of these patients had been admitted with an oropharyngeal complaint and two had specifically complained about their mouths; the remaining patient had been admitted with HIV infection.

The screening showed various oral conditions, including thrush (six cases), active dental disease (11), benign cystic lesions (two), erythema migrans (one), and an infected wisdom tooth (one). Most importantly, however, six cases of oral ulceration were detected. In four of these the cause seemed to be traumatic, while in one an ulcer of no obvious cause was healing. The remaining ulcer was in the right retromolar area in a man with a history of cancer of the larynx treated with local radiotherapy; further examination showed no overt sinister characteristics, and the patient is currently under review.

Clearly the priority at the time of any medical admission is the cause of that admission, but once the patient is in a stable condition in the ward full clerking by the house officer is undertaken. This should provide the opportunity for simple oral screening of easily visible tissues to detect any oral ulceration that may need review. Better training is needed to ensure that this opportunity is not missed.

N R SAEED
Medical student

Department of Oral and Maxillofacial Surgery,
Royal London Hospital,
London E1 1BB

J A GOLD
Medical student

St Bartholomew's Medical College,
London EC1A 7BE

1 Hutchison IL. Improving the poor prognosis of oral squamous cell carcinoma. *BMJ* 1994;308:669-70. (12 March.)

Misinterpreted radiograph

EDITOR,—I am amazed that the barium swallow reported by Duncan McCrae was misinterpreted.¹ The film published clearly shows the patient's hand holding the cup of barium at an angle projected over the much narrower oesophagus, the cup not having been discarded on a ledge between the beam and the film (as McCrae would have us believe). Assuming that the radiologist did not make the error of interpreting the cup as a foreign body responsible for the patient's recurrent episodes of acute total dysphagia, the Royal Liverpool University Hospital should instigate an inquiry into why the radiologist's report was not considered and who was responsible for the misdiagnosis.

J VIVE
Consultant radiologist

Crawley Hospital,
Crawley,
West Sussex RH11 7DH

1 McCrae D. Minerva. *BMJ* 1994;308:1178. (30 April.)

Confusing photographs

EDITOR,—The legend to the photograph in C M S Royston and colleagues' article on training in laparoscopy highlights an increase in the incidence of damage to the common bile duct since the advent of minimally invasive surgery.¹ If, as the photograph suggests, trainees are now being taught to look for the gall bladder in the pelvis rather than the right hypochondrium, is this really surprising? Is even the *BMJ*'s photo library underfunded? Or have the editors just forgotten their anatomy?

PETER SAUNDERS

St Albans AL3 5UB

1 Royston CMS, Lansdown MRJ, Brough WA. Teaching laparoscopic surgery: the need for guidelines. *BMJ* 1994;308:1023-5. (16 April.)

BMJ's English confuses readers

EDITOR,—I was amazed by the title of a recent editorial, which implied that overdose could be treated with calcium channel blockers.¹ I was reassured, however, to read that overdose of calcium channel blockers was being discussed, rather than treatment of overdoses of other drugs with calcium channel blockers. In the same issue Tony Smith mentions *extraversion* instead of *extroversion*² and Bernard Dixon wrote, as the first word of his article, *it's*—meaning *it is*—when he meant *it has*.³ T R Wiggan, who wrote of recovery from near drowning, was let off the hook when "I found *me* head above water," only to succumb to "*rigours* and generalised myarthralgia."⁴ Even Minerva, who is usually precise and efficient in her use of English, managed "treatment with a *cyclovir*" and then sent me scurrying to my dictionary to find the meaning of *coruscating*.⁵ In the same issue are some long, unpunctuated sentences. Try reading aloud Smith's "Women are under represented in politics and the top flights of business despite generations of effort to eliminate prejudice and despite a handful of notable exceptions who have become women prime ministers," or Wiggan's "what did impress me apart from the emetic and laxative effects of saline and adrenaline were the rigours and generalised myarthralgia that we both experienced afterwards."

The *BMJ* is probably the premier medical journal in the English language published in Britain. The issue I quote from contained other errors. English should be a live language not constrained by rigid adherence to fussy rules, but in the *BMJ* the English should be accurate and understandable, and obscure words should be avoided.

