referrals from some practices are to private clinics and are not paid for out of the NHS budget.² Unless a formula weighted by need that predicts use of private hospitals can be devised, practices in better off areas will be overfunded in a capitation scheme.

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- 1 Hart. Growing doubts over fundholding. *BMJ* 1993;307:1234. (13 November.)
- 2 Bradlow J, Coulter A, Brooks P. *Patterns of referral*. University of Oxford: Health Services Research Unit, 1992.

Israeli counterpart of the Red Cross

EDITOR,—In correcting Judy Siegal-Itzkovich¹ F Levy misses the point.² "Magen David" means shield of David and refers to the symbol, more commonly known as a star of David, which the Israeli counterpart of the Red Cross uses in lieu of a cross, much as Muslim countries use a red crescent. In both cases this is because of the Christian implications of the cross, which are not appropriate to the cultures of these countries.

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- 1 Siegal-Itzkovich J. Palestinians start planning health services. *BMJ* 1993;307:822-3. (2 October.)
- 2 Levy F. Israeli counterpart of the Red Cross. *BMJ* 1993;307:1215. (6 November.)

Undergraduate medical education

EDITOR,—Stella Lowry¹ has commented on the General Medical Council's draft revised recommendations on undergraduate medical education.² These do not depart much from the council's consultative document,³ which stimulated King's College School of Medicine and Dentistry to review its curriculum. To inform the process it sought views on the proposed changes from some of its recent graduates, surveying 478 who had qualified from King's between 1985-6 and 1989-90. Altogether 371 graduates (78%) returned completed questionnaires. The respondents felt strongly about most issues (table).

Most respondents opposed the proposal to establish a "core and options" approach to medical education and to reduce the factual content of the course by a third. Reasons given were that the course should be comprehensive and broad based to ensure safe medical practice, appropriate referrals, and a good foundation for future specialisation. There was also anxiety about encouraging specialisation too early, before a career path had been chosen. One respondent, now working in emergency medicine in the United States,

commented: "This is a move to the American system. As an MD now, working in the United States, I call it folly. My seniors here are in awe at the breadth of knowledge and experience I gained in Britain. Don't throw it away! We need general doctors not more specialists." Concern was also expressed that students might lack the maturity and experience to choose options sensibly.

Most respondents, however, agreed with more problem based learning, greater emphasis on communication skills (videos were recommended), contact with patients from the first year, basic medical science throughout the five years, more self directed learning, and research and experiment permeating the course. Respondents suggested, however, that students should have contact with patients only as observers initially, with further contact after they had become more mature. Caution was also urged over introducing self directed learning in view of the immaturity of some British students, unlike those in the United States, who are already graduates. Close guidance and supervision were therefore advocated.

Many respondents agreed that within the hospital more use should be made of outpatients for teaching. Special teaching clinics were considered to be necessary because service clinics were too busy. There was no consensus on more prominence for public health medicine or more teaching in the community.

These results suggest that students may be worried that their courses will not be sufficiently comprehensive to meet their needs. Medical schools must therefore present any curricular reforms so that these fears are dispelled. The definition of the core course will be crucial in this respect.

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- 1 Lowry S. A model for British medical education. *BMJ* 1993;307:1021-2. (23 October.)
- 2 General Medical Council. *Recommendations on undergraduate medical education*. London: GMC, 1993.
- 3 General Medical Council. *Undergraduate medical education. The need for change*. London: GMC, 1991.

Limited registration and racial discrimination

EDITOR,—Esmail and Everington have highlighted racial discrimination by employing authorities against doctors with Asian sounding names.¹ Another kind of discrimination also operates against overseas doctors, predominantly Asian, on account of their limited registration with the General Medical Council. Unfortunately, a large proportion of these doctors leave Britain—either after the maximum permitted period of five years or sometimes, in frustration, before that—without realising that they have been discriminated against.

Under the Medical Act 1983 overseas doctors are allowed to receive training in Britain while holding

limited registration. The act limits them in a few specific ways, described in sections 22 to 24. In practice, employing health authorities have been discriminating against these doctors in recruitment procedures, despite the doctors having the desired professional competence and qualifications, solely on account of their foreign status and giving their limited registration as the cause of non-selection for posts. Regrettably, the General Medical Council, which is empowered by the Medical Act 1983 to monitor the performance of these doctors, seems to be aware of these practices.

In my own experience, and through information gathered from various offices of the Commission for Racial Equality, I have identified some of the ways in which limited registration has been deployed as a scapegoat for discriminatory practices. (1) Health authorities have deliberately omitted to shortlist overseas doctors on the grounds of their limited registration. (2) A health authority offered an overseas doctor a post that had not been approved by the Royal College of Physicians, which he was unable to take up while holding limited registration. This resulted in his contract being terminated before he started the job. (3) Discriminatory job advertisements that discourage doctors who hold limited registration from applying for posts for which they are eligible have been placed in medical journals by some health authorities.

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- 1 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993;306:691-2.

Research in general practice

EDITOR,—Heather A Waldron and Ronald F Cookson correctly state that increasing numbers of general practitioners are participating in clinical trials sponsored by drug companies.¹ I am concerned about their comments concerning ethical approval.

All general practitioners must submit their proposals for research to their local research ethics committee. This should be regarded as a requirement, not an option. Local research ethics committees exist to review all research on humans within their geographical area and to protect both the subjects of research and the researchers. The standards of independent ethics committees may vary and may not reach those of the clinical trials ethics committee of the Royal College of General Practitioners.

General practitioners may not be familiar with research protocols and consent forms, and they ignore the skill of their local committee at their peril. I would urge all general practitioners contemplating taking part in a clinical trial to submit the protocol to their local committee for approval.

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- 1 Waldron HA, Cookson RF. Avoiding the pitfalls of sponsored multicentre research in general practice. *BMJ* 1993;307:1331-4. (20 November.)

Graduates' views on General Medical Council's proposals for change in curriculum. Figures are numbers of respondents to questionnaire

	Strongly agree/ agree	Neutral	Strongly disagree/ disagree	Total No of respondents
Reduction of one third in factual content of course	141	39	188	368
Curriculum based on "core and selected options" approach	118	39	212	369
Vertical integration, with contact with patients from first year	209	69	92	370
Basic medical science throughout five years	207	52	111	370
Greater emphasis on communication skills	276	63	31	370
More prominence for public health medicine	131	125	114	370
More teaching in the community, less in hospital environment	149	87	134	370
In hospital more use to be made of outpatients for teaching and less of inpatients	176	109	85	370
Finding out: research and experiment should permeate course	193	93	82	368
More problem based learning	287	51	15	353
Greater use of self directed learning as teaching method	201	85	83	369

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