abolition of airways obstruction usually takes about 7–10 days and your article was misleading when it referred to the maximum effect of an oral steroid being evident after 9–12 hours. You recommend that, because infection is a common precipitating cause of severe asthma, a broad-spectrum antibiotic should be given. Many studies have shown that asthma is commonly provoked by respiratory viruses and antibiotics can be of value only if there is secondary bacterial infection.

The most difficult problem in the emergency management of asthma is to assess its severity. Usually the patient is first seen by a GP and therefore the vital initial assessment has to be made on clinical grounds alone, to ensure that an attack is not only missed if the patient can converse with frequent pauses and it may be very severe long before he has become too dyspeptic to speak at all.

Maintenance does not end with the patient's recovery and the return of his ventilatory function to its optimum value. Every attack of severe asthma should be regarded as a failure in his previous medical care and a searching inquiry must be made into the circumstances leading up to it in order to avoid a repetition of these. The whole emphasis in the management of asthma should be upon teaching patients to treat themselves in their own best interest and most effectively. Those taking an oral steroid should regularly increase their maintenance dose on their own initiative whenever they have an exacerbation of asthma from whatever cause. Those taking a steroid aerosol must be given a reserve supply of oral steroid, which they should take in high dosage for a few days if they become unable to inhale their aerosol effectively and are thus deprived of any steroid protection.

JAN GREGG
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1 Gregg I, Respiration, 1969, 26, suppl 123.
4 Gregg I, in Royal College of Physicians of London, AIDS Reports, 1975, 1, 3.

SNR,—While subcutaneous adrenaline injection is admittedly easy to administer it could actually exacerbate bronchospasm in acute asthma. Because of beta-adrenergic blockade in severe asthma the alpha receptors may be even more markedly stimulated than the beta by adrenaline injection. I do not agree, therefore, with Dr P Harris (p 288) that your leading article (11 October, p 65) was "remiss in not mentioning the role of subcutaneous adrenaline in the management of acute asthmas."

PAUL CROSSBY
Marple, Cheshire


SNR,—In your leading article on the management of acute asthma (11 October, p 65) you do not seem to stress that the treatment advised is essentially for adult cases. Furthermore, it appears to me that you have preferred the frequent administration of "note" rather than "status asthmaticus." The word "note" to the "status asthmaticus" still defies generally agreed medical definition. Status asthmaticus, however, is widely accepted as implying an acute attack of asthma resistant to the usual bronchodilators. Why then do you introduce a further term?

In contrast to adults, many children show moderate to severe hypoxaemia with hypercapnia and moderate metabolic acidosis (non-respiratory) acidosis. Oxygen therapy may, however, only worsen respiratory depression in children with hypercapnia. Viral respiratory tract infections may precipitate asthmatic attacks in children but there is little evidence to suggest that bacterial infection is associated with wheezing. Status asthmaticus is common in children, and certainly so in our area. I do not use antibiotics as a routine and find it difficult to accept your advice on the use of broad spectrum antibiotics.

Corticosteroids are no doubt the drugs of choice in status asthmaticus. A higher dosage and duration is required for more than a few days in most cases. Is there any evidence to suggest that oral potassium supplements must be given with such short courses of prednisolone?

S A HAIDER
Bury General Hospital, Bury, Lancs

SNR,—Your leading article (13 September, p 606) on the epidemiological aspects of choriocarcinoma very generously credited my colleagues and me with having shown that choriocarcinoma was more common in Indians and Malays than in Chinese and Malays in Singapore. Our paper did not in any way discuss choriocarcinoma in Singapore: it was on the epidemiology of hydatidiform mole in Singapore. While the incidence of hydatidiform mole in Chinese, Indians and Malays was 1 in 811 (151 out of 1247000 pregnancies) and 1 in 879 viable pregnancies (39 out of 276000 pregnancies) respectively, the incidence in Indians and Eurasians was 1 in 680 (20 out of 156000 pregnancies) and 1 in 310 viable pregnancies (3 out of 53800 pregnancies) respectively. The higher incidence of hydatidiform mole in Eurasians is thus much more apparent than real. These differences in incidence of hydatidiform mole do not apply to choriocarcinoma, which is a different condition.

