fresh group of ulcer patients and controls. To use an analogy, if I see three cars with registration plates which all bear registration numbers below (say) 10, I would not be sensible to test if this was an odd distribution by comparing with a matched control of the next three cars; yet this is what Mr Thompson seems to have done. His answer may be correct; his method of examination does not seem to be.

M J S LANGMAN
DAVID HENRY

University Department of
Therapeutics,
City Hospital,
Nottingham NG5 1PB

Drugs for chronic diarrhoea

SIR,—The short report by Drs C D Shee and R E Pounder (23 February, p 524) confirms the widely held belief that one proprietary antidiarrhoeal preparation is much the same as another, but regrettably their study did not go far enough.

The first important question to be addressed is whether any of the preparations they investigated are effective at all. Their study showed that whatever drug regimen their patients followed they still had an average of 3.9 bowel actions a day, of which 72% or 73% were "loose." I do not agree that it would have been unethical to include a placebo in the trial. Two weeks of diarrhoea, while uncomfortable, is not likely to have any serious effect, particularly in this group of patients, and there would have been a high yield of useful information about the efficacy of the drugs under evaluation.

Secondly, it is a pity that the authors did not compare the effect of the "traditional" antidiarrhoeal drugs in their study with prostaglandin-synthetase-inhibiting drugs. There is good evidence¹⁻⁷ that many diarrhoeal states are mediated by excessive production of prostaglandins within the gut. A trial with simple aspirin or one of its analogues may be surprisingly effective in preventing chronic diarrhoea.

PAUL BUISSETER

Louisiana State Medical Center,
New Orleans, Louisiana 70112,
USA

¹ Cummings JH, Newman A, Misiewicz JT, Milton-Thompson GJ, Billings JA. *Nature* 1973;243:169-71.

² Gould SR. *Lancet* 1975;ii:988.

³ Mennie AT, Dalley VM, Dineen LC, Collier HOJ. *Lancet* 1975;ii:942-3.

⁴ Bennett A. *Adv Prostaglandin Thromboxane Res* 1976;2:547-55.

⁵ Robert A. *Adv Prostaglandin Thromboxane Res* 1976;2:507-20.

⁶ Buisseret PD, Youtlen LJF, Heinzelman D, Lessof MH. *Lancet* 1978;i:906-8.

⁷ Buisseret PD, Youtlen LJF, Heinzelman D, Lessof MH. *Monogr Allergy* 1979;14:197-202.

Investigating constipation

SIR,—Your leading article (8 March, p 669) mentioned a stricture complicating ulcerative colitis in a manner implying that such a stricture might well be benign. Two clinical dicta must be remembered in conjunction with that statement. A benign stricture in association with inflammatory bowel disease colitis nearly always means that the colitis is granulomatous and not ulcerative. A stricture in association with true ulcerative colitis is nearly always malignant and must be so regarded. Error in the former decreases

diagnostic accuracy; in the latter it may cost a patient his or her life.

JOHN FIELDING

Dublin 2

London's medicine

SIR,—The dermatologists working in the South-east Thames Regional Health Authority area are worried by the proposals in the Flowers report (8 March, p 731) on the relocation of the Institute of Dermatology and St John's Hospital for Skin Diseases, in a truncated form, at the new St George's Hospital, Tooting. They support strongly the letter of Dr R H Meara (29 March, p 936).

All of us, and this includes colleagues elsewhere in the Home Counties, lean heavily on the services offered by the institute and hospital. These include separate clinics specialising in the lymphomas, contact dermatitis, occupational dermatitis, leprosy, photo-dermatitis, and urticaria. St John's also has a large photochemotherapy department for patients with psoriasis; many district hospitals do not possess this facility.

While some form of rationalisation of both undergraduate and postgraduate centres is necessary and inevitable, some of the proposed changes seem to be irrational on both economic and demographic grounds, and will certainly—in our specialty—eliminate services which are not available elsewhere.

The journey from outlying areas of Sussex and Kent, and from the Greater London area to the centre of London, is one which most patients can reasonably undertake. Tooting and the site of the new St George's are relatively inaccessible. Likewise our junior medical staff with a heavy clinical commitment will be deterred from attending essential weekly seminars and lectures owing to the travelling time involved.

PATRICK HALL-SMITH

Chairman, South-east Thames
Regional Health Authority
Dermatology Subcommittee

Hove, Sussex BN3 3JD

Medical school intake and manpower implications

SIR,—The letter "Medical school intake and manpower implications" (22 March, p 859) by representatives of the collegiate members of three Royal Colleges of Physicians suggests that the intake to medical schools should be held static until a standing forum has been set up to provide continuing informed advice on medical manpower from student intake to retirement. This is a striking reversal of the sentiments that were widespread only a few years ago and that led to the conclusions and recommendations of such bodies as the Royal Commission on Medical Education to increase the output of medical graduates.¹

The high and rising prevalence of doctors in the past few years should not have come as a surprise. It could have been predicted. It has occurred in obedience to an epidemiological law—prevalence equals incidence multiplied by duration. The duration of doctors is about 40 years on average. The incidence, the number of new graduates each year, has increased greatly over the past 30 years. This is responsible for the profuse supply which is leading to a surplus. I have to confess rather ruefully that I did not identify explicitly the underlying epidemiological law in my publi-

cations on medical manpower, which began about 15 years ago²; but at least I can claim to have expressed scepticism about the recommendations of the Royal Commission on Medical Education regarding medical manpower.^{3,4} I wish I had been bolder; but then probably no one would have listened even if I had.

