collected to estimate basal copper excretion, the patients were then each given 450 mg of penicillamine hydrochloride, and urine was collected for six hours. After 48 hours the test was repeated, only on this occasion penicillamine was replaced with a dose of 500 mg of metronidazole (a slightly larger dose on a molar basis, the molecular weight of metronidazole being 171 and that of penicillamine HCl 176). The findings are given in the table below.

It is apparent from these results that metronidazole does not have a sufficient cupruric action to warrant long-term trial in patients with Wilson's disease. Until an alternative compound is found which will actively promote the excretion of copper, triethylene tetramine dihydrochloride remains the best available therapy for penicillamine-intolerant patients with Wilson's disease.

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Tests on overseas doctors

SIR,—Your leading article on "Tests on overseas doctors" is indeed interesting reading (6 December, p 542). The Overseas Doctors' Association, since its formation in early June, has been in constant touch with the BMA, the royal colleges, and the General Medical Council and is concerned and conscious of the problems of overseas doctors who are coming to work in the United Kingdom. The DHSS, the Temporary Registration Assessment Board, and the GMC are concerned in examining overseas doctors as to their competence by clinical testing and language tests before they are given registration to practise in the United Kingdom. Unfortunately these tests have been organised rather in a hurry and some of the procedures of this are far from desirable.

As chairman of the Overseas Doctors' Association I attended as an observer at one of the examinations and my comments have been sent to the chairman of the TRAB. It was a pity, as you rightly said, that no representatives of the overseas doctors were asked to explain their position at the meeting of the National Association of Clinical Tutors at the Royal College of Physicians on 25 November. If an opportunity like this arose again the ODA will be happy to express their views and give constructive suggestions regarding these tests. Our views are that a test of this sort is absolutely essential. The test should be carried out three months after a preliminary acclimatisation period during which these doctors would be attached to a district hospital to go through the various departments and work as a

clinical clerk. At the same time, in the evening, they would attend evening courses in the English language so far as it relates to their practice, and such courses are now being organised in various universities and polytechnics. At the end of the three-month period these doctors would then be asked to sit for the examination. The present examination is far from satisfactory and space does not allow me to elaborate on this at present.

Sir, the whole question of junior doctors training in the United Kingdom is in turmoil and in this situation the overseas doctors feel that they are being made scapegoats. It is indeed interesting to note that in the *BMJ* you publish the pass lists for the MRCP and FRCS but you do not mention the number of candidates who sat for the examination and the number of candidates who failed. But in the overseas doctors' test examination you publish both the figures.

While we do not oppose a test we do object to the ways and means with which the test is carried out. I feel confident that, given time, we shall be able to solve this problem with good will on both sides.

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SIR,—We are very worried about the effect of the new examination which is being run by the General Medical Council for foreign doctors wishing to work in Britain, as it seems that the standard set is so high that the majority are doomed to failure.

To quote a recent example, we have had for several years a connection with Barcelona and have had three excellent men who came here as orthopaedic house officers and progressed to registrar level. A fourth man came recently with a strong recommendation for further training in orthopaedics. His English was excellent and his background entirely satisfactory. He has failed the examination and has had to go back to Spain. We have no doubt that the three previous men would also have failed and yet they all turned out to be excellent in every respect.

If it is made exceptionally difficult for a foreign doctor to pass this examination our supply of such people is going to run out, with obvious effects on the staffing of many hospitals. It also means that Britain will quickly lose its image as a place for the training of doctors from many countries and this would be to our detriment as well as theirs. Obviously there must be some kind of test of reasonable competence, but we feel strongly that this examination is too difficult, and it would be interesting to know whether other consultants have formed the same opinion.

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Vocational training for general practice

SIR,—There are suggestions that the period of vocational training for general practice

Copper excretion	Basal urine 1 (15½ hours)	Six hours after penicillamine	Basal urine 2 (15½ hours)	Six hours after metronidazole
Case 1				
Total (µg)	15.1	155	20.7	13.0
Rate (µg/min)	0.017	0.430	0.022	0.034
Case 2				
Total (µg)	33.0	210	26.8	21.5
Rate (µg/min)	0.035	0.583	0.029	0.060

should culminate in a compulsory examination. Most of the pressure comes from members of the Royal College of General Practitioners, who argue that trainees and trainers alike need an objective standard to measure the success of their work and that an examination is the only way of improving the status of general practice. In support they frequently refer to the recommendation of the Merrison report¹ that general practice should be recognised as a specialty and that the period of specialist training should conclude with a test of ability to practise.

I question whether this argument meets with the approval of the majority of general practitioners, who rarely take part in academic politics. While the work done by college members has benefited general practice enormously, can we truthfully say we have reached the stage when the prerequisites of good general practice can be not only identified but measured? In general practice we have always prided ourselves on our individuality—is there not the danger that the need to conform to yet another examination syllabus will crush that individuality? What will be the future of those who fail such an examination?

Although academic knowledge is vital for any doctor, the unique long-term nature of the doctor-patient relationship in general practice makes other factors of at least equal importance. The ability to mix with one's fellows, to earn their confidence and respect over the years, does not depend on academic ability alone, yet it is a vital quality for success in general practice. It cannot yet be identified in an examination.

