that the North West Thames document suggests four accident departments for the whole of greater London. The document, of course, refers to North West Thames region. I was disappointed to learn that Professor Yates believes consultants should concentrate only on ensuring an increase of middle grade staff, improving training of senior house officers, and organising their departments better. I hope there are many in the specialty who would agree that a consultant also has a clinical role, as in all other specialties. I for one did not enter the specialty to become a manager.

The specialty of accident and emergency medicine has made great strides in the past decade. We need now to make practical plans for the next decade so that trained accident and emergency specialists will take specialised responsibility for patients 24 hours a day. We cannot devolve our responsibilities out of hours and it would seem sensible to put our own house in order rather than have regional health authorities—or even, in the brave new world, purchasers—do it for us.

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1 Kirby N. Accident and emergency services. *BMJ* 1991;**302**:110. (12 January.)
2 Nuffield Provincial Hospitals Trust. *Confidential enquiry into perioperative deaths*. London: The King's Fund, 1987.
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Referrals to rheumatology

SIR,—Dr P S Helliwell and Professor V Wright conclude, in association with running a rheumatological referral unit, that better communication is required to prevent waste of resources.[1]

In dealing with issues such as waste of resources a wide view must be taken. At a general practice level I may have a patient who finds it difficult to accept his diagnosis of osteoarthritis. After referral to a hospital rheumatologist the diagnosis is accepted. The patient no longer consumes regular medical time, demands regular physiotherapy or other allied professionals' time, or insists on consuming large amounts of expensive drugs in the search for a "cure." Clearly, in terms of resources, the referral is appropriate. In spite of this it is acknowledged that the hospital rheumatologist may well feel frustrated at seeing yet another patient to whom he has little to offer.

Communication, like education, is a two way process. If communication is to be successful it must be relevant. A hospital rheumatologist teaching hospital rheumatology to a general practitioner undertaking primary care rheumatology will never be well attended. But although hospital rheumatologists will readily give a lecture on rheumatoid arthritis, they have only lately become interested in the ubiquitous osteoarthritis—a fact acknowledged by Professor Wright earlier.[2]

This new interest is responding to a need. The need is apparent in the work by Billings and Mole, who found that the vast majority of patients referred for musculoskeletal conditions were suffering from non-inflammatory diseases.[3] Does the problem lie with those referring or with those who offer a service that is ill matched to requirements?

These issues concerning the interface between primary and secondary care rheumatology are currently being considered in Britain. Some five years ago the Primary Care Rheumatology Society was founded by general practitioners. Part of its aim is the improvement of communication with hospital rheumatologists. It is an active affiliated member of the British League Against Rheumatism.

With the enthusiastic support of many hospital rheumatologists the society holds two national conferences a year, is currently involved in research and educational initiatives (including the formulation of a distance learning package), and has a permanent central office and staff. The clearest indication of its drive to improve communication is the formulation of consensus meetings. These focus on a shared issue, such as the use of second line antirheumatoid agents in general practice, and lead to the formulation of protocols by equal numbers of general practitioners and hospital rheumatologists. These are then published and used as a basis for a series of regional and district meetings of the local rheumatology team and general practitioners.

So much of what is hoped for by Dr Helliwell and Professor Wright is already under way. The society acknowledges the support of the Arthritis Rehabilitation Centre, of which the professor is an active member.

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1 Helliwell PS, Wright V. Referrals to rheumatology. *BMJ* 1991;**302**:304-5. (9 February.)
2 Wright V. Osteoarthritis. *BMJ* 1989;**299**:1476-7.
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SIR,—It is good to see the *BMJ* taking arthritis, the major cause of physical disability in the United Kingdom, seriously.[1,2] Arthritis Care receives thousands of letters and telephone calls from people seeking advice and reassurance; some are desperate to be referred for a consultant's opinion—and need to be.

