For those of us in the second rank of GPs, who are, of course, the majority, vocational training can undoubtedly be of great importance in moulding attitudes and in developing clinical skills. Unfortunately it can be manipulated to serve undesirable objectives. That so many of these courses are in the hands of zealots more concerned with the power game than with the careful development of their own practices is a matter for deep concern. The danger is that some trainees will become conditioned to an attitude that places a higher value on group discussions and on committee decisions, on conformity to a norm established on high, than on personal commitment to the care of one's patients.

Indeed, perhaps the biggest problem facing us today is that young doctors tend to be shielded for too long from direct and continuing acceptance of clinical responsibility for their own patients in their own practice. This commitment must be the ultimate goal of all training, and to defer its realisation unduly is a fundamental mistake.

Speed limits, and tests for learner drivers, have to be set with the objective of making the worst drivers as safe as possible; one accepts that. But the analogy should not be applied strictly to training for general practice, or we shall destroy that individuality and sense of personal commitment which is at the core of our work.

The imposition of a rigid three-year package, culminating in the membership examination as the sole portal of entry to general practice, in a service under the control of a monopoly employer would be a disaster for our patients. Dr Brown's letter underlines the real threat that just such a process is now taking place.

CYRIL HART

Peterborough PE7 3RH

The middle grade

SIR,—Since surgeons and physicians have to have assistants but train more than one successor during their life time, the career structure must by necessity take the form of a pyramid. I have never understood how this basic fact can be ignored. It seems to be accepted by other professions. Not every major becomes a colonel or every teacher a headmaster. But in medicine today everyone who has put a foot on to the bottom rung of the ladder demands a guarantee of promotion to the top.

It has not always been so. When I worked for the London County Council before the war, I met competent men who preferred a 9-5 (or 10-4) job to the atmosphere of Harley Street and the medical school. I remember a physician who because of a mitral stenosis wanted a quiet life, and a surgeon who did a very adequate cholecystectomy or hernia repair but whose passion for bridge filled up all the spare time which he might have spent on reading or on attending meetings. It was accepted that they would not set the Thames on fire and that they had exchanged a fairly limited salary for a more peaceful existence. I believe also that there was no shortage of applicants for such a grade. I knew several SHMOs who were perfectly happy with their lot. But nothing was heard of them, since it was not they who organised protest meetings or wrote letters to the press. The grade may

well attract a man who has difficulties with examinations or likes to get home to his children when he has finished his work.

A few months ago I listened to a BBC programme called "The Leader of the Orchestra." The duties of this man were described (rehearsals) and his position (spokesman for the orchestra and sometimes mediator between it and the conductor), and then finally the interviewer felt obliged to ask the awkward question: "How did they feel about not having reached the top?" The replies were much in line with my thinking. They were given by people to whom a quiet life of an orderly foundation had greater attraction than the hectic glamour of the star performer with its richer rewards but its nervous strain.

The value of such appointments to the hospital service has been amply described by Professor Norman Browse (15 September, p 682) and I need add nothing to that. I will be told that an assistant grade could easily be abused. But any relationship can be abused, and I am not particularly impressed by this charge because I have heard junior staff complain alternately that the chief "never lets them do anything" or that he never turns up and that they "do all the work." What I would admit is that it is the detractors who get the publicity nowadays, whether their subject is marriage, parents and children, or medical career structure. It was the detractors' sneer about cut-price consultants which led to the end of the SHMO grade, a grade of the greatest value to the hospital service and one which can give immense satisfaction for that very reason.

E G HERZOG

Sheffield

Medically qualified preclinical academics

SIR,—A report on medical academic staff (14 July, p 146) mentions that the Vice-Chancellors and Principals Committee is examining the possibility of medically qualified preclinical staff being offered clinical appointments. I would like to point out that a concurrent clinical attachment should not be the prerequisite for a better income. Many such academics are primarily inclined towards basic research, and indeed contribute significantly to medical knowledge. The research output of these valuable workers will be hampered by this new responsibility, which would be regarded as a form of "moonlighting."

The award of an equitable remuneration should instead be based upon the simple and obvious fact that medically qualified preclinical academics play a vital role in the professional training of medical students.¹ In view of the rapid scientific advances and increased curriculum loads nowadays, only such academics have the competence to rationalise, select, integrate, and teach effectively those basic principles which are relevant to professional requirements. We have only to recall our own preclinical experiences to realise that much of what was essential was invariably taught by medically qualified staff; their professionally orientated guidance not only facilitated learning and generated interest but also provided a sound and lasting foundation for the clinical subjects.