JOHN M LAST

Faculty of Health Sciences,
University of Ottawa,
Ottawa, Ontario K1V 6A6,
Canada

¹ Royal Commission on Medical Education. *Report 1965-68*. London: HMSO, 1968.

² Last JM. *Med J Aust* 1964;ii:244-52.

³ Last JM. *Lancet* 1968;ii:166-7.

⁴ Last JM. *Br Med J* 1969;i:769-72.

Protecting superabundant doctors

SIR,—It is widely believed that in the near future there will be a superabundance of doctors in Britain, and there are already signs that it is becoming less easy to find posts in general practice. Similar conditions prevailed 25 years ago, and at that time many stories of exploitation of young doctors were to be heard. The General Practice Reform Association was formed to try to combat such abuse as the assistantship with view in which the partnership never materialised, and partnerships that were offered on disadvantageous terms with long periods to parity. It was not very successful and was disbanded when the turn of events made its activities unnecessary.

It is our fear that although the structure of general practice today makes some of these abuses less likely other abuses may still be inflicted on too many young doctors competing for too few vacancies. Very shortly all entrants will need to have completed three years' vocational training and are all the more deserving of fair treatment and consideration by those of us who are established principals.

Is there any way in which a code of practice can be introduced which would perpetuate the present customs of a short period of mutual assessment followed by a reasonably generous starting share and not more than three years to parity?

R L S RICHARD

J P LESTER

Walsall, West Midlands WS1 1UG

Clinical complaints

SIR,—Mr William Russell's article (22 March, p 877) on the failure of Jack Ashley's Bill to allow the Health Service Commissioner to investigate matters of clinical judgment does not tell the whole story and should not be allowed to give us the feeling that the problem and threat are now over.

The public, represented by certain politicians and the House of Commons Select Committee, are anxious to see complaints about clinical methods and judgment investigated fairly without the need to start an action for negligence. The Joint Consultants Committee came up with a solution (two independent consultants investigating and reporting to the local regional medical adviser), which I am afraid will simply not be enough to satisfy what occasionally are legitimate complaints. There is also the pressure for automatic no-fault compensation schemes in cases of "medical injury" where negligence is not an issue. We doctors in turn are be-

devilled by the minor but growing epidemic of complaints about diagnosis and treatment—some of which go to court as negligence cases and where judgment may be against us for no more than errors of our own judgment. The campaign to reduce this trend may have been won (but I doubt it) after the Appeal Court judgment in *Whitehouse v Jordan*.

It is, therefore, fair to say that both we and the public could benefit from a change in legislation. Personally, I think it debatable, to say the least, whether no-fault compensation is a good thing: it would be expensive to run, but it might help doctors in the end, and it would certainly keep medical defence costs down.

Purely for debate and to provoke some thought on the matter, may I suggest the following scheme in cases where there is no question of negligence but where there is a complaint by a patient—for example, where disability is alleged as a result of treatment, and where personal contact between the doctor and the patient has not resolved the matter.

(1) Any inquiry must be under the authority of the Health Service Commissioner, and therefore totally independent of the local RHA and its officers, and the DHSS.

(2) The patient would have to agree in writing that the HSC's decision would be final and that no subsequent legal action would be entered into whatever the HSC's decision.

(3) The HSC would arrange in each case a tribunal consisting of a lawyer, a chairman, and two clinically active consultants advised if need be by a consultant in the specialty concerned; this would be very similar to a medical appeal tribunal. The patient's full notes would be available to the tribunal.

(4) The patient, with his advisor if he wished, would be seen and examined by the tribunal.

(5) The doctor(s) concerned would be seen separately to discuss the case with the tribunal.

The tribunal's report would be sent to the HSC to make a final decision and judgment and award compensation if suitable. Malicious and frivolous complaints could be discouraged by the awarding of token costs against the claimant, who would not be receiving legal aid.

To those who have followed the negligence saga too closely, this may all seem very far fetched but I believe some discussion on these lines will soon be essential. An articulate (even if ill-informed) section of public opinion is against us and we need to defend ourselves—but, equally important, we do have a real gain to make if we can get the negligence business tidied up and see courts used only for malpractice and not to punish honest errors of judgment.

J E WOODYARD

Staffordshire General Infirmary,
Stafford ST16 2PA

Exemptions from vocational training

SIR,—The consequence of the regulations of the NHS Act 1977 published in Statutory Instrument 1644 prescribing training for general practice are becoming evident. Doctors who have extensive experience of work in general practice as assistants or locums and who would have been ready for a principal post in the near future will have to comply with the training requirements.