A poll by NOP Market Research Ltd in September 1990 showed that a quarter of people over 40 with arthritis thought that their general practitioners were indifferent or unsympathetic. It is against this background that so many people turn to Arthritis Care for advice on their rights to a second opinion. More medical education in rheumatology, at undergraduate and postgraduate levels, would be an important step forward.

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1 Helliwell PS, Wright V. Referrals to rheumatology. *BMJ* 1991;**302**:304-5. (9 February.)
2 Ennals S. Understanding benefits. *BMJ* 1991;**302**:160-2,284-5. (19 January, 2 February.)

SIR,—To audit our rheumatological health promotion clinic we conducted a telephone survey of patients suffering from rheumatological disease as recorded by our index of disease in our practice population (total 8300 patients) and identified 39 patients, 23 seropositive and 16 seronegative. Two patients did not respond, showing a 95% response rate.

Of 28 patients under the care of rheumatological specialists, 17 were satisfied with the care that they received from their specialists. Of the 11 who were not satisfied, all were dissatisfied at travelling (60 miles) to the specialist and all preferred not to see his junior colleague and were particularly critical of seeing a different junior at nearly every visit.

We would therefore like to expand on the statement of Dr P S Helliwell and Professor V Wright that patients who continue to be seen by the hospital are a drain on hospital resources.[1] In our situation, 60 miles from the rheumatology centre, continued inappropriate follow up may also be a source of patient dissatisfaction.

In the rural areas particularly but probably all over the country there is a case for a peripatetic rheumatologist working from and in general practitioners' surgeries. He or she would be able to do domiciliary visits with a general practitioner colleague, which would give educational help, and see the patients who find it most difficult to get to a hospital based clinic. Such a rheumatologist would be a true "consultant."

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1 Helliwell PS, Wright V. Referrals to rheumatology. *BMJ* 1991;**302**:304-5. (9 February.)

Leptospirosis update

SIR,—We note with Dr Ian Ferguson that over 50% of cases of leptospirosis are of occupational origin and that warning cards containing simple advice can play a central part in alerting people to the risks.[1] Last year the Health and Safety Executive published such a card, "Leptospirosis—are you at risk?" Copies are available free of charge at any local office of the Health and Safety Executive.

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1 Ferguson I. Leptospirosis update. *BMJ* 1991;**302**:128-9. (19 January.)

SIR,—Our experience in Scotland during 1967-90 based on weekly returns from laboratories to the Communicable Diseases (Scotland) Unit shows similarities to that in England and Wales and also some differences.

Over the 24 year period there was a total of 179 cases of leptospirosis with a mean of 7·4 and a range of 1-15 infections per year. There were two deaths, one due to infection with *Leptospira icterohaemorrhagiae* and the other to infection with *Leptospira* spp. Three patients acquired the infection abroad; 140 were in the age group 15-65; the overall male to female ratio was 6·4:1. A seasonal pattern was noted, with the incidence of infections rising from June to a maximum in December. In addition, a cyclical pattern was evident over the 24 years, with a steady rise reaching a peak in the early 1970s followed by a fall in incidence over the next decade and then another rise to the present day.

Although in Scotland only 58% of isolates were serogrouped, in contrast to the 85% in England and Wales,[1] a different pattern of serogroup prevalence emerges. *L sejroe* serovar *hardjo* remains the most frequently reported (26%); *L canicola*, not seen in England and Wales, accounts for 16%; *L icterohaemorrhagiae* constitutes 13% of isolates; and other identified serogroups account for 3%.

Previous studies have also reported a higher incidence of infection due to *L canicola* in Scotland.[2,3] The incidence of *L canicola* infections in Scotland, most of which were in farmers and their dog contacts, does seem to be declining in recent years—the last reported case was in 1988.

In Scotland the main occupational group at risk from leptospirosis is farmers and agricultural

workers. We have not yet seen a rise in infections associated with recreational activities, which to date account for only 2% of cases.