Commonwealth universities also have difficulty in recruiting medically qualified pre-clinical teachers because of poor salaries in

comparison with clinical scales. The well-known unsatisfactory effects of this deficiency need no elaboration. Only one Commonwealth university in the Far East, to my knowledge, laudably attempts to minimise the salary disparity by awarding a "medical allowance" to attract and retain medically qualified preclinical academics; but no clinical attachment is necessary.

Administrators often voice concern over the serious shortage of medically qualified preclinical teachers and yet, pathetically, lack the foresight to tackle the real root of the problem. Policies appear to be influenced by non-medically qualified key administrators who presumptuously decide the preclinical needs of the medical profession. An example of this is the grossly unsound opinion of the Department of Education and Science that a medical qualification is not needed.

We must unite in pressing for a satisfactory solution and make it clear that all decisions on our professional requirements are entirely our responsibility. I am sure that all medically qualified preclinical teachers in Commonwealth universities will be following with great interest the achievements of the Medical Academic Staff Committee.

C W OGLE

Department of Pharmacology,
Faculty of Medicine,
University of Hong Kong,
Hong Kong

¹ *British Medical Journal*, 1979, 2, 146.

² Lewin, W. *Journal of the World Medical Association*, 1978, 25, 76.

Consensus management

SIR,—Professor G P McNicol's comment on consensus management (6 October, p 844) prompts me to invite him to come to Dundee. We think that he will find an executive group which is neither mediocre, indecisive, lacking in imagination and drive, or prone to shilly-shallying and procrastination.

We could not identify a prima donna in our mixed sex group, but what we do have is a sense of humour which enables us to take such generalisations in our stride.

G G SAVAGE

Secretary, Tayside Health Board

Dundee DD1 9NL

Medical examination for elderly drivers

SIR,—I would like to be enlightened about the present situation between the BMA and the motor insurance companies over this matter.

Some years ago I wrote to the BMA about this and received the reply that negotiations were difficult but in hand. Since then I notice an increasing number of the elderly, hesitantly proffering their report forms which all contain the sentence "any fee charged must be payable by the policy holder." Some companies, with crocodile tears, have inserted the word "unfortunately." Surely, this unsatisfactory, embarrassing, and sloppy state of affairs has gone on long enough.

I feel strongly that this examination should be paid for by the insurance company that requests the certificate, and I do not understand why this is not the norm. After all, these insurance companies have all had hundreds, if not thousands, of pounds in premiums from their senior citizen clients in

the past. It is amusing to compare their inability to pay for this service with the alacrity with which they press payment for life assurance reports and examinations, often even before the work has been done, so as to get the junior citizens on their rolls.

I submit, therefore, that there is a strong case for our negotiators to remedy this situation. The very debatable point of whether this work should ideally be done by the patent's own GP or an independent doctor is surely a separate problem.

J R GREAVES

Eassey, Kent CT13 OHQ

Advertising for locums for one week or less

SIR,—I write in response to the question why hospitals advertise for locums for a period of a week or less (13 October, p 941).

Essex County is a self-respecting hospital where all doctors employed work hard and employ their time fully. Providing internal cover usually would create such a drain on what previous free time any have that the pressure would be intolerable. I am at present a house physician here working on a busy one-in-two rota. In my case "providing internal cover" would involve doing two people's jobs. This is entirely impracticable, not to say inhuman. Your correspondent should have thought a little more carefully before accusing the NHS of wasting money.

Admittedly, locums are paid at somewhat exorbitant rates but such rates should be reduced rather than attempting to provide internal cover. Overstretched doctors do not give of their best and patients suffer as a result, which is surely to be deprecated.

G PFARRER

Essex County Hospital,
Colchester, Essex

Saving money on the drug bill

SIR,—Does the Health Service need more money or better management? Clearly it needs both, but it has become fashionable to argue, even in socialist journals like the *New Statesman* (see the recent article by Ruth Levitt,¹ that the latter is more important than the former. I do not subscribe to this view. Though further economies are possible, by and the large the Health Service gives good value for money. Far from spending too much on health, Britain spends too little, particularly where capital construction is concerned. The urgent need at the moment is to find some way of persuading the Government that it should exempt the Health Service from the savage cuts it intends to make in public spending.

Nevertheless, it would be foolish to deny that some waste exists, and in this age of stringent cash limits everyone who wishes the Health Service well must search for ways of saving money. I would like to suggest a method by which considerable savings might be realised in prescribing costs. This is to set a target sum each year to cover the drug costs of all the patients on a GP's list. If the doctor stays below the target, he should be allowed to keep one-half of the saving. Suitable reviews would have to be made to make sure patients received the drugs they required.