When they planned their careers this legislation had not been considered, and the likelihood there would ever be anything like it may have been judged as remote for independent contractors. To ask them to embark

on training now is something of an insult. The Joint Committee on Postgraduate Training for General Practice (JCPTGP) may allow them a certificate of "equivalent experience" or the appeal body may uphold their appeal if the JCPTGP refuses, but this machinery is untried and utterly unpredictable. This retrospective effect of the new law must be a matter of concern as it is against natural justice.

The contemporary evidence from the majority of GPs advertising for new partners suggests that a vocational training requirement is a non-priority. An analysis of the advertisements in the *BMJ*s of 25 February, and 1, 8, and 15 March (the four weeks immediately following the training regulations coming into operation) indicates that 55% stated no training requirement, 22% mentioned vocational training, and 23% mentioned other training—most commonly obstetrics (total 153 consecutive advertisements). Thus the sample of GPs represented by the advertisers is not ready now to impose on successors the requirements to be demanded in future by the law.

These developments have to be seen against the rapidly changing circumstances in the labour market. The yearly increase in the number of doctors registering, and the number now emerging trained from existing vocational training schemes is fast increasing the competition for most vacancies. Existing principals and FPCs have the future standard of entrants firmly in their hands and its maintenance should be that much easier in future with the pool of experienced and trained doctors available.

All these factors taken together should at least promote reflection on the regulations. There surely must be a *prima facie* case for urging the Secretary of State to use his powers in section 32(3)(a) of the NHS Act 1977 to exclude from the provision of the Act all doctors who were fully registered on or before 9 December 1979. It is not too late to reconsider this matter at the Annual Conference of Local Medical Committees and at the Annual Representative Meeting this year.

JOHN D SINSON

Leeds 17

***The Secretary writes: "The GMSC welcomes the introduction of mandatory vocational training for general practice and would not support the exemption from the regulations of doctors who have hitherto been engaged in a different branch of medical practice. It believes that the possibility of obtaining a certificate of equivalent experience adequately protects those doctors with extensive service in general practice other than as a principal. Furthermore, it has requested that doctors who have worked for more than one year as assistants or locums, or who were principals more than nine years before the introduction of the regulations, should be enabled to enter a training scheme. (This is at present impossible under para 38.5(a) of the SFA.)"

Pension penalties for specialists in the NHS

SIR,—Many senior doctors with their retirement in sight within the next 10 years will find themselves considerably disadvantaged

in their pension arrangements. They are those who interrupted their employment in the NHS in order to advance their professional experience or to undertake research work within universities, either here or abroad, and returned to the NHS at a later date.

Even if they were far-sighted enough to make arrangements to freeze their contributions, or were out of the NHS for only a short time, they will find that they have lost all credit for their war service before the period when they first undertook to work for the NHS. Their colleagues who have worked only in the NHS can, in contrast, claim pensionable years right back to the time of their first job, plus their previous war-time service.

Those who find that their pensionable years have been unduly amputated in this way may wish to write to the Secretary, BMA Superannuation Committee so that the responses may be collated and submitted to the committee, which will be meeting later this year.

A ST J DIXON

Royal National Hospital for
Rheumatic Diseases, Bath

Crisis in Uganda

SIR,—Makerere University Medical School faces a crisis. It has been held in the highest esteem among the educational and research institutions in Africa, and indeed in the Commonwealth. It has not escaped unscathed from the troubles experienced by Uganda in the last decade but it survives, and great credit is due to those who have kept it alive.

Depletion of medical, technical, and maintenance staff, combined with economic difficulties, has resulted in a potentially reversible reduction in the service to patients at Mulago Hospital—a formidable problem for Uganda's Ministry of Health. Our concern is with the restoration of function and of recognition of the medical school. It has lost many senior teachers and urgently needs a rapid transfusion of doctors to teach the students and, even more crucially, the recently qualified doctors—the next generation of teachers.

The undergraduate and postgraduate students are a fine body of highly motivated and industrious men and women. In the last qualifying examination a large proportion performed well, despite the inevitable gaps in their training. Determination to maintain standards at high levels meant a lower pass rate than usual, but this is surely a sign of academic health. There was in these examinations no hint of tribal bias or political influence.

We have all visited Makerere in the last two months, and feel that the needs of the medical school can best be met by aid from outside. Britain and Uganda have enjoyed the closest ties in the past, and we would urge that Britain provide this aid. As few as six or seven senior lecturers, serving for a year or more, would greatly strengthen the departments in greatest need. We believe that such help would promote a speedy recovery by the medical school, to the immense benefit of the whole of Uganda.

J A BENNETT	J R MOORE
I R F BROWN	R SCHRAM
N MCD DAVIDSON	J P STANFIELD
H G EDGELL	D A TIBBUTT
G J FELLOWS	S D V WELLS

Makerere University Medical
School,
Kampala, Uganda