for people on the ladder to go abroad in case they lose their place. However, if these people are seconded as part and parcel of a rotational scheme of training they have the security of a job to return to, and this makes the idea very attractive. It is therefore very important that the respective universities do come to formal arrangements with specific places, whether in East or West Africa or even Saudi Arabia. Most of the teaching centres can easily afford to second someone from a group such as I have described, but the scheme could be very simply expanded by exchanging personnel, with increasing benefit to the developing country.

With Government support the extra money involved in such a scheme would be simply peanuts. The main problem is to avoid getting embroiled with politicians in both countries, but this should not be insuperable.

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Medical audit

SIR,—The need for medical audit has again been recognised by the LMC conference but no practical recommendation has emerged.

May I suggest that medical audit need have nothing whatever to do with supervising doctors in their work—rather we should be taking a closer look at what we are actually doing and evaluating its usefulness. Thus we should take a fresh look at the clinical management of the main diseases we encounter: firstly to study the natural history, then to find what intervention can modify this to the benefit of the patient, and then to see who is best placed to do this work, whether it be in general practice or in hospital. This logical approach would provide a more convenient, economical, and effective service to the community.

The obstetric services provide a shining example of this approach. Certain well-defined conditions arising in pregnancy have been recognised and a scheme of co-operation between hospital and general practitioner has evolved, each understanding the part he has to play in the recognition and treatment of disease arising in pregnancy. The system is under constant scrutiny (audit?) and is modified as new information becomes available. Communication is excellent, with the co-operation card providing instant feedback to both sides.

In contrast to this, the management of diabetes provides an example of confusion. There is no clear plan. Is this condition best managed by a diabetic clinic or by the patient's own general practitioner? At present it is a combined muddle and neither the patient nor the doctors know who is in charge; it is wasteful of valuable doctor and patient time and scarce NHS resources. Another source of irritation is the hypertension clinic, where patients with perfectly normal blood pressure continue to attend hospital unnecessarily.

There are many other examples of poor integration and organisation of our work. More genuine discussion between hospital and general practice is required before we adopt any form of audit.

GEORGE STRUBE

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Manpower

SIR,—The report of the BMA Council Working Party on Medical Manpower, Staffing, and Training Requirements, as published in the *BMJ* (19 May, p 1365), and your leading article "Registrars in the 1980s" (p 1299) appear to open out a further chapter of problems in respect of hospital staffing and the service needs of the vast majority of hospitals in this country.

(1) The essential message that the report gives us is that once again the service needs of our patients are to be tailored to the career aspirations of the trainee doctors wishing to remain in hospital practice.

(2) The second message, which is implied but not clearly stated, is that the whole concept of the team approach to specialist hospital medicine, especially in our district general hospitals, is to be changed to a more individual approach, although (very understandably) the true extent of this is left to the reader's imagination.

(3) The basic contradictions of the three progress reports remain unaltered and endorsed—namely, that on the one hand consultant work and standards would remain unaltered, while on the other hand the number of trainees should balance the available consultant career vacancies, although a subconsultant grade is rejected.

(4) Having already endorsed a fundamental contradiction in the practical implementation of the original staffing policy, the subcommittee, almost as an afterthought (recommendation J), talks about protecting the interests of senior NHS and academic staff by placebo negotiations aimed presumably at procuring some sort of monetary compensation. Alas, we have only too recently had an example of such efforts in respect of the new consultant contract.

(5) Perhaps many of your readers may not have quite appreciated the practical long-term implications of these recommendations—namely, that registrars may well suffer a reduction of around 35% or more, while we could expect SHOs to suffer an even more drastic reduction, by nearly 60%. Although the actual consultant expansion that would be required to meet such reductions in supporting staff, together with the ever-increasing service demands, is carefully avoided, I think we could place this at a very conservative estimate as being at least double the current numbers. We are assured that adequate funding (for all this means) can be expected to compensate for such drastic changes in the pattern of hospital staffing, although earlier on in the same document we are given absolute proof that even a modest 4% expansion of the consultant grade could not be achieved.

(6) I submit that a satisfactory staffing policy for our NHS hospitals can only be achieved if the following basic principles are observed: (a) Specialist services in hospitals must be based on a *team principle* and not on individuals, no matter how highly trained they may be. (b) The composition of such a team will of necessity vary from specialty to specialty but must be based on the service and other demands, and flexible norms will accordingly have to be worked out for individual specialties. (c) Within the team principle, we will have to balance the potential trainees to at least two career end points, bearing in mind that it is both illogical and

uneconomical to train all young doctors to a point beyond the normal service requirements.

I have attempted within the constraints of this letter to criticise constructively the BMA staffing proposals and have also indicated a possible solution to the current dilemma, and I trust the subject will attract the attention and debate it deserves.

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SIR,—As a consultant working in another "shortage" specialty, I write to support Dr J T R Bavin's comments (9 June, p 1559) on your leading article (19 May, p 1299).

Your solution for the disparity between a young doctor's expectations and the reality he finds—namely, a change in the consultant-trainee imbalance—accepts the persistence of the far more urgent and distressing imbalance between "popular" and "shortage" specialties. British medicine rightly glories in the element of apprenticeship in undergraduate and post-graduate training. Thus it is not surprising that we continue to produce doctors who competently deal with acute dramatic illness, since it is in these areas where most apprenticeship is undertaken. Two weeks on an undergraduate geriatric attachment is unlikely to change three years of adverse comment by senior doctors about the problems of the elderly and those who care for them.¹

The impartial observer must surely echo Dr Bavin's pertinent strictures on our profession's record concerning those patients unfortunate enough to have an "uninteresting" disease.

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¹ *The Times*, 15 June 1974.

Minor operations in general practice

SIR,—Dr J S Brown's article (16 June, p 1609) has shown not only the economy but also the possibility of doing minor surgery in surgery premises. The logical consequence of this is to abolish the restriction whereby GPs cannot charge their own patients for items beyond the normal terms of service. If GPs were allowed to operate on, and charge, their own patients, everyone would benefit and no one would suffer. All patients would have the choice of going to hospital and being treated free, as is now the case, or of paying their own GP for treatment if both were agreeable.

The first advantage would be that the patient paying would get his operation more quickly and at greater convenience. Secondly, those who could not pay would go to hospital and get their operation more quickly because there would be a shorter waiting list. Thirdly, the GP would have more job satisfaction and more pay. Fourthly, the surgeon would not be troubled by "minor ops" (often irritating) and would have more time for more complicated cases, and also be less stressed. The surgeons' fears that incompetent GPs would start doing operations beyond their abilities are groundless. No one wants to get into a situation which he could not cope with, especially before an awake patient. Finally, the Government would be pleased because it would save money.

But what are the "normal terms of service"? For years I have maintained that we need to