those who possess the skills and motivation to do good research. Regional health authorities, post-graduate deans, and royal college advisers should be trying to end this obsession, which not only wastes an enormous amount of hospital staff time but also debases the currency of the scientific medical literature and steals research resources from those who desperately need them.

ROGER A FISKEN

Walton Hospital,
Liverpool L9 1AE

Self referral to consultants

SIR,—There seem to be two main objections to our letter (27 February, p 640). Dr Stephen Herman (19 March, p 860) and Dr John Dunn (9 April, p 1067) suggest that many general practitioners do not make themselves properly available to their patients, who then have to refer themselves direct to hospital, often via the casualty department. I am sure that this happens, but I do not think that it justifies consultants seeing patients who refer themselves privately.

The second argument, put forward by Drs M M Lieberman and Patrick Hall-Smith (19 March, p 861), is that many general practitioners are not trained sufficiently in paediatrics and other specialties, and, therefore, patients have a right to refer themselves and the consultants a right to see them. This is a denial of the whole basis of general practice in Britain. Of course general practitioners are not skilled at everything. Their training leads them to know when to refer patients for further advice and treatment while maintaining continuing responsibility.

It was sad that there was no response from the provident associations. If they were willing to pay only those claims where the patient had been referred by the general practitioner usually responsible for them this problem would be almost totally solved and the provident associations' money would be spent more responsibly on second opinions.

GERALD MICHAEL

Edgware Postgraduate Medical Centre,
Edgware General Hospital,
Middlesex

Health care in West Germany and Britain

SIR,—As a West German medical student, having done 14 months' of my clinical training in British hospitals, I would like to support Dr Helga Rhein's Personal View (9 April, p 1063).

The basis of any profit based institution, as in West Germany, is necessarily one of commercial interest. Hospitals and doctors are paid by insurance companies per patient, per investigation, and by duration of treatment. This often leads to overinvestigation and overtreatment. Hospitals are obliged to make maximum profit for minimum output, while all self employed general practitioners and specialists are financially encouraged to treat as many patients for as long as possible with the most profitable methods.

Not surprisingly, patients lose faith in our professionals, believing that their ill health is being exploited. This creates a feeling of distrust in the patient, leading to an increasingly demanding attitude and a complete lack of responsibility for, or personal input into, their health system (I have never come across any fund raising or charity for a German hospital). Community medicine, preventive medicine, and health education remain underdeveloped, presumably because of lack of financial incentives.

West Germany has an inflated reputation for health care owing to its high standards of technology and the absence of waiting lists, which are achieved only with immense expenditure on health insurance.

Another major difference is medical education. The clinical teaching I have experienced (in Aberdeen, Nottingham, and Newcastle) not only reflects more humane treatment of patients and students but is far better than West German training, which is mainly theoretical and includes little contact with patients. The assessment of our students is based almost entirely on multiple choice questions, with no consideration of practical abilities or "bedside manner." Consequently increasing numbers of West German students are voting with their feet in applying for clinical attachments in the United Kingdom. Does this major difference in the educational system reflect the different ethos inherent in the German health care system?

It seems ironic that despite such strong public sympathy for the NHS the government continues to underfund it. I support the many doctors battling to save it.

ANNETTE KISSENBECK

Dryburn Hospital,
Durham DH1 5TW

Withdrawal of recognition for vocational training

SIR,—The Joint Committee for Postgraduate Training in General Practice is proposing to withdraw recognition of vocational training for general practice in the North East Thames region (see p 1319).

A visiting team from the joint committee came to the Bloomsbury vocational training scheme in June 1987, and its subsequent report made several criticisms of quality on the evidence it received from five training practices in the region. Its major concern was with minimal criteria for the appointment and reappointment of trainers in the region. Subsequently, the joint committee has informed the regional advisers of North East Thames that recognition of general practice training will be withdrawn from the whole region with effect from February 1989.

If we concede that the criticisms in the visitors' report are reasonable (one is to the effect that the region is underresourced in regional/associate adviser time) and that something should be done to meet them given a history of criticisms since 1983, what are the options? Possible options for the joint committee include: (a) further discussion/negotiation with those concerned; (b) setting new absolute targets for the achievement of specified aims; (c) giving notice of specified sanctions if there has been no improvement within a certain time; (d) disciplinary action against regional and associate advisers and (?) the general practice subcommittee; (e) further investigation (visits) to examine in greater depth the true situation in North East Thames (inevitably this would lead to a dialogue); or (f) action against all training in the region.

The situation has much in common with an industrial dispute between management and unions. Newcomers to the scene (on both sides) tend to harden their views easily and prefer not to listen to the other side. Skilled representatives on either side of such a divide know from bitter experience that negotiation is a better tool and that "final offer" strategies usually herald a damaging battle or a Pyrrhic victory.

The major criticism in the joint committee's June report on its Bloomsbury visit derives from

two (unidentified) trainers out of five visited. These were in practices that were specifically selected by the regional adviser and relevant course organiser (one of the undersigned) in the hope that the visitors might be able to help in discussion to bring them up to standard. In the event the outcome was different.

Of the six disciplinary options listed above only one closes all other escape routes and inevitably leads to crystallised attitudes and warring factions. Everyone has to take sides, and a battle is inevitable. No one can emerge with credit. This, however, is the joint committee's preferred option. The greatest damage is done to a whole cohort of trainees, spanning a four to five year period, and the nation is effectively robbed of 10% of its trainers, including many of undisputed excellence. Moreover, this decision effectively puts a blight on the whole of North East Thames region and diminishes the likelihood of attracting high quality staff—in all aspects of primary care—for an indefinite period. The accusation of guilt by association is no respecter of persons or quality.

Such a strategy might well be expected from any autocratic regulatory institution or from a politically motivated régime. It does not sit well on the shoulders of our profession's senior education committee. If not rescinded this edict will return to haunt us all for a long long time.

MARIE CAMPKIN
DONALD GRANT
HEATHER SUCKLING
Course organisers

Kentish Town Health Centre,
London NW5 2AJ

Financing health care

SIR,—Dr John Black supports the financing of health care by redistributive taxation and argues for preservation of the principles on which the NHS was founded (2 April, p 1000).

He dismisses an increased contribution from non-governmental sources on the basis of the American experience with private health maintenance organisations. In terms of outcome, however, the Americans are doing very much better than us in preventing premature death and disability from ischaemic heart disease—one opportunity for major treatment cost savings.

The eight countries of Britain and Scandinavia have comprehensive health provision schemes that are free and funded from taxation. In all eight countries the age adjusted mortality from ischaemic heart disease is high and not declining appreciably. Doctors are not paid to look for extra work so they concentrate on diagnosing and treating patients who present themselves for cure. In the United States health care is paid for by the consumer on an item of service basis with a full or partial refund from personal insurance cover. The age adjusted mortality from ischaemic heart disease has declined by nearly 30% since 1960. American doctors are entitled to sell their services and charge a fee for their work, which includes screening for the risk factors for ischaemic heart disease, especially hypertension and dyslipidaemia; indeed they might risk a malpractice suit if they did not recommend such screening.

In Britain and Scandinavia we have opted for the so called population strategy of prevention, which, in contrast to the case finding approach of the United States, has for ischaemic heart disease at least been a total failure. Not only does the evidence support case finding as effective but there are now three studies in which large groups of high risk men have been subjected to advice of the type embodied in the reports of the National