dented opportunity to kill two birds with one stone, for community medicine desperately needs a role and prevention equally desperately needs a formal advocate within the Health Service. Without a determined effort to knit together these two loose threads of the report neither is likely to survive the economic rigours which lie ahead.

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Self-concern about health and NHS work load

SIR,—In its conclusions the Royal Commission on the NHS (28 July, p 290) states that "groups of the population, now uncaring for their health, might become more self-conscious and take a pride in it, reducing the burden on health services."

There are obviously no hard data to support the notion that greater concern for health would reduce NHS work load. Indeed, one might consider that *community* concern for health, as shown by the founding of the NHS, has *increased* work load in so far as it is at least partly responsible for creating an aging population.

I would suggest that greater individual concern for health, while decreasing the sociomedical problems related to lack of exercise, smoking, alcohol consumption, and the like, would go hand in hand with a greater demand for regular medical check-ups, more costly health screening programmes, and a generally increased desire for all the available expensive techniques of preventive medicine. While such an outcome might be no bad thing, it would certainly not decrease the burden on health services.

Indeed, greater self-concern for health would probably add to the problem of the aging population, calling for more facilities for geriatric care. Average lifespan might increase, but since death is inevitable and often to be preceded by chronic ill health there is no reason to speculate that such increased individual interest in health would in any way decrease the burden on the NHS.

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Occupational health in the NHS

SIR,—The Royal Commission and the DHSS have both strongly recommended the provision of occupational health services for NHS employees. There will be continuing difficulties in attracting occupational health physicians of the right calibre unless the salary of these physicians is aligned with that in industry.

Advertisements in the *BMJ* are for senior clinical medical officers, and not only is the top of the SMO scale £2400 below the scale recommended for 1980¹ but the annual increments are more than £350 (gross) less. Apart from salary scales there are no fringe benefits in the NHS, unless six week's annual leave (about one week more) can be counted.

The BMA must campaign for similar scales for doctors doing essentially similar work. Should this be unsuccessful, the *BMJ* should refuse to accept advertisements for these posts from area health authorities. Until at least some of these anomalies are resolved, not only

will the NHS be unable to recruit high-calibre doctors and nurses but the occupational health physician in the NHS will rapidly become a second class doctor, which I am sure is not BMA policy.

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¹ *British Medical Journal*, 1979, 3, 347.

Vocational training

SIR,—Until recently there has been surprisingly little comment upon the Vocational Training Act, a measure which seriously restricts freedom to practise.

Whatever the merits of specialist registration, general practice, by definition and in reality, is not a specialty and it should be open to any fully registered practitioner. A system of rotating internships, with or without a period of attachment to a general practice, has much to commend it and could be of advantage to the intending specialist no less than to the aspiring general practitioner; but it would be quite wrong if entry into such schemes were to lie in the gift of an appointed representative of the Royal College of General Practitioners. The public utterances of the college spokesmen and the articles published in its journal, for the most part self-evident truth disguised in jargon or pretentious rubbish, lead one to suspect that its activists have become divorced from reality.

The man-in-the-street—nay, even the woman at an Islington soirée—still says, "I am going to see my doctor" and expects to be attended by a competent and kindly, if irascible and eccentric, general practitioner. I have yet to hear a member of the public announce to friend or neighbour that he intends to go to the health centre in order to apply for the services of the primary health care team and I do not believe that he wishes to be interviewed by a role-playing team leader, still less counselled by an amateur psychosexologist or automated Balint model. We have witnessed the building of empires by fringe pressure groups: but empires are built to fall, and so we may hope that the destinies of general practitioners will not long remain in the hands of a small clique of zealots.

R D FRANCE

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SIR,—I have recently returned from many years in the mission hospital field, whither I fled in the 1960s to avoid the fate of practising clerical medicine in the general practices of that era.

It has been a rewarding life, and nothing would have dragged me back save the recently enacted proposals for vocational training, which threatened to make me redundant in mid-career. Now, as a principal in general practice, I see nothing has changed except the verbal dressing. GPs are still fulfilling their function of rationing hospital medical care and allocating sickness benefits for the DHSS. Their clinical responsibilities have if anything diminished with the passing years.

It is therefore depressing to see suggestions that vocational training should be extended to embrace the unsuspecting mission hospitals in Africa. The sort of doctor who feels so lacking in confidence that he needs three years' training to become a British GP is not the sort of

doctor who is going to fit well into a mission hospital, except possibly as an outpatient clerk. The work is demanding and requires a degree of clinical responsibility that many recent British graduates feel they are not qualified to accept. In fact, we have in the past few years tended to discourage UK graduates in favour of Australians and South Africans, as the British appear to lack any experience in the practical skills required, although their theoretical knowledge is often as astounding as their proliferation of certificates.

Much of this is due, of course, to the decline in the quantity and scope of clinical material available to the British graduate in training, and this has undoubtedly driven many of them into the sort of paramedical training that leads to the MRCGP examination. A course more unfitted to the practice of mission hospital medicine I cannot imagine.

I fear that we will be soon having mandatory five-year courses in mission hospital care from a newly formed Royal College of Tropical Physicians before our graduates, then aged about 60, will be allowed to work in Africa.

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Costs of unnecessary tests – and staff duplication

SIR,—Dr G Sandler (7 July, p 21) has cogently argued how £3598.72 per clinic per annum could be saved on useless investigations; for the NHS a saving of £1 651 422 is estimated. History taking, especially by an experienced doctor asking discriminating questions, is probably the most important basis for parsimony in diagnostic logic.¹

According to this valuable paper on a very important subject, a medical registrar or SHO assessed each patient at the first attendance. A return visit followed after a short interval, when the consultant did a complete reassessment. That unnecessary duplication of medical work—that is, by junior staff followed by consultant—does not seem to have been an essential part of the investigation: some of the savings could be explained away by the difference between the practice of an inexperienced and an experienced doctor. (There is also considerable economic loss in unnecessary visits by patients with or without escorts.)

Unnecessary duplication of medical work is very wasteful. If such duplication is standard practice in this clinic then either the registrar or the SHO is redundant—that is, a further saving of around £5962 pa (annual salary of SHO + registrar ÷ 2, to average the effect of a public RAWP) could be achieved; but that figure might be more fairly reduced by 50%, say, to allow for work by the juniors which is done independently of the consultant. (Of course, it is entirely understandable that a filtering system tends to be evolved in response to excessive pressure of work.) Such an estimate is a purely monetary approximation, of course, which is only a part of the frustration related to those SHOs and registrars who have poor prospects of promotion. With customary restraint, a recent *BMJ* editorial (19 May, p 1299) said, "The staffing structure in the hospital service—a distorted pyramid—is a scandal. . . ." Let us hope that this serious iatrogenic (in both senses of the word) disease,