care, the number of patients who are assigned to generalists is far lower than the number Marsh proposes. Thus Marsh's statement that what should be done can be done in half the number of visits is not supported by the American experience. We have half the number of visits, twice the cost for the same level of care, and far less effective prevention than in the United Kingdom.

General practice in Britain is, with all of its faults, a model of efficient, personalised, accessible care compared with what is available in other industrialised countries. Unless there is a large pot of money in the British economy to pay for the increased numbers of nurses, educators, and other staff who are required to care for 4000 patients making half the current annual number of visits to their general practitioner, I suggest sticking with the present ratio of patients to general practitioners or risk the loss of a major asset of the NHS—the good will of patients toward their general practitioners.²

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1 Marsh GN. Caring for larger lists. *BMJ* 1991;303:1312-6. (23 November.)

2 Frey JJ. Making a visit: an American GP practising in the NHS. *BMJ* 1982;285:614-6.

Training in obstetrics

SIR,—I was pleased to see several articles in a recent issue devoted to the inadequacies of post-graduate training in obstetrics and gynaecology.^{1,3} It is a severe indictment of the specialty that a third of those who become members of the Royal College of Obstetricians and Gynaecologists then leave, having completed the worst phase of training, when work for examinations is combined with long hours of clinical duty.¹ I attended the meeting held to investigate problems with the present career structure that Susan M Blunt reports.¹ It was clear that one of the major hurdles facing trainees has not been recognised: it is presently almost impossible to train fully within the NHS to become a consultant.

Progression to senior registrar level is blocked if you do not leave the NHS to spend time in research. Blunt made only a passing reference to this, and a paper presented at the college meeting suggested erroneously that second degrees were unnecessary as few senior registrars had them. The wrong question had been asked. Almost all successful applicants for recent senior registrar posts have spent time in research posts whether or not they have completed their MD.

Registrars who have obtained their membership face difficulty and uncertainty in competing for charitable funds to support them in research unless they work in infertility or menopause clinics in the private sector. Most trainees suffer a large cut in salary during this period, which places a heavy financial burden on those with families to support. When they compare themselves with their contemporaries at university, comfortably established in general practice, many leave the specialty.

The college and the NHS management must decide whether they require all consultants in obstetrics to have research experience. If this is genuinely considered to be important, as I believe it is, it should be an integral part of our training properly funded by the NHS, which ultimately benefits. This would allow proper planning of projects, which would enhance both the quality of research undertaken and the benefits to the trainee. Research should not be just another means of weeding out the least tenacious trainees.

Those who are disheartened enough to leave the specialty deter many more from joining. The current system tends to select for trainees with

aggressive ambition and hence loses many with more caring qualities, an emphasis that the women in our care would doubtless reverse. In addressing these problems the college must clarify its attitude to research and ensure that training can be completed within the NHS.

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1 Blunt S. Training in obstetrics. *BMJ* 1991;303:1416. (7 December.)

2 Ennis M. Training and supervision of obstetric senior house officers. *BMJ* 1991;303:1442-3. (7 December.)

3 Smith LFP. GP trainees' views on hospital obstetric vocational training. *BMJ* 1991;303:1447-52. (7 December.)

SIR,—The question asked of trainees at a recent meeting at the Royal College of Obstetricians and Gynaecologists¹—"What's wrong with the specialty of obstetrics and gynaecology?"—has a relatively simple answer. There is nothing wrong with the specialty but a good deal wrong with its perception.

Input and dropout rates of trainees have been well documented in the college's manpower reports and the downward trend recognised. Many of the dissatisfactions highlighted by juniors confirmed earlier suspicions, and these have served to accelerate steps to improve the structure of training in the United Kingdom. But major changes take time. The college is already committed to organising structured training programmes, re-evaluating the training for and assessment of the MRCOG examination, and accepts that part time training and job sharing should improve the quality of life (a major issue, according to trainees).