Something like this has been tried by an American insurance company to cover all the treatment patients receive and considerable savings have been realised in hospital costs. Provided suitable safeguards can be established to prevent neglect, the experiment seems worth trying in Britain.

FRANK HONIGSBAUM

London W2 5BS

¹ Levitt, R, *New Statesman*, 19 October, 1979.

The care of children in hospital

SIR,—All those who have the welfare of sick children at heart will strongly support the view expressed by the president of the British Paediatric Association welcoming the Marre Report (15 September, p 665). Although it is axiomatic that the hospital care of children should be in the hands of nurses as well as doctors whose training and first interest is devoted to children and their illnesses, the shortage of suitably trained nurses reaches crisis proportions, and I do not find the sanguine optimism of the General Nursing Council at all reassuring.

The present schemes for registered paediatric nurse training—a combined course for the State-registered Nurse and Registered Sick Children's Nurse qualifications, lasting usually three years eight months, and a 13 months' postregistration RSCN course for state-registered nurses—are unfairly discriminatory in that prolonged training and further qualification is without special recognition either in status or in pecuniary reward.

The arguments in support of general registration as a prerequisite for specialisation are that without it a proper career structure is lacking and that general registration is required for EEC recognition. The former argument may apply to those who aspire to the higher echelons of nursing administration outside children's hospitals, but it seems to me to be irrelevant when applied either to children's units in general hospitals or to children's hospitals. As for the second argument, according to my reading of relevant EEC regulations, general registration is established as the legally accepted recognition for general nursing throughout the Community, but even this qualification would not necessarily entitle a British nurse to work in another member state without a test of specialist or linguistic competence. Moreover, a British nurse with the RSCN certificate only would not be debarred from working in her own country or within the Nine, although in the latter case she may have to submit to a test of profession competence at the discretion of her prospective employer.

If the present serious and worsening shortfall of children's nurses is to be met, urgent changes must be adopted in their training and closure of RSCN schools reversed. I advocate the three following options. (1) Reintroduce a three-year training scheme for the RSCN certificate and accept this as the basic qualification of nurses working in paediatric units, with a salary and career structure similar to that for SRNs undertaking general nursing. (2) An optional extra year at a suitable general hospital would allow a nurse with the RSCN certificate to obtain the SRN as a post-registration qualification. Remuneration during this extra year

would be similar to that of a first-year trained nurse. (3) The present postregistration RSCN courses for state-registered nurses should be maintained.

I believe that I represent the views not only of many paediatricians but also of a large number of children's nurses in expressing strong dissatisfaction with the effects of the present training schemes, which seem to owe more to a slavish desire for bureaucratic tidiness than to the needs of sick children and the career aspirations of those who wish to serve them.

JOHN WILSON

The Hospital for Sick Children,
London WC1N 3JH

If I was forced to cut

SIR,—The proposals of "Dr Pilbrick" (13 October, p 905) include two which I find unacceptable.¹ Since it is easier to save £x from a budget of £100 than a budget of £10, you should start with the larger one.² Renal dialysis should be a prime target for cash limits.

Dr Pilbrick found that his renal physicians were treating more patients one year than the year before. Had they not been doing so they should have been sacked for incompetence or idleness. If dialysis and transplantation are successful the total number of patients being treated will rise from year to year until deaths equal new intake. Even countries which have striven to treat all comers for the last decade have not yet reached that plateau; Britain has provided a restricted service from the start and must be many years from achieving that target. Cash limits applied to the renal failure service mean that fewer patients will be accepted this year than last year although the number of candidates for treatment remains virtually the same.

This is a totally different situation from most other medical services; cash limits applied to the repair of hernias, the treatment of myocardial infarction, etc, will cause little hardship. Applied to cardiac transplantation they will restrict Britain to one heart transplant a year. If cash limits are not to ossify medicine in its present mould there must be willingness to run down present services in place of new ones. Dr Pilbrick rightly questions the importance of stripping varicose veins; so far I have kept mine unstripped; one of my relatives has had his done after 15 years of prevarication. There are some patients for whom it is a crucially important operation but for most it is of marginal importance. If we cannot provide a comprehensive health service there is something to be said for concentrating on catastrophic medicine and hiving off the less essential to private practice. We have rent rebates and similar allowances for the needy; it should not be beyond the wit of man to devise a reimbursement scheme for the needy who require stripping of their varicose veins. Whether we have the will is another matter.

DAVID KERR

Department of Medicine,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

SIR,—I read the ramblings of Dr Pilbrick (13 October, p 905) with increasing dismay. May I refer particularly to his attitude to his nephrological colleague, whom he apparently