DAVID SMITH
Senior lecturer in anaesthesia

Shackleton Department of Anaesthesia,
Southampton General Hospital,
Southampton SO9 4XY

- 1 Kenny J. Treating overdose with calcium channel blockers. *BMJ* 1994;308:1046. (16 April.)
- 2 Smith T. Sex and ambition. *BMJ* 1994;308:1046. (16 April.)
- 3 Dixon B. Bacteria and newsprint. *BMJ* 1994;308:1046. (16 April.)
- 4 Wiggan TR. So nearly a disaster. *BMJ* 1994;308:1047. (16 April.)
- 5 Minerva. *BMJ* 1994;308:1050. (16 April.)

*"Good prose," said George Orwell, "is like a window pane." We agree entirely with Orwell, and that is what we try to achieve in the *BMJ*. Sometimes we fall short, and Dr Smith is right to chastise us. Although we might dispute some of his points, we accept the spirit of his letter and will try still harder.—ED, *BMJ*

Hospitals and benefactors

EDITOR,—The anguish felt by benefactors when their gift is apparently spurned is understandable, but it would be disastrous if potential benefactors were discouraged by the current furore about funding hospital building in south London.¹ Charitable money has become essential to services and research.

People like to see something for their money; thus equipment is easy to fund, especially if it has to do with hearts, children, or cancer. Public collections for the construction of buildings have a long history, as inscriptions on many hospitals testify. What is difficult is to get money in a form that is easily used.

Accepting donations is not simple: there has long been tension among those who wish to give, those who wish to receive, and those who will be left with the consequences. As soon as donated equipment arrives it requires staff and running

costs; when it has proved its worth it will eventually need replacing. Time and again, hospitals fail to plan for this. We try to insist on a business plan before accepting donations, but, with the continual changes in the priorities of purchasers and the siting of services as well as the high turnover of administrative staff with differing goals, donations tied to specific purposes will almost inevitably fall foul of the vagaries of the system from time to time.

What services, teaching, and research need in hospitals and universities is uncommitted money. The trend towards project oriented research may suggest good value for money, but most advances arise serendipitously. Novel findings require a change of course in the middle of a project, and the doctrine of "*cy pres*" (using money for a purpose as near as possible to the original one) recognised in law does not go down well with grant giving bodies. Programme grants are hard to find, and the result of the present straitjacket can be seen at scientific meetings: the obvious questions are answered, but innovative communications are rare.

We need benefactors to concentrate on people rather than equipment and buildings. Four fifths of the costs of providing health care are attributable to staff, but a fraction of donations goes towards employing staff. The government could help by relaxing the squeeze on the dual support system: donors are discouraged by the need for universities to demand ever increasing proportions of salaries as overhead costs. If donors knew that their support to an institution would be used entirely for services and research they would not feel constrained to make it so difficult to use effectively. The fallacy of believing that this can be done by donating equipment or buildings is clearly shown by the current imbroglio.

C G D BROOK
Chairman

University College London Hospitals Medical Committee,
Middlesex Hospital,
London W1N 8AA

1 Dyer O. Charities demand money back in Guy's changoover. *BMJ* 1994;308:935.

General Medical Council

Is under threat

EDITOR,—The independence of the General Medical Council is under threat from the government.¹ The Department of Health has set up several committees to monitor the education and performance of doctors, which were previously—and should be—the sole preserve of the council. Rumours suggest that the government plans to split the council into Scottish, Welsh, Irish, and English divisions and to assume the role of coordinator, which in effect means that it would take full control of the council. Doctors need to protect the council from such measures.

But the council has become stagnant, and there is widespread discontent over its performance. Radical reforms are needed to make it a strong organisation accountable to the profession and the public. I have two suggestions.

Firstly, a person should not be allowed to serve as a member for more than two consecutive terms. The royal colleges and universities have persisted in choosing the same people, who are unwilling to see change, as their representatives to the General Medical Council. They need to be replaced by people who could bring about change. Moreover, the president should always be an elected member. The president has never been a woman or a doctor from overseas. This suggests discrimination on grounds of sex and race and needs to be set right.