The success of these policies depends much on the enthusiasm and commitment of trainers. Present consultants brought up on long, unrealistic hours of duty and years of residency may justifiably ask how their future colleagues will gain necessary experience from reduced exposure to acute problems and shortened hours of work. Surely the answer lies in a more methodical approach akin to that in the United States, where a licence for independent practice is usually achieved by the age of 33 after formal structured training but the specialist is then monitored by mandatory continuing medical education and even recertification—ideas already being seriously considered by the college.

Far from being inactive, the college is alive with fresh and innovative ideas aimed at raising and maintaining the profile of obstetrics and gynaecology, and the successful listening exercise, initiated by the president, showed an encouraging positive attitude. Finally, Susan M Blunt's call for increasing the numbers of consultants¹ is central to the success or otherwise of recruitment and retention in the specialty, and all concerned with training must seize every opportunity to persuade those with influence to accept this premise.

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1 Blunt SM. Training in obstetrics. *BMJ* 1991;303:1416. (7 December.)

Junior doctors' working practices

SIR,—I presume that the main reason for the proposed changes in junior doctors' working practices is to benefit those same junior doctors.¹ Yet when I talk to my colleagues the general impression I get is that shift systems will probably worsen our quality of life. Instead, why could not

the government have offered the following, which is what every junior doctor wants?

(1) Non-medical staff trained to carry out phlebotomy, intravenous drug administration, electrocardiography, portering, and routine clerical work and to find empty beds.

(2) Overtime pay equal to daytime rates.

(3) A half day off work after a busy night on call.

The government's failure to implement these demands boldly and swiftly indicates a brutality reminiscent of working practices in the nineteenth century.

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1 Beecham L. Juniors may still reject pay deal. *BMJ* 1992;304:10. (4 January.)

SIR,—As a junior hospital doctor, I believe that once again we are about to be let down by the BMA, on the issue of hours of work.^{1,2} What hospital management is going to agree to pay doctors 100% of basic pay for out of hours work in a full shift system when it can get away with paying 50% for an on call rota, with the additional cost advantages of employing fewer doctors and consequently fewer administrative costs and claims for such items as removal expenses?

Of course junior doctors would prefer to work fewer hours for the same pay, but in a system where—especially if the expected influx of doctors from the rest of Europe occurs—there are more doctors than jobs few will refuse to take a job because of the hours required and risk a period of unemployment with a gap in their curriculum vitae to explain.

The suggestion that prospective cover should be included in any agreement to reduce hours shows a complete lack of understanding of the situation. When all doctors take their full allowance of annual and study leave a 1 in 3 rota with prospective cover is a 1 in 2 rota for half of the time; a 1 in 4 rota with prospective cover is a 1 in 3 rota 70% of the time; a 1 in 5 rota with prospective cover is a 1 in 4 rota 86% of the time; and a 1 in 6 rota with prospective cover is actually a 1 in 5 rota for all but two weeks of the year, when it is a 1 in 4 rota. This assumes that doctors are covering the leave only of doctors on the same rota as themselves, that lieu days are not taken on on call days, and that no one goes off sick.

Until excessive hours are prohibited by the high cost to employers or legislation they will remain.

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1 Beecham L. Juniors may still reject pay deal. *BMJ* 1992;304:10. (4 January.)

2 Beecham L. BMA recommended "affordable" out of hours pay. *BMJ* 1992;304:57. (4 January.)

Corrections

Dogs that bite

A printer's error occurred in this letter by Simon N Voss and Hugh F Thomas (11 January, p 116). The final sentence of the second paragraph should have read: "A crude extrapolation . . . suggests that about four people per million of the population of West Midlands are referred to plastic surgeons with dog bites each year."

Heart valve records falsified

An editorial error occurred in this letter by Matthew Shiu (11 January, p 118). The fourth sentence should have read: "As the risk of valve replacement is currently much higher than that of strut fracture, explanation is not recommended."