In contrast to the assertion in your leading article that choriocarcinoma was more common in Indians and Eurasians than in Chinese and Malays in Singapore, studies carried out on choriocarcinoma arising from different forms of antecedent pregnancy showed that choriocarcinoma was more common in Malays than in Chinese. In fact, the incidence of choriocarcinoma in Indians and Eurasians was the lowest, but this was more apparent than real as the numbers in these two ethnic groups were small.

The hydatidiform mole and the reverse effect of blood group AB on choriocarcinoma.

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A study in London showed that the risk of choriocarcinoma was higher in women with blood group A whose partner was blood group O than those whose partner was blood group A. The role of HLA antigen in trophoblastic disease has not been clearly established. In patients with hydatidiform mole HLA antigen typing in both the patients and their spouses showed no obvious histoincompatibility. However, there was a preponderance of HLA-A antigen in these patients with hydatidiform mole.

When the HLA antigen types for different parts of the world were examined it emerged that HLA-A was more common in those parts of the world such as the Far East, Mexico, and Greenland. In those parts the HLA antigens are more frequent than in other parts of the world. This would suggest some sort of genetic or immunological factor in the risk of developing hydatidiform mole. The full significance of the above observation of HLA-A and molar pregnancies remains to be explained and further investigations along this line are likely to be fruitful.

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6 Dawood, M Y, Jossy, V, and Lok, Y K, unpublished data.

** We thank Dr Dawood for pointing out our mistake. The London and Singapore series he refers to agreed about the lack of hydatidiform mole in Singapore and the above observation of HLA-A and molar pregnancies remains to be explained.

Medical training in developing countries

SNR,—May I comment on the important article by Dr B Senewiratne and his colleagues in your issue of October, p 27? My original support for the idea of altering the medical course in order to stem the flood of emigration and serve the needs of the developing country better (26 April, p 190) concerned the entire medical education and its basic structure. Medical education within Britain itself is in a state of flux, as the article by Dr J S P Jones on the Nottingham medical course (14 October, p 29) shows; should the teaching in developing countries be based on a probably outdated structure? The feeling even in Britain is more and more that the student must get out of the hospital and into the community; surely this is much more the case in the developing world.
To take three points specifically:

1. Curriculum. Certainly most diseases in tropical countries are “non-tropical,” but this should not imply that the spectrum there resembles that in Britain. The diseases are predominantly those of poverty, for whose management a community approach is essential. Is this inculcated in the usual British perspective? To take an example: faced with a child suffering from malnutrition the British-trained doctor’s response is to admit to hospital and commence milk supplements and vitamins, then discharge the child when improved. The more appropriate response, for which a differently directed training is needed, is to treat mother and child outside hospital in a nutrition rehabilitation centre and, together with agricultural workers, teachers, and others, to attempt to improve the nutritional standards of the area.

2. Preventive medicine. A sharp distinction is drawn between this and curative medicine, the former to be the preserve of public health personnel, the latter that of doctors. Is such a distinction not more likely to lead to the lowering of standards that is suggested since it will fail to appear that those prestigious doctors are not interested in prevention? Is not an integrated approach more desirable—with auxiliaries at rural level concerned with both prevention and cure, and doctors at district level supervising both? In this capacity the value of the teaching of management in the medical course will be appreciated (and this does not mean the same as administration).

3. Medical auxiliaries. The fear that they will eventually replace doctors will be obviated if co-operation is encouraged by joint activities during training and if the team approach is always promoted.

Medical students in a rich country are being prepared in a situation in which the consultation with a single patient is the ideal. This may happen in developing countries—were the few in the cities, and maybe for the majority in the far future; but at present the doctor’s main concern in these countries must be for the community, where the needs are the greatest. Education for the nation will not be inferior but may well be different.

Tony Waterston
Royal Hospital for Sick Children, Glasgow

Hospitals for the developing world

Sir,—Your leading article on “Hospitals for the developing world” (8 November, p 309) is excellent. There are some further details which should be considered as priorities.

The under-fives and their mothers will be the most urgent patrons of those in need of health care and supervision. But there should be no rigid segregation of the under-fives. The success of medical care and supervision is greatly enhanced by continuity—through the age and school age—together with continuity through episodes of sickness and health and continuity through hospital, health centre, and home. Continuity must be encouraged through the attendance of those in the school age, together with the attention to and the confidence in family care.

The article mentions “a separate health and nutrition rehabilitation unit.” These are better not separate but closely annexed to the hospital or health centre, where convalescents can be kept under informal but continuous supervisory and education conditions.

