district general hospitals that teach undergraduates, and a mechanism needs to be set up to ensure that this transfer of funds actually takes place. Unless this happens the quality of services in these hospitals and of undergraduate education is threatened.

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- 3 Smith CL. Service increment for teaching and research (SIFTR): the Southampton experience. *BMJ* 1992;305:97-8. (11 July.)
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Prisoner of conscience in Tibet

EDITOR,—I recently worked for six months with Tibetan refugees in India and heard many accounts of repression in Tibet. I would like to draw attention to the plight of Jampa Ngodrup, a Tibetan doctor who formerly worked at the Lhasa City Barkor Clinic in the capital of the Tibetan Autonomous Region of the People's Republic of China. He was detained by the Chinese authorities in October 1989 and formally arrested in August 1990. He was accused of having "with counter revolutionary aims, collected lists of people detained in the disturbances (asserting Tibetan independence) and passed them on to others, thus undermining the law and violating the laws of secrecy." The verdict at his trial in December 1990 was that "in order to strengthen the unity of the motherland, to strengthen and protect the motherland and to enforce the democratic rights of the people, defendant Jampa Ngodrup, having committed the crime of being a spy, is sentenced to 13 years' imprisonment."

Jampa Ngodrup is reportedly detained in Drapchi prison in Lhasa. Amnesty International considers him to be a prisoner of conscience detained solely because he exercised his right freely to give and receive information. Amnesty calls for his immediate and unconditional release.

Please send appeals urging Dr Jampa Ngodrup's immediate release from Drapchi prison to Gyaltzen Norbu Zhuxi (the chairperson of the government of the Tibetan Autonomous Region), Xizang Zizhiqu Renmin Zhengfu, 1 Kang' andonglu, Lasashi 850000, Xizang Zizhiqu, People's Republic of China; and to Li Peng Zongli (the premier of the state council of the People's Republic of China), Guowuyuan, 9 Xihuangchenggen Beijie, Beijing 100032, People's Republic of China.

For further information write to Amnesty International, 1 Easton Street, London WC1X 8DJ.

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Assessing GP trainees

EDITOR,—We were concerned to read that the General Medical Services Committee thought that the interim report by the Joint Committee on Postgraduate Training for General Practice was "woolly, flawed, and inconsistent."¹ We think that similar sentiments may be applied to some of the suggestions of the GMS's education and audit subcommittee.

Hospital training for general practice and the problems of the senior house officer grade are already priorities for action in our regional strategy

for general practice education in the west midlands. With the support of the regional postgraduate dean we will be endeavouring to improve the education of all senior house officers in the near future. Such improvements will include assessment of the educational and service aspects of each post.

We are puzzled as to how we would recognise fairly those trainees "unlikely at the end of their training to be competent to practice as principals" without assessing all trainees. This already takes place, with our regional assessment package assessing trainees at three, six, and 11 months in the trainee year. This concept of formative assessment should allow us to identify the trainees' strengths and weaknesses so that any shortcomings may be rectified as soon as possible. After all, under the joint committee's guidelines formative assessment is mandatory for all regions from 1 January next year.

We note the recommendation that "trainees should be selected more carefully" but bear in mind paragraph 38.5(h) of the red book, which states that the trainer is responsible for appointing the trainee. There are no restrictions at present concerning age, experience, or suitability for general practice. In this region the regional general practice education committee has included in its criteria for approving trainers that a trainer should be able to select a suitable trainee. In our assessment package candidates are reviewed before employment, which necessitates discussion with the local course organiser for all prospective trainees not on a formal vocational training scheme. The onus for appointment still, however, rests with the trainer, and any further restriction on selection of trainees would require changes in the red book.

We believe that we have failed a trainee if at the end of the year the first inkling of poor performance is the trainer's refusal to sign the VTR 1 form. Surely the purpose of formative assessment of all trainees is to identify poor performance earlier in the training and to arrange further remedial education and assessment. In this way the hurdle of summative assessment is minimised.

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- 1 Beecham L. Assessing GP trainees. *BMJ* 1992;305:316-7. (1 August.)

Public health heresy

EDITOR,—Paula Whitty and Ian Jones are right to blow the whistle on the new "purchasingspeak" of "health gain" through health service contracts.¹ We agree that much of the talk about the contribution of district health authorities to the public health has been informed by ideology and ignorance rather than a real understanding of the social and economic determinants of health and disease. In this context our overall objectives in the department of public health of City and Hackney Health Authority can be summarised as threefold: to strengthen our multiagency work; to develop provider programmes (mainly on health promotion and control of communicable diseases); and to involve local agencies in implementing plans for community care and in assessing the health and health care needs of our population.

To assess the extent to which we are actively pursuing these objectives we conducted a three week prospective audit of how we spend our time. Those taking part in the audit were eight medical staff, two senior non-medical staff (a researcher and a planner), and three health promotion staff. Although there are shortcomings in the methods we used—such as agreeing definitions of activities—the table shows that both medical and non-medical staff spend only a small proportion of their time on purchasing activities. Indeed, a much

Percentage of time spent on various activities each week by staff in department of public health of City and Hackney Health Authority

Activity	Medical staff (n=8)	Non-medical staff (n=5)	Total
Multidisciplinary work (eg, joint planning)	21	28	24
Training and teaching (eg, teaching students)	27	16	23
Management and administration (eg, correspondence, interviewing)	17	28	21
Being trained (eg, courses, time with trainers)	15	5	11
Needs assessment	7	15	10
Service provision (eg, advice on infectious disease, health promotion)	7	7	7
Contract advice and purchasing	6	1	4

higher proportion of time was spent on wider public health work (for example, joint planning and preventive services). In our view, the key to maintaining this important perspective lies in integrating health promotion and communicable disease control services within public health departments. Those public health departments most at risk of a narrow purchasing perspective are those that have merged into "megadistricts" or have ceded these vital public roles to provider units.

It is wrong to assume, however, that we should not aim to influence the pattern of health care spending, especially as some of this money might be better spent on health promotion rather than acute care (which currently uses up 99.7% of district funds). We have made a start this year by ensuring that equal proportions of the district's capitation growth money will be spent on health promotion and treatment and care. We see this as a small but essential contribution that every district should make towards fulfilling its wider public health objectives.

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- 1 Whitty P, Jones I. Public health heresy: a challenge to the purchasing orthodoxy. *BMJ* 1992;304:1039-41. (18 April.)

Treating Jehovah's Witnesses

EDITOR,—The title of a recent news item—"Court says doctors were right to treat Jehovah's Witness"—is inaccurate.¹ As the text makes clear, the patient at the centre of the decision by the Court of Appeal was not, in fact, one of Jehovah's Witnesses.

While declaring that a doctor has a duty to offer appropriate counselling and to point out any risks attendant on a patient's choice, the court affirmed that a mentally competent adult patient "has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."² That is all that Jehovah's Witnesses ask for: the right to choose medical management that does not entail blood transfusion, accepting its risks in exchange for its benefits. We thank those doctors who respect our wishes.

All three lords justices cited with approval the Canadian case of *Malette v Shulman*, which confirmed the validity of the advance medical directive or release customarily carried by bona fide Jehovah's Witnesses, executed of their own free will as an expression of deeply and sincerely held religious scruples.³ "Doctors who treat such a patient against his known wishes do so at their peril."⁴

In an effort to be helpful and avoid confrontations Jehovah's Witnesses maintain a network of