defined period, so that they will avoid the insecurity of not knowing whether they will become a fully fledged specialist until they obtain a consultant appointment. This insecurity has bedevilled the British system. Finally, the 52% of female medical students in the first year will be able to look forward to a probability of becoming a specialist equal to that of male students. This large pool of talent needs to be used even handedly, especially as medical training is largely subsidised by British taxpayers.

Articles and letters of unhappiness from junior staff have been published periodically in the British medical press throughout my professional life. The equivalent unhappiness is rare in the American medical press.

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1 Roberts J. Specialists in the United States: what lessons? *BMJ* 1995;310:724-7. (18 March.)

Coping with psoriasis

EDITOR,—Susan Weingarten's account of the realities and humiliations of having psoriasis provide a useful insight for anyone who cares for patients with skin disease.[1] The particular aspects that Weingarten emphasises accord closely with the results of two recent national surveys that used a standard questionnaire, the psoriasis disability index. In 538 patients in the Netherlands one of the highest scoring questions related to having to wear different types or a different colour of clothes (H H Haisma *et al*, sixth international congress on dermatology and psychiatry, Amsterdam, 20-22 April 1995), and in Britain 70% of 369 patients stated that their psoriasis had interfered with sport, including swimming.[2] Other high scoring questions related to having to take more baths, problems at the hairdressers, and problems caused by the treatment itself. Two fifths of patients answered that over the past month they had either smoked more or drunk more alcohol because of their psoriasis—echoing Weingarten's mother's comments. It is important for dermatology staff to discuss these effects of psoriasis with their patients and hence to formulate practical strategies to alleviate these problems.

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1 Weingarten S. Psoriasis—how we coped. *BMJ* 1995;310:1076-7. (22 April.)
2 Finlay AY, Coles EC. The effect of severe psoriasis on the quality of life of 369 patients. *Br J Dermatol* 1995;132:236-44.

Malaria prophylaxis

EDITOR,—I have concerns about the recommended wider use of mefloquine as prophylaxis for British travellers advocated in a recent Fortnightly Review.[1] I am currently responsible for and supervising some 250 mining engineers and their families based in west Africa who have been using mefloquine prophylaxis. Side effects have often occurred in this group with such a frequency that more than 162 people have developed problems, which include malaise, lethargy, headache, and dizziness. The symptoms have presented not only within the first few weeks but sometimes after 6-8 weeks of use.

Dehydration seems to increase the frequency of side effects and is a particular problem for subjects working out of doors (175 or 70% of the workforce). Some wives (80 in all, representing 50%) are not taking mefloquine. Their religious beliefs prevent them from taking contraceptives; they would therefore be at risk of conceiving while taking the drug. Their alternative regimens complicate family prescribing. Medical authorities in these African countries have been reticent in introducing mefloquine to delay the onset of resistance to drugs, as seen in South East Asia.

We also exclude subjects who operate vehicles, aircraft, and machinery from using mefloquine, which again restricts its use in our practice. Advice given by the United Kingdom Civil Aviation Authority also restricts the use of mefloquine in pilots.[2] I therefore have reservations about the wider use of mefloquine because of its toxicity and think that its introduction may have the same consequence as the adoption of Fansidar as a prophylactic.

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1 Bradley DJ, Warhurst DC. Malaria prophylaxis: guidelines for travellers from Britain. *BMJ* 1995;310:709-14. (18 March.)
2 United Kingdom Civil Aviation Authority. *Air information circular 2/95*. London: UKCAA, 1995. (Pink [Medical] 107, 12 June 1995.)

Vitamin E deficiency

EDITOR,—Minerva suggests that vitamin E is a vitamin without a deficiency disease.[1] This is incorrect. In both children and adults vitamin E deficiency has been shown to cause a progressive neurological syndrome, consisting of cerebellar ataxia, posterior column loss, and peripheral neuropathy.[2] Importantly, treatment with vitamin E may halt the progression of neurological symptoms. Doctors should be aware of this and should check vitamin E concentrations in patients who have this constellation of features without a known cause.

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1 Minerva. *BMJ* 1995;310:1080. (22 April.)
2 Harding AE. Vitamin E and the nervous system. *Crit Rev Neurobiol* 1987;3:89.

Unified training grade

Purchasers cannot put the cart before the horse

EDITOR,—Trevor J Bayley suggests that, during their negotiations with trusts, purchasers of services should insist on an increase in the number of consultants in specialties in which the number of career registrars exceeds likely demand.[1] Without this, he states, the many efforts to improve specialist training in Britain will have been for nought.

Firstly, the function of purchasers is to assess their population's health needs and negotiate the delivery of relevant health care interventions from appropriate providers. As in other purchaser-provider relationships, the planning of staffing levels, medical or otherwise, is a matter not for the purchaser but for the provider of services.

Seondly, if expansion of a particular specialty is genuinely needed in any location then purchasers should be calling on trusts to develop those services independent of the number of career registrars. It would be wrong, however, for purchasers to seek, let alone insist on, new consultant appointments in specialties in which they are not needed. For Bayley to suggest that they should do so is simply special pleading. It would be a dereliction of their duty to secure the best balance of health services for their population if purchasing authorities sought these new appointments simply to provide secure employment for people who found themselves in the unfortunate position of being career registrars without specialist registrar posts to move to.

The simple fact is that possession of a registrar post has never been a guarantee of progression to senior registrar and consultant employment. In the past many hundreds of doctors have reached a considerable degree of skill in their specialty (often holding higher degrees) at the registrar level but have been thwarted in their attempts to get senior registrar jobs purely for reasons of an imbalance of staff.

To state that without this special treatment of current career registrars the many efforts to improve specialist training in Britain would have been for nought is absurd. The improvements resulting from the implementation of a unified training grade and the increased emphasis on training that go with it will be of enormous benefit, whether or not all current career registrars find specialist registrar posts.

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1 Bayley TJ. Unified training grade. *BMJ* 1995;310:1020-1. (22 April.)

Expanding consultant numbers is not enough

EDITOR,—Trevor J Bayley suggests that the unified training grade will improve the lot of senior house officers and registrars.[1] What matters is not what they are called but whether they hold recognised posts in organised training schemes and can find jobs on accreditation.

I disagree with his statement that a simple, sudden expansion of the number of consultants can be the key to successful implementation of the system. In some specialties this may be feasible, but in surgery, at least, we face considerable problems. We could achieve a small expansion by promoting senior registrars and some highly experienced registrars, but what of the trainees of the future? Our latest trainees are expected to acquire the experience necessary to become consultants in roughly half the number of years that their predecessors served, while working fewer hours each week. The aim is laudable, but how is this to be achieved, especially with increasing demands for a consultant based rather than a consultant led service?

I suggest that trainees can reach the level of current NHS consultants so quickly only by means of increasing subspecialisation and a total reorganisation of our present system. Current trainees are scattered among large numbers of hospitals, each providing a broad based service to a relatively small population, thus diluting the trainees' experience. I believe that we should concentrate all emergency and major elective surgery in units serving much larger populations than the current district hospitals serve. All trainees would be based in these units, with their constant throughput of specialised cases and where periods on call would provide worthwhile experience. Patients with more routine problems could be managed more efficiently in the remaining hospitals in the absence of conflict with emergency services, and visiting trainees would again benefit from the greater concentration of routine cases in regular sessions. I see no reason why these principles should not apply to several other branches of hospital medicine.

Sadly, although our political leaders have in