Rooming-in for maternity patients is essential and so is, whenever possible, the admission of the mother with the sick child. If, however, the conditions may be, the doctor, nurse, or medical auxiliary in charge should learn to use and rely on a microscope.

Cicely D Williams
London SE24

Trainer-teaching techniques

Sir,—It would be unfortunate if Dr C Joseph’s letter (25 October, p 224), which was almost unreservedly supported by four out of five subsequent letters (8 November, Vocational training is still in its infancy, and organised trainers’ courses. It has always been easier to destroy than to build.

Dr Josephs concedes that trainers’ courses are necessary, as surely he must, for only the young will come to teach without first learning how. He jibs at educational jargon. An educationalist might equally jib at a letter I had today from an ophthalmic surgeon who contained the words “hypermetropic astigmatism,” “amblyopia,” and “slowing in her vertebrovascular circulation” in just a few sentences. Words are not necessarily wrong when we do not understand what they mean. The list of jargon he quotes can be translated freely as, “allow the trainee to develop his own potential, don’t force your ideas on him, test his progress, and if he is not progressing well you may have to learn from your fellow-teachers to modify your teaching methods.” Is that not reasonable advice?

He complains also that the plenary sessions invariably failed to reach a conclusion. Vocational training is still in its infancy, and all ideas for improving it are welcome. Is it not better to offer a choice of ideas and methods than to insist “you must do it my way”?

C W Savile
Eastbourne

Sir,—Dr C Joseph’s letter (25 October, p 224) illustrates three points: (1) that excellent teachers are born, not made, and do intuitively what others have to learn to do; (2) that they, in common with other leaders of their profession, run so fast that they forget to look back to see if the rest of us are following; and (3) that those who learn best from didactic teaching tend to rise high up the professional ladder and then perpetuate the conditions (including the choice of the method, because his approval so greatly affects his learning, and (b) the measurement and assessment of the knowledge, skills, and attitudes acquired during the training period and the years that follow.

In contrast to Dr Josephs, on my course of one-day-a-week for 30 weeks, I learnt a tremendous amount. Not only a variety of teaching methods (including a judicious use of the didactic method) and the knowledge that I must learn to be flexible to suit the needs of the subject, the trainee, and the community, but also a new insight into my own thought processes, attitudes, prejudices, etc. Even if it could be proved that I am no better as a trainer, I would insist that I am a much better doctor as a result of the course.

Perhaps the difference is that Dr Josephs is a giant whereas most of us are not and some of us are even intellectual pygmies. What part the lesser fry should and will have in the vocational training schemes remains to be seen, and even the most devoted enthusiasts of modern methods agree that the case is as yet not completely proved, yet surely all of us should still be capable of learning. If over the years we, the recipients of old-style teaching, have become incapable of continuing and continuing learning is this not the most damning indictment yet of the old didactic system?

R J L Davis
Dover

Sir,—I was very interested to read Dr C Joseph’s letter (25 October, p 224). From my own experience as a trainee in 1966–7, I feel that having the trainer singlehanded, assisted at that time only by a part-time practice nurse, and his teaching technique was simple. He gave me only a few weeks’ and one eight day per week to do, and I also attended the local GP hospital and an industrial rehabilitation unit of which he was unit medical officer. I sat in on surgeries with him for the first few weeks and accompanied him on his visits on the first day. From then on I may have been physically on my own but I was always readily available in the background for advice and assistance.

He did not have the benefit of the present role explosion and had to get along without dynamic ongoing feedback or even total interview programming involvement. If he subscribed to the modern pretence that general practice is a specialty (how can something general be special?) he gave me no indication of so doing. He merely had a powerful and highly infectious enthusiasm for general practice, saying that it was what you made it.

But in that year I learnt at least as much as, if not more than, I had learnt in six years at medical school and two years of house jobs put together.

M G Barley
Brighton

Medicine and pharmacy

Sir,—I wish to compile a list of persons with dual qualifications in medicine and pharmacy. The reason is that I am frequently asked to suggest persons for various technical and professional committees, and there are times when it would be most useful to have a person with qualifications in both professions. For example, the Standing Pharmaceutical Advisory Committee consists solely of persons with pharmaceutical qualifications, but we think it is useful to have a member also qualified in medicine and have usually appointed someone practising medicine but having a pharmaceutical qualification (not necessarily a registered pharmacist). In this instance a general practitioner...