Secondly, the council should state clearly that long hours of work are detrimental to the edu-

cational needs of junior doctors and to patients' care.

The General Medical Council is an organisation of doctors for doctors and for which doctors pay. We pay to protect the welfare of the public as well as that of the profession. We should fight to protect it from the government.

A C SRIVASTAVA
Member, General Medical Council
Department of Genitourinary Medicine and AIDS,
Royal Cornwall Hospital (City),
Truro TR1 2HZ

1 Smith R. The end of the GMC? *BMJ* 1993;307:954.

Complaints may reflect racism

EDITOR,—The overrepresentation of doctors from ethnic minorities in cases brought before the conduct committee of the General Medical Council that we have highlighted raises important questions concerning disciplinary procedures in the medical profession which may discriminate against such doctors.¹

We examined the minutes of the professional conduct committee of the General Medical Council between 1982 and 1991 to determine the nature and outcome of cases brought before it. Ethnic group was determined by the name of the doctors. Of the 402 cases brought before the committee over the 10 years, 294 were cases of professional conduct and therefore solely under the jurisdiction of the General Medical Council. Table 1 shows the offences with which these doctors were charged after complaints made to the professional conduct committee. The odds ratios in table 1 were calculated on the basis of 63 000 whole time equivalent NHS practitioners, of whom 18% are from ethnic minorities. The odds ratio represents the risk of ethnic minority doctors being charged with specific offences compared with white doctors. Table II shows the outcome of these charges by ethnic group.

Table I shows large differences between the types of offences that doctors are charged with. Ethnic minority doctors are 12 times more likely to be charged with indecent behaviour than white doctors, whereas white doctors are more likely to be charged with forming an improper relationship with a patient. There is no readily available information on how the General Medical Council differentiates between these two offences, but both charges may involve an element of sexual behaviour which can be regarded as professional misconduct. Can we believe that the charge of improper demand for fees is the prerogative of only ethnic minority doctors, or are people more ready to make this specific complaint against ethnic minority doctors than white doctors?

Table II shows that once doctors are brought before the professional conduct committee, the manner in which they are dealt with is not influenced by ethnic group. None of the differences in outcome between ethnic minority and white doctors are significant.

Our figures suggest that the overrepresentation of ethnic minority doctors brought before the

TABLE II—Outcome of charges by ethnic group (figures are numbers (percentages))

Outcome	Ethnic group	
	Ethnic minority	White
Struck off	27 (15.8)	25 (20.3)
Not guilty	43 (25.1)	35 (28.5)
Given warning	37 (21.6)	25 (20.3)
Suspended	29 (17.0)	23 (18.7)
Others (conditional registration, renewal of registration, etc)	35 (20.4)	15 (12.1)
Total	171	123

conduct committee may be due to more complaints being made against ethnic minority doctors than white doctors.

While we do not question the validity of the charges brought before the General Medical Council, we think that it is important that the General Medical Council has safeguards that prevent racially motivated complaints from reaching the professional conduct committee. The professional conduct committee should also publish a breakdown by ethnic group of all complaints made against doctors so that we can be sure that complaints are dealt with fairly and without prejudice.

ANEZ ESMAIL
Vice president, Medical Practitioners Union
Department of General Practice,
University of Manchester,
Manchester M14 5NP

SAM EVERINGTON
General practitioner
London E1 4UH

1 Dillner L. Ethnic minority doctors more likely to face GMC. *BMJ* 1994;308:875. (2 April.)

BMA fails to attract women candidates

EDITOR,—The number of elected women members of the General Medical Council is in danger of falling sharply below the present 10 after the current election. The BMA has failed to attract women candidates seeking its sponsorship. This may be because candidates were chiefly sought from the BMA's representative body, which has few women, and not from its members, roughly a third of whom are women.

Women are represented by men, and vice versa, in many situations. This is neither necessary nor appropriate in an election where every constituency has more than one seat, and England has 42. The elected candidates will be representing a profession of which nearly a third is female; half of the doctors now qualifying are women. Thirty five of the 120 candidates for this year's election to the General Medical Council are women; 23 of these are members of the Medical Women's Federation.