While no one can deny the basic sincerity of these members of the RCGP it must be said that they have a vested interest in the establishment of a compulsory examination. If membership of the college becomes the essential qualification for entry into general practice then the college will gain greatly in financial and political power. Even if the college were to administer a different examination the prestige and importance of its office bearers would be enhanced considerably. At present they exert great influence. When the Merrison Committee was established the only two general practitioners appointed were both fellows of the college, one the secretary, although the majority of general practitioners are not members. It is hardly surprising that the committee accepted the evidence of the college when its own specialists helped to formulate that evidence, but it is misleading now to cite the Merrison Report as impartial support for the stance of the college. My own opinion is that the profession could more usefully spend its energy devising more sophisticated criteria for entry to the profession at university intake level than follow the route indicated by Merrison and the college. Shall we have a meaningful debate before the issue is settled over our heads?

IAN H MCKEE

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¹ *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, Cmnd 6018. London, HMSO, 1975.

A case for private practice?

SIR,—In his article (6 December, p 591) Mr Rudolf Klein states that “the private sector

is . . . largely a specialised sector. The emphasis is heavily—though not exclusively—on cold surgery and minor procedures.” I believe this to be a misconception. Admittedly a surgical procedure is likely to require admission, and the final charges will therefore be considerable; it is not unreasonable that the surgeon should charge a realistic sum for performing an operation and assuming clinical responsibility in the pre- and postoperative period and that the hospital or nursing home should cover its expenses. It is likely, therefore, that in gross terms the surgical specialties are responsible for the major proportion of the moneys paid out by patients seeking private treatment. Physicians do not often resort to surgical procedures and certainly admit fewer patients than their surgical colleagues. Yet between them they see very many patients who are investigated and treated on an out-patient basis. Similarly, radiologists and pathologists probably perform the greater portion of their private work on outpatients.

I therefore dispute Mr Klein's conclusion in the relevant section of his article and believe that the opportunity to practise privately is necessary to guarantee professional independence, and that it is not only patients with surgical conditions but patients with most common medical or surgical conditions, whether they seek private advice or not, who will benefit from the continuing availability of a strong private sector. It is surely somewhat silly of Mr Klein to state that “the issue of people being able to buy better quality treatment could be discussed with less emotion than is often the case: it is more difficult to whip up political passions about hernia repairs than about coronary care.” The inaccuracies and faulty conclusions of this section of his article materially weaken an otherwise carefully argued and well-balanced approach.

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SIR,—I for one welcomed Mr Rudolf Klein's closely reasoned article (6 December, p 591). However, one point in favour of the private sector was not made clear. It is that for a surgeon success in his private practice is usually the earned result of having given a more than satisfactory service to his NHS patients; in this way the incentive for good work in the public sector is always present. The experience of some senior surgeons suggests that the full-time consultant contract often leads, after a few years, to apathy and so to a lowering of standards.

The very nature of a career in surgery demands that this incentive be preserved for the ultimate benefit of every patient.

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Future of the NHS

SIR,—I am still extremely optimistic for the future of our Health Service and it saddens me to see our consultants and junior doctors taking actions which will achieve practically nothing and endanger patients' lives. It will achieve nothing for the following reasons. (1) Whatever the Government or royal com-

mission decides about pay-beds, it will eventually be the ancillary unions who force their closure. Far better to take the initiative ourselves and arrange, through industry and insurance companies, the rapid building programme of entirely private hospitals. Then perhaps the country will see what sort of standard of care it ought to be getting from the NHS. (2) The juniors' case is seen by the public and Government as an attempt to breach the pay policy and, as such, will be strongly resisted. This is not the time to press their perfectly justifiable claim but to use the existing negotiating machinery of the Review Body, however slow. It did, after all, recognise their case earlier this year, and would, I am sure, deal fairly in the future with their grievances.

Now for the optimism. When this action is over there will be very long backlog of out-patient appointments and operations. Could I suggest that all consultants, general practitioners, junior doctors, nurses, clerks, and technicians offer to do extra sessions at no charge and in our own free time to help mop up this backlog? Secondly, for all consultants to have a closer look at all their follow-up clinics. Is it really necessary to see every surgical patient at six weeks? Is it ever necessary to see him to take out his stitches? Is it necessary to take his blood pressure? The general practitioner could easily absorb these follow-up examinations and thus free many junior staff who could then see new patients or do minor operating lists, etc.

There is still tremendous good will among colleagues in the medical profession, and with restricted resources we can still offer a good service to our patients by a rearrangement of our priorities. To resign now will risk the Government introducing an even more politically dominated service with doctors having even less voice than at present. Better the devil we know, etc.

J STUART BROWN

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Representation of junior clinical academic staff

SIR,—I have recently received the statement for my annual subscription of £40 to the BMA. This coincides with the result of the junior hospital staff ballot, which brings to light a point not previously understood—namely, the disfranchisement of academic junior staff holding honorary NHS contracts. These junior staff are supposedly represented by the Association of University Clinical Academic Staff (AUCAS), an organisation to which few belong.

I fail to see the logic in AUCAS representing academic junior staff for the following reasons. Firstly, the majority of academic junior staff eventually return to NHS permanent appointments, some obtaining senior registrar posts from research fellowships, others consultant posts from either the lecturer or via the senior lecturer grade. Thus their long-term interests are not served by moving from one association to another. Secondly, academic staff salary parallels the NHS scales without further bargaining between employer and employee. Therefore junior staff benefiting from awards have a responsibility to belong to the association that does the negotiating and a right to have