The task of the trio is often difficult and can be critical in the determination of a colleague's career. As for the acceptance of a fee, how unfortunate if this came to be measured in pieces of silver.

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¹ *BMA News Review*, 1979, 5(9), 72.

The forgotten men

SIR,—Qualifying in 1942, I took a surgical house post, and showing some surgical skill was invited to take a vacant surgical registrar post at the end of the year. I thus entered a reserved occupation, undertaking surgery possibly far beyond my capability for four years, first at the General Hospital in Birmingham and then at the Queen Elizabeth Hospital in the same city. In March 1946 I was directed to the Royal Air Force, which I served first as a flight-lieutenant and later as a squadron-leader/surgeon in India until demobilised in September 1947. There are many in my position who worked in a reserved occupation for the period of the war and later did their service time, brief though it may have been. Present regulations provide for half the period of war service to be recognised as pensionable—for example, service in the Forces from 1939 to 1945 represents an additional 3/80ths to their final pension.

So far no consideration appears to have been given to the "reserved" class. I and many others were directed into occupations to serve the community at much the same risk as those in the Forces. We could not leave these reserved occupations. Why should this group of "forgotten men" and possibly women not have their period in a reserved occupation recognised as war service, and added to any period of service they undertook?

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Clinical practice and community medicine

SIR,—Professor E D Acheson (6 October, p 880) suggests that community medicine specialists should have the opportunity of practising without their own specialty. This practice is rather uncommon in other branches of medicine and seems of doubtful merit. Certainly if I were a patient I would feel better served by a doctor who was engaged full time in the specialty appropriate to my illness.

The article shows that many doctors involved in community medicine have had several years' clinical experience prior to entering the field. This may indicate that their advancement in the clinical specialties was poor enough to make the second choice of community medicine (which is generally rather unpopular) appealing to many. If this is the case it is unreasonable that a "back door" entry to clinical work should be allowed, especially in certain hospital disciplines (the most popular choice among the community medicine specialists questioned) which are already fully manned with doctors expressing a *principal* interest in such work.

It may well be that an option to practise in a clinical field would encourage recruitment

into community medicine, and although those engaged in that specialty would seem to be in favour of such an option I wonder if their full-time clinical colleagues would be as enthusiastic.

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First things first

SIR,—Was Professor Norman Browse (15 September, p 682) writing as a surgical scientist or as a doctor simply expressing an idea when he described his plan for the future staffing of our hospitals? How did he determine that a consultant plus his house officer and the sessional support of someone in the hospital practitioner grade (albeit with some registrar experience) would provide adequate standards of care for the average hospital patient?

Frankly, I doubt that we should pay much attention to such pronouncements from the ivory towers because, rest assured, such changes will not affect the major teaching emporia. We have already seen the refusal by some to be RAWPed of their junior staff, and there is little chance that they will participate in any future policy for a reduction in junior staff or an increased consultant presence at the bedside. Nevertheless, the stage is set for a prospective pilot study, and if those who are agitating for changes in medical manpower can wait a little longer perhaps Professor Browse might show us how his idea works in practice, and how it truly affects patient care.

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Lack of flexibility in vocational training?

SIR,—For some time I have been aware that the control of vocational training for general practice has been taken over by a minority of very active doctors who have an almost fanatical zeal and rigidity. I have had an impression of empire building, but have hoped that I am wrong. I have, however, met a number of other general practitioners from various parts of the country, all concerned with vocational training, with views similar to mine. For five years, as a course organiser, I have voiced my opinions in my own region and as a result have come into sharp conflict with those who control vocational training here, and who seem to feel that there is no place for any view other than the "party line."

I applaud the high ideals and hard work of those who have improved the standard of vocational training over the years, but I am afraid that at present they are in real danger of losing sight of their objectives in the mass of educational jargon and apparatus they are using. There seems to be a total lack of flexibility in the use of modern educational methods in vocational training. Our trainees are required to learn in small groups, with audio and videotapes and with endless questionnaires. No account is taken of the fact that not everyone will learn most readily with all these gadgets. We are dealing with adult, qualified doctors, each of whom is an individual, and we must not try to force them into any educational mould. The educational programmes and methods which we use must be tailored to encourage each individual doctor to fulfil

his own potential in his own way, not to stifle him and make him conform to the pattern of a standard good general practitioner. In Stafford we have tried to apply this approach, using a high level of co-operation between hospital consultants and local general practitioners; and at times methods may have been unorthodox. I am sure that there is both room and need for vocational training schemes of this type, as there is for more rigid and formalised ones.

There must be standards by which trainers and training practices are selected, but these must not be too rigid. Before he has a trainee in his practice a trainer can reasonably be expected to have made some attempt to understand the basic principles of postgraduate education. Indeed, our postgraduate medical centre organised the original courses at Keele University for this purpose, but I feel that it is quite unnecessary to have to attend repeated small group meetings to keep up to scratch. Occasional refresher courses certainly, but our main job is to treat our patients, and this is what we should be doing. For most general practitioners the teaching commitment is secondary, although carried out with the same conscientiousness and individuality as the first.

I am concerned that the approval of a training practice can be withdrawn at any time and without any reason being given, even on appeal. While this procedure continues, I cannot see how an aspiring trainer who has not met with the approval of the powers-that-be can hope to improve himself. Most of us are prepared, when criticised, to look at the grounds for criticism and decide what we can change, but this cannot be done if we have no idea of what is being asked. The approach used by visiting teams to assess practices and training schemes has left a feeling of uncompromising arrogance with general practitioners and consultants alike. This does nothing to commend the college in the eyes of hospital consultants, who know a good deal about the clinical competence of general practitioners, and whose views on this might be of more use in assessing a potential training practice than, say, a detailed knowledge of its premises.

I realise that my views could become as rigid as are those I criticise, and I keep this point in mind. I am not trying to throw out the vocational training baby with the bath water, but hope that it will not be allowed to drown. I am deeply disturbed to find that we have, at the heart of postgraduate training for a large number of doctors in this country, an organisation which deals with its critics by elimination. Suddenly, Siberia seems to be much nearer.

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If I was forced to cut

SIR,—“If I were forced to cut,” please.

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*.*It seems that neither form is incorrect. If the first be distasteful, then we are sorry. Nevertheless, we have no desire to linger at the decline and fall of the English subjunctive mood, but prefer to accept the advice given in Sir Ernest Gowers's *Complete Plain Words* and get along without it whenever we can.—
ED, *BMJ*.