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1 Ferguson IR. Leptospirosis update. *BMJ* 1991;**302**:128-9. (19 January.)
2 Ross CAC. Leptospiral aseptic meningitis (west of Scotland). *Communicable Disease (Scotland) Weekly Report* 1969;**3**(11): 15-6.
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Choosing a partner in general practice

SIR,—The paper by Drs Jennifer King and Michael Whitfield and the letter by Dr S G Barber and colleagues confirm the general opinion about which hospital jobs are desirable for general practitioners in training.[1,2] They do not, however, provide reasons why obstetrics, paediatrics, etc, are so desirable.

During a year spent as a trainee general practitioner in 1988 I recorded details of the most relevant specialty for each consultation. The most relevant specialty was the specialty that would be chosen for referral if it were appropriate to do so. For example, a 5 year old with otitis media was recorded as ear, nose, and throat surgery because if the condition were chronic referral would be made to an ear, nose, and throat surgeon rather than to a paediatrician. The table shows the results. Obstetrics was underrepresented because I was not at the time on the obstetric list, but an additional 138 consultations would have been required for this specialty to reach the top four.

Ten most common specialties required by trainee general practitioner

	No of consultations	% Of all consultations
Ear, nose, and throat surgery	714	19·7
Geriatrics	442	12·2
General medicine	369	10·2
Orthopaedics	356	9·8
Paediatrics	318	8·8
General surgery	302	8·4
Accident and emergency	283	7·8
Obstetrics and gynaecology	219	7·1
Dermatology	214	5·9
Psychiatry	190	5·3

From these data I conclude that would be general practitioners should have postgraduate experience in ear, nose, and throat surgery, geriatrics, general medicine, and orthopaedics as these subjects covered 52% of the workload. If paediatrics and general surgery are added the total is nearly 70%, whereas the six specialties suggested by Dr Barber and colleagues covered only 51% of the workload.

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1 King J, Whitfield M. How to choose a new partner in general practice. *BMJ* 1990;**301**:1258-60. (1 December.)
2 Barber SG, Staveley K, Down A. Choosing a partner in general practice. *BMJ* 1991;**302**:53. (5 January.)

SIR,—As an MRCGP cohabiting with a divorced MRCGP, both of us principals in general practice for over 10 years, I was interested that respondents to the survey in north Devon by Dr S G Barber and colleagues generally thought that single, divorced, and cohabiting doctors were undesirable as partners. It would be fascinating to examine exactly what "undesirable" meant for them. Surely not less caring or competent? Unstable? Subversive? Odd? Left wing? Homosexual?

For us, cohabitation rather than marriage has been simply a matter of personal style as we are not religious in the church sense and do not care to have the state define the terms of our relationship. Others cohabit for different reasons; everyone who marries does it in their own way too. One in three marriages are said to end in divorce. What, then, happens to partners who divorce after joining a partnership? Do they become undesirable?

Similarly people choose to be "single" for a multitude of reasons, including homosexuality for about 10% of the population. Single people are discriminated against in many ways by the prevailing couple mentality. They should not have to face this discrimination in the job market. Some of the most committed general practitioners I know are single people, some of them gay, and most do it all without the support of someone to cook, shop, clean, and wash for them.

Within the population as a whole one third of marriages end in divorce, 9% of households consist of single people under 65 living alone, and 7% of women and 13% of men cohabit.[2] These Devon doctors are making a moral judgment by saying they would rather not take on such people as partners, and they should perhaps examine closely what the implications of this are in terms of their attitudes to their patients, and the effects of this on the doctor-patient relationship.

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1 Barber SG, Staveley K, Down A. Choosing a new partner. *BMJ* 1991;**302**:53. (5 January.)
2 Central Statistical Office. Households and families. *Social Trends* 1990;**20**:35-43.