For the BMA to preserve its credibility as the only doctors' organisation that is recognised for national negotiating purposes on behalf of all doctors, action is necessary. The BMA will wish to draw attention to the fact that, although it is sponsoring candidates for all seats in the con-

stituencies of Scotland, Wales, and Northern Ireland, it is sponsoring only 22 candidates for the 42 seats in England. The BMA's powerful publicity resources should be used to persuade doctors to vote if they have not yet done so, and to vote with the need for balanced representation of the profession in mind.

ANN GRÜNEBERG
Member, General Medical Council
London N6 5EX

Candidates are unrepresentative . . .

EDITOR,—I am glad the BMA is highlighting the importance of the forthcoming elections to the General Medical Council by sponsoring candidates. But I am sorry that, of the 22 candidates sponsored by the BMA, only two are women. This is surely not representative of the profession as a whole and serves to illustrate how unrepresentative our representatives are.

ADAM MOLIVER
Consultant in old age psychiatry
Mental Health Base,
Delancey Hospital,
Cheltenham,
Gloucestershire GL53 9DU

. . . too many of them are over fifty

EDITOR,—I agree with I M Peek's comments about the forthcoming elections of members of the General Medical Council.¹ Analysis of the list of nominees for the election shows that young general practitioners such as myself are unlikely to be adequately represented on the new council. There are only three practising general practitioners under the age of 40 on the list, and only 12 under the age of 50. The council has expressed itself content with the way that it has conducted the nomination process. Had it been serious in its intent to encourage more young general practitioners to seek election, however, it would have published plenty of details two or three years in advance of the election and not only partial details two to three months in advance. It would also have approached the Royal College of General Practitioners in good time for its help in publicising the election among its younger members.

Unfortunately, the many problems specific to younger general practitioners are now unlikely to be acted on. The widespread exploitation of junior partners in general practice, for example, needs to be dealt with under the section on serious professional misconduct in any revision of the General Medical Council's blue book. I had hoped to bring these serious problems to the attention of the council, but I did not see the grossly inadequate election notice in the one edition of the *BMJ* in which it appeared. I did, however, see the insert in a recent issue of the *BMJ* that listed BMA sponsored candidates for the election. If the General Medical Council had announced the election with a similar insert in the *BMJ* and *Lancet* I can guarantee that there would have been at least one more young general practitioner on the list of nominees.

Ninety eight (62%) of the 158 candidates for the election are aged over 50. I would ask the General Medical Council whether this is substantially different from the proportion in previous elections and if not why not? I urge all younger members of the profession to vote for those younger colleagues who have put themselves forward for election to ensure that the issues concerning junior doctors are properly dealt by the council; they have not been properly dealt with previously.

JOHN BEAVEN
General practitioner
Glossop,
Derbyshire SK13 8SH

1 Peek IM. Election of members of GMC. *BMJ* 1994;308:1044. (16 April.)

TABLE I—Offences with which doctors were charged by ethnic group

Offence	Ethnic group (% of all charges)		Odds ratio (ethnic minority:white doctors) (95% confidence interval)
	Ethnic minority	White	
Forming improper relationships with patients	3 (1.8)	19 (15.4)	0.72 (0.17 to 2.56)
Canvassing	11 (6.4)	5 (4.1)	10.03 (3.23 to 33.02)
Disregard of responsibility to patients	97 (56.7)	48 (39.0)	9.28 (6.48 to 13.31)
Improper prescribing of drugs	18 (10.5)	19 (15.4)	4.32 (2.17 to 8.60)
Indecent behaviour	19 (11.1)	7 (5.7)	12.38 (4.93 to 32.38)
Improper demand for fees	7 (4.1)	1 (0.8)	31.91 (3.99 to 690.6)
Use of false qualifications	5 (2.9)	5 (4.1)	4.56 (1.15 to 18.07)
Other (breach of confidentiality, undue influence, false accounting, etc)	11 (6.4)	19 (15.4)	
Total	171	123	6.41 (5.24 to 7.86)