not commit, bad though this may be, but because she spent 18 years in prison. She suffered from the sentence, not the verdict. Doctors cannot disclaim the consequences of their professional contributions.

In many countries a majority of the population supports capital punishment and a doctor's beliefs are a matter of personal conscience. It must, however, be a matter of public concern if medicine is contributing, even if at some distance, to injuring someone's health so lethally that the victim ceases to exist. There is an unbridgeable gap between that and what the ancients had in mind when, in composing the Hippocratic Oath, they wrote "Whatsoever house I enter, there will I go for the benefit of the sick."

The bottom line must surely be that doctors should not use their professional skills to influence judicial proceedings towards a guilty verdict when sentences might be expected to harm a defendant's health. Whether purists would say that includes prison sentences in this country's current penal system is another story.

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Preparing for a foreign fellow

EDITOR,—Having trained in very different health service, professional, legal, and social welfare systems (NG trained in India and AC in South Africa), we would like to highlight areas in addition to those outlined by Lindsay J Smith and Catherine Marraffa¹ where the need for information is essential to the successful integration of doctors coming from Third World countries.

Although the NHS may be well known in most parts of the world, few of us arrive with a working knowledge of its actual structure and hierarchy. The general practitioner as the gatekeeper for access to specialist care is by no means a universal model, and the relative absence of "walk in" outpatient clinics surprises many—as does the amount of communication and correspondence required between the primary and secondary care staff.

Intraprofessional hierarchies and job titles vary widely, and working in a multidisciplinary environment can prove difficult for the uninitiated. Statutory responsibilities, particularly under the mental health legislation, are likely to be totally unfamiliar. The problem, however, is wider than this, and the entire medicolegal framework may appear alien to the newly arrived doctor. Given the dilemmas faced even by those conversant with the system,² this should not be unexpected.

The royal colleges' overseas doctors training schemes now provide a focal point for the entry of many foreign graduates, and the Royal College of Psychiatrists has taken the initiative by addressing most of these issues in its recently introduced induction courses. None the less, there remain many entrants outside such formal schemes. We believe that those proposing to host such visitors should, in addition to Smith and Marraffa's "shopping list," also note the potential difficulties we have mentioned above.

This is not to say that visitors should not make their own preparations—Dan Veale provides an excellent example.³ In particular, psychological readiness to enter a new medical system at a position often lower in the pecking order than that occupied in the home country will go a long way towards improving peer relations and job satisfaction.⁴ Although working in a foreign country, living in an alien culture, and frequently using a language other than one's mother tongue will inevitably be a challenge, it is not necessarily

difficult to make an overseas sojourn one of life's most rewarding experiences.

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Pain during mammography

EDITOR,—I am astonished at the tone of D R Rutter and colleagues' paper on discomfort and pain during mammography.¹ They suggest that the pain reported by 6% of women undergoing mammography can be excused given that it had largely disappeared within 5-10 minutes; this is unacceptable as a reason for not acknowledging that for some women the experience is sufficiently unpleasant that they choose never to return, and tell their friends. I am sure that if male doctors had to undergo the same squeeze technique on their testicles because it detected testicular cancer early they would tell their friends and vote with their feet in the same way. Why not acknowledge that for a third of women the procedure can be anything from uncomfortable to exquisitely painful depending on the degree of premenstrual breast tenderness as well as the other reported contributing factors? The issue of adequate pain relief for the examination must be addressed, otherwise more and more women will forgo it.

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- 1 Rutter DR, Calnan M, Vaile MSB, Field S, Wade KA. Discomfort and pain during mammography: description, prediction, and prevention. *BMJ* 1992;305:443-5. (22 August.)

Euro exams

EDITOR,—Other monospecialist sections of the European Union of Medical Specialists have watched with interest the urologists' lead in setting pan-European examinations.¹ I look forward to seeing the results of these examinations and am interested to read that 10% of eligible urologists have applied to sit the examination so far. The cardiologists have taken a different view and have favoured a system akin to that already in operation in the United Kingdom—that is, approval of training posts and "accreditation" once a trainee has spent the requisite number of years in post.

There is general agreement that some form of accreditation is necessary for specialists in Europe. But I, and others, doubt whether an examination is applicable to all medical specialties. The variation in methods of assessment, however, is a healthy sign since we will be able to learn from each other's mistakes.

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- 1 Euro exams. *BMJ* 1992;305:13. (4 July.)

EDITOR,—The urologists and anaesthetists are not alone in seeking to bring some standardisation of training in different European countries.¹ The European Society of Medical Oncology, comprising some 1500 members from 35 European countries,

is particularly concerned to ensure the highest possible standards of training for cancer physicians throughout Europe.

In 1989 we instigated a certification process for medical oncology on the basis of a review of the applicant's curriculum vitae and passing a multiple choice examination. The examination has been set annually since 1989 and despite being available only in the English language has proved popular. Already over 400 oncologists have been certified.

Great Britain is most fortunate in having the college structure to monitor training and the guidelines from the Joint Committee on Higher Medical Training of the Royal College of Physicians are being used to assist colleagues in other European countries to devise appropriate training programmes.

Medical oncology is recognised as a discrete subspecialty of internal medicine in only a small proportion of European countries, and consequently many non-specialists find themselves involved in treating cancer. The narrow therapeutic index of systemic therapies for cancer makes this situation highly undesirable on both health and economic grounds. The European Society of Medical Oncology is seeking recognition for medical oncology throughout the European Community and encouraging the development and monitoring of training programmes.

Clearly, examination is only one method of assessing standards of competence, but it is hoped that the initiative taken by the society will contribute to lessening professional discrepancies between oncologists in the European countries and improve the level of oncological training throughout Europe.

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- 1 Euro exams. *BMJ* 1992;305:13. (4 July.)

Americans and SI units

EDITOR,—Magne Nylenna and Richard Smith make too much of our decision to use both conventional and SI units, in that order. Certainly, it stretches things quite a bit to see it as "akin to the WHO deciding that trying to eradicate polio is just too tiring." The purpose of our decision was simply to permit our American readers to understand the data we publish—not an unreasonable goal for a journal. It was a pragmatic decision, not an ideological one.

We appreciate that we are an international journal, and we greatly value our growing readership outside the United States. For this reason, we are using SI units in addition to conventional units and sending to our subscribers abroad a conversion booklet at no charge.

Whether we (and Nylenna and Smith) like it or not, American physicians (who constitute most of our readership) and the institutions in which they practice do not use SI units, and we have learnt that our journal cannot force them to do so. All we seemed to be accomplishing in using only SI units was to limit communication—a quixotic and, we believe, arrogant position for us to take. The contention of Nylenna and Smith that we have some overriding responsibility to continue to do so strikes us as overdrawn by at least several scruples.

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