Twenty years of vocational training in Scotland

SIR,—As members of an orthopaedic unit in a Glasgow training hospital, we find the article by Drs Diane R Kelly and T S Murray[1] somewhat at odds with our local experience. General practitioners in the catchment area of our hospital regularly request from the consultant staff extra postgraduate instruction in the management of common orthopaedic ailments, and even in more specialised aspects of orthopaedic management. General practitioners often state that they wish they had spent more time in orthopaedics during their training.

Despite inquiries in the University of Glasgow's department of general practice and at the Scottish Home and Health Department, we were unable to uncover any data on the orthopaedic caseload of the average Scottish general practitioner, but accepted anecdotal figures suggest that up to a quarter of a general practitioner's caseload is either orthopaedic or rheumatological (back and neck pain and soft tissue disease). Orthopaedics is presently a list B post in vocational training and, as is evident from Drs Kelly and Murray's paper, few general practitioner trainees undertake such a post. As much of their caseload may well consist of dealing with diseases of the locomotor system it would be of benefit for more than the present 3% of general practitioner trainees to spend some time in orthopaedics.

With special reference to the orthopaedic training in the west of Scotland, the University of Glasgow has recently reduced undergraduate teaching in orthopaedics, from an eight week term in the penultimate year of a five year course to a three week attachment in the third and fourth years. A further week is spent in teaching in rheumatology. It is likely, therefore, that in future postgraduate training in orthopaedics will become more necessary.

We agree that general practitioner trainees should attend clinics in gynaecology; ear, nose, and throat work; and ophthalmology, but we strongly suggest that a period spent in orthopaedics at the postgraduate level is as important a part of a prospective general practitioner's vocational training.

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1 Kelly DR, Murray TS. Twenty years of vocational training in the west of Scotland. *BMJ* 1991;**302**:28-30. (5 January.)

SIR,—Drs Diane R Kelly and T S Murray made no suggestions for improving the lot of future trainees in Scotland.[1]

I would dispute their conclusion that "two years seems to be a reasonable period to spend in hospital training." As they themselves go on to state, trainees are still treated as junior hospital doctors rather than trainees for general practice. This view was recently supported by Kearley.[2] I would also argue it is not just that "attitudes need improving and balances correcting" but that the creation and implementation of curriculums for learning and training of future general practitioners in hospital posts are required.

The trainee subcommittee (of the north west faculty of the Royal College of General Practitioners) together with the department of postgraduate medical studies organised two regional study days for trainees (in hospital and general practice posts) in November 1990, with the aim of defining such curriculums. Small group work with brainstorming, discussion, and debate led by the regions' course organisers led to the production of curriculum checklists for each of the following specialties: obstetrics and gynaecology, medicine or geriatric medicine, psychiatry, accident and emergency medicine, and paediatrics. I hope that these will be used in assessing hospital posts for suitability as training posts for future general practitioners, as well as being guidelines or prompts to trainees in these posts.

Attending clinics in gynaecology, ophthalmology, and ear, nose, and throat work was cited by our trainees as only part of their learning needs, being particularly useful to expand their knowledge base. Much more contact with general practice—patients, trainees, trainers, and staff—was thought to be a vital but at present deficient component of training in the "skills and attitudes"[3] appropriate for general practice.

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1 Kelly DR, Murray TS. Twenty years of vocational training in the west of Scotland. *BMJ* 1991;**302**:28-30. (5 January.)
2 Kearley K. An evaluation of the hospital component of general practice vocational training. *Br J Gen Pract* 1990;**40**:409-14.
3 Working Party of the Royal College of General Practitioners. *The future general practitioner: learning and teaching*. London: RCGP, 1972.

Proposals on dental anaesthesia

SIR,—Dr Adrian Padfield is not alone in his concerns about the provision of general anaesthesia for dentistry.[1] For many years we in north Clwyd have been advocating the development of general anaesthetic services in the community clinic environment using hospital based anaesthetic staff. In the local district general hospital there is