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.

DAVID H STONE

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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.

J P M PENNEY

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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

Girton, Cambridge

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.

M HARRIS

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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,

being diagnosed with increasing frequency by social oncologists,^{2,3} will soon, though belatedly, receive radical social surgery.

C I PHILLIPS

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¹ Phillips, C I, and Wolfe, J N (editors), *Clinical Practice and Economics*, p 101. London, Pitman Medical, 1977.

² Phillips, C I, *Lancet*, 1973, 2, 33.

³ Working Party on General Professional Training (chairman: Professor I R C Batchelor), in *Postgraduate Papers 1970-72: Collected Reports of the Scottish Council for Postgraduate Medical Education*, p 59. Edinburgh, 1972.

Information about wanted persons and medical ethics

SIR,—My force medical officer has drawn my attention to the letter (4 August, p 337) from the chairman of the BMA Central Ethical Committee.

I should like to support Dr M J G Thomas in his concern that doctors might be persuaded to gather information about their patients and to pass on this information in the absence of either their patient's consent or a court order. In this force senior officers are well aware of the need for medical information to remain strictly confidential unless the patient gives signed agreement that it may be divulged, preferably to a specified person.

I am asking the editor of my force newspaper to publish copies of the letter from Dr Thomas and of this letter to ensure that all ranks are reminded of a principle on which we all depend.

A HAMBLETON
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Domesticated doctors

SIR,—Were Elizabeth Garrett Anderson still alive, she would surely shudder at the type II and type III "bleating" from Dr Ruth Ferguson in Nottingham (16 June, p 1632, and 4 August, p 337).

At least to her (as indeed to many other professional women and their organisations—for example, teachers), the answers would appear quite clear—full-time employment, with statutory nursery school provision by the employing health authorities; tax relief on domestic expenses incurred in the pursuit of one's profession; adequate maternity and paternity leave; and an expansion of the higher career grades. To demand anything less is merely to perpetuate the status quo.

JACQUELINE S CHAMBERS

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SIR,—I have read the recent correspondence about "domesticated doctors" with interest. While I accept (having sampled HM(69)6) that the available training schemes for us are imperfect I cannot agree with Dr Ruth Ferguson (16 June, p 1632; 4 August, p 337). I think that from the outset we must accept that if we marry and have children there will be a certain limitation of our careers. However, those people who are not sufficiently motivated and organised to work at least five sessions for postgraduate qualifications and training are

unlikely to gain sufficient expertise in any specialist field to allow them to work on equal terms with their full-time colleagues.

Surely within two or three years of qualifying most people have some idea of where their interests lie and which fields could be compatible with part-time training if that becomes necessary. I think that, in an age where something like 50% of doctors will be female, a little careers guidance and common sense would bear far more fruit than "finding niches" for women who do not have the foresight to carve them themselves.

ANGELA R CUNNINGHAM

London SW15

*.*This correspondence is now closed.—ED, *BMJ*.

New consultant contract

SIR,—I wish to endorse wholeheartedly the comments made by Dr P M O'Connor (28 July, p 276), about the concept of emergency recall fees for consultant and other medical staff being anathema to the profession. Having seen the process in action for two months and having sensed the degradation of status and stature involved, I must urge our negotiators to test medical opinion before renegotiating further terms.

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Reconciliation with HCSA

SIR,—The Hospital Consultants and Specialists Association was pleased to learn from Dr P J Hoyte's letter (28 July, p 277) that his motion at the BMA's ARM "to welcome a reconciliation with the HCSA," though slightly amended, was carried. The HCSA in turn would welcome a reconciliation and would be glad to make the first move.

We regret that previous attempts to reach agreement have foundered because of the reluctance by the BMA to accept the fact that HCSA members do not wish to be represented through a standing committee of the BMA—the Central Committee for Hospital Medical Services. The HCSA is the only independent organisation uniquely devoted to the interests of senior hospital doctors and our members will not allow their association to be swallowed up by the BMA. For these reasons and because the HCSA recognises the need to find a satisfactory solution we have been obliged to seek the help of an independent arbitrator—the Advisory, Conciliation, and Arbitration Service.

The DHSS is willing to give ACAS assistance in considering representation on the Joint Negotiating Committee. The HCSA will assist ACAS in every way to achieve a representative system that will gain the support of the vast majority of senior hospital doctors. In the light of the ARM's response to Dr Hoyte's motion we feel sure that the BMA too will co-operate fully in achieving this aim.

A B SHRANK
Deputy Chairman,
Hospital Consultants and
Specialists Association

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Specialist units and the allocation of resources

SIR,—The mutiny on the South Bank is not about overprivileged teaching hospitals: it is about the funding of specialist units. If the Lambeth, Lewisham, and Southwark Area Health Authority fails to blackmail Mr Patrick Jenkin into providing more money the most likely, and the least discussed, outcome is that renal dialysis and insertion of pacemakers will continue but economies will be made in the services for the old and mentally sick, as they are the section of the community least able to object.

This affair should stimulate the Secretary of State and the DHSS to think about the absurd paradox which arises when a specialist unit treats patients from other AHAs (or RHAs). The greater the number of patients who come from other areas the less money is available for the basic services in the area housing the specialist unit. Thus there is constant pressure on specialist units from administrators, community health councils, and local politicians.

The argument that all AHAs should be self-sufficient is quite untenable, since scarce and expensive skills and apparatus cannot be dispersed in a number of small uneconomic units. Nevertheless there has been great reluctance to identify and designate specialist units as "supra-area" or "supraregional." I believe that the reason for this lies in the administrators' dream that one day doctors and patients will give up the struggle, and all patients will meekly go to their local hospital without untidily crossing boundaries; or, better still, they will be told which hospital they can attend. If this ridiculous idea can be finally scotched we might make a little progress.

Perhaps this whole affair will stimulate discussion on the setting up of a workable method of charging the area in which the patient lives for specialist services received from another area. There is a precedent for this in the laboratory services. It is already clear that the RAWP formula and SIFT (service increment for teaching) are not relevant to this problem.

It is disappointing that the Royal Commission on the NHS became too concerned with the difficulties of the London teaching hospitals and did not seem to appreciate the problems of specialist units in teaching and non-teaching hospitals outside London. However, when discussing priorities they commented as follows: "But even after listening to careful explanations by representatives of the DHSS about the way in which the needs of particular priority groups are taken into account in the allocation of resources to health authorities, we remain mystified. We are bold enough to think that this is because there is some cloudiness in the Department's thinking about these matters, which are as important as anything in the Department's care."

JOHN BLACK

Sheffield 11

¹ Royal Commission on the National Health Service, *Report*, Cmnd 7615, p 56. London, HMSO, 1979.

*.*A joint working party has been set up by the royal colleges and the BMA to discuss with the DHSS the funding of multi-regional specialties (11 August, p 398).—ED, *BMJ*.