The grant will include an allowance for the extra responsibility taken on by a trainer and his partners since they are ultimately responsible for patients treated by the trainee. I do not deny that after varying lengths of time working within a practice the trainee may contribute significantly to the reduction of the work load of the practice. On the other hand, there are also unsatisfactory trainees who despite all the trainer's efforts may still cause great anxieties within a practice.

It appears to me, after considering the above, that the average trainer will be able to contribute from two to four hours' teaching per week to his trainee. This seemed to be the average amount of teaching given according to the questionnaire survey organised at Exeter. Incidentally, most trainees seemed to think that this was about the right amount of time. One regularly hears about trainers exploiting trainees but one can be forgiven for thinking that some trainees would like to exploit their trainer and his partners.

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Points

Changes in MRCP (UK) examination

Dr M GRIMMER (General Infirmary, Leeds LS1 3EX) writes: Yet again the relevance and emphasis of the MRCP (UK) examination are brought into question (2 August, p 391)—on this occasion in respect of its pertinence to overseas graduates. This is a valid point but I think it is a problem to which individual overseas graduates should address themselves and come to their own decisions. Our colonial days are over and this should be appreciated by all, not just the British educational authorities. . . . There is implicit criticism of the undergraduate system by insinuation that new graduates are inept in history taking and examination. Perhaps the undergraduate course and examination bear some frivolous parallels to driving instruction and the driving test. Having been successful at these hurdles one does not become a good driver or a shrewd clinician overnight. At best, with good luck and by following the rules one hopes to avoid any major catastrophe. The sensible junior clinician learns not only from his own strengths and weaknesses but also from those of his peers and more senior colleagues. This is true education, which should only cease under normal circumstances in ventricular fibrillation or asystole. . . . In conclusion, perhaps the most important functions of the postgraduate examination system in the UK are not to certify accredited specialists but to ensure that those with such aspirations have a high standard of clinical competence and thought that are used in a mature and comprehending way. . . .

Medical education

Dr M HARRIS (London SW12) writes: I see from the press that Ms Renée Short is about to accept evidence from interested parties about medical education, as she is chairwoman of the House of Commons Committee on Social Services which is looking into that subject. The latest date that interested parties can offer written or oral evidence to the committee is 10 October. Looking at Ms Short's track record leaves me with no doubt that she will come down in favour of as much collective control of doctors' education as they will bear, and in particular she is almost certain to be thrown into ecstasy by the suggestion that the MRCGP should be made mandatory for all principals in general practice; for, like many left wingers, Ms Short confuses certification with competence. Voices crying out in this collective wilderness, such as those of Dr Adrian Rogers (9 August, p 457) and myself . . . should write to the committee at the House of Commons (no stamp required). . . .

Vocational training for general practice

Dr JOHN R HEDGES (Royston, Herts SG8 6JH) writes: Dr Adrian Rogers asks (9 August, p 457) whether there would be a significant deterioration in patient care should vocational training for general practice cease. My answer is a resounding "No," for I am pleased to have been spared the constraints of a general practice traineeship, especially when I read[1] that the third and fourth most frequent repeat prescriptions in an anonymous urban training practice are for nitrazepam and diazepam respectively.

[1] Anonymous. *Update* 1980;21:316-9.

Dr J F WILMOT (Leamington Spa CV32 5SS) writes: Women general practitioners may experience in a particularly acute form the difficulties in finding a post described by Dr D W Wall (7 June, p 1379) for doctors in general at the conclusion of their vocational training. . . . Not only the patients but the partners in a group practice may benefit from the presence of a female member. Should we general practitioners be more ready to take on part-time or salaried partners, as family practitioner committees may now pay the basic practice allowance and similar payments for doctors working in excess of 20 hours per week? I calculate that for a vocationally trained doctor a group practice would gain £7615 a year, apart from any additional income from cervical cytology and contraceptive services. This would permit a very reasonable salary to the part timer, in exchange, of course, for a considerable portion of the work, at no detriment to the existing partners. Surely a bargain?

Changing to A4 folders and updating records

Dr VIRGINIA MURRAY (Harrods Ltd, London SW1X 7XL) writes: . . . Drs G N Marsh and J R Thornham (19 July, p 215) made no mention of confidentiality, though using non-medical staff for transcribing, collating, and summarising records of their practice patients. I wonder how much privacy was afforded to their patients during the updating of the incomplete records. I gather that this could be done by any member of the medical team, including the receptionists. How did the patients feel when questioned about family history or even social facts such as "severe financial deprivation" or "battered wife" under these conditions? In my job, as in all medical practice, confidentiality has to be a strict habit so that patients can tell their innermost problems with confidence. Thus we who look after them have a clear all-round picture on which to base our decisions.

Are pensions subsidised by doctors?

Dr T L PILKINGTON (Claypenny Hospital, York YO6 3PR) writes: The obituary pages of the *BMJ* give solemn comment to the current debate on whether index-linked pensions can continue. One hundred recent consecutive notices reveal that less than half (46%) of doctors survived beyond the age of 70; no fewer than 22% died before reaching the age of 60, and therefore presumably collected no pension at all. Could it be that medical superannuation contributions are subsidising colleagues in other professions who enjoy greater longevity?

Information on rabies

Dr RAMSAY G SMALL (Tayside Health Board, Dundee DD1 9NL) writes: The value of the excellent statement on rabies (9 August, p 462) from the Communicable Disease Surveillance Centre is lessened by one major defect: nowhere in the text is it made clear that the arrangements it describes for obtaining rabies vaccine or human rabies immunoglobulin and for obtaining information about the geographical distribution of rabies apply to England and Wales only. . . . Practitioners in Scotland wishing to have information about rabies or the availability of prophylactic agents are advised to contact either the community medicine specialist (with responsibility for communicable diseases) in the relevant health board or the Communicable Diseases (Scotland) Unit (tel 041-946 7120).

Anorexia nervosa in diabetes mellitus

Dr BRUNO BRUNI (Ospedale Maria Vittoria, Turin 10144, Italy) writes: Drs C G Fairburn and J M Steel, referring to a case of anorexia nervosa in diabetes (10 May, p 1167), state that they have found only one case previously reported. I would like to add our case, which we presented in 1972 at the eighth annual meeting of the European Association for the Study of Diabetes. . . .

"Let us now praise famous men"

Dr E LIPMAN COHEN (London W1N 1AH) writes: *Ecclesiastes* came to the mind of Professor H A F Dudley inappropriately (26 July, p 297). Credit for the wise remarks about praising famous men and honouring a physician should have gone to *The Wisdom of Jesus the Son of Sirach* or *Ecclesiasticus*. The references are 44, 1, and 38, 1.

Correction

Retroperitoneal fibrosis associated with atenolol

An error occurred in the letter by Dr W M Castle and others (26 July, p 311). The first reference should be: Koep L, Zuidema GD. *Surgery* 1977; 81:250-7.