purchaser-provider split in the health service is now almost universally welcomed.

Kernick also contends that doctors are being offered large handouts of cash to reward incompetence and encourage early retirement. No such scheme is now to be implemented, but the debate about how to address poor performance should be conducted in less pejorative terms.

The concept of the core content of general medical services, which Kernick reviles, has been developed because of the realisation that general practitioners' workload has been increasing,³ often without any additional remuneration and in the absence of any practical mechanism for them to identify, contract for, and secure remuneration for new services. Far from being a negative concept, it is intended to allow the roles of general practitioners and of primary health care to expand and develop, so long as the necessary resources to allow such development are provided. In attacking a strategy that is intended to deliver fair rewards to general practitioners in the future Kernick is out of touch with colleagues.

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- 1 General Medical Services Committee. *Core general medical services and the classification of general practitioner activity: a discussion paper*. London: GMS, 1994.
- 2 Kernick DP. General practice's last stand. *BMJ* 1995;310:1613. (17 June.)
- 3 Health Departments and BMA. *General medical practitioners' workload survey 1992-93: report to the Doctors' and Dentists' Review Body*. Leeds: NHS Executive, 1994.

Only a third of adverts for vocational trainees result in an appointment

EDITOR,—There has been much in the medical press lately concerning the falling popularity of vocational training for general practice. The practice in which I work advertised in the issue of the *BMJ* published on 4 February for a trainee to start in August. There was little interest, so six weeks after the advertisement appeared I wrote to all the other practices that had advertised in that issue to determine their experiences.

I sent out a letter with a questionnaire printed on the reverse, and I enclosed a stamped addressed envelope to encourage replies. Practices were asked the number of inquiries that had resulted from the advertisement, the number of applications that had resulted from the advertisement, whether a trainee had been appointed, and if applicable, whether the appointment had been a result of the advertisement. Comments were also invited. Practices that were in the process of appointing someone were contacted six weeks after their initial reply to gain an accurate record of events.

Forty six practices were questioned, and 43 replied (response rate 93%). Twenty two practices had had no inquiries, 26 had had no applications, and 29 had failed to appoint a trainee (table).

The results do much to confirm fears about recruitment of trainees in general practice, and the high response rate may show a measure of concern

Distribution of inquiries about, and applicants for, 43 posts for vocational trainees in general practice advertised in "BMJ," and number of appointments made. Figures are numbers of practices

	No of inquiries/applicants			
	0	1	2	3
Inquiries	22	13	6	2
Applicants	26	11	6	
Appointment made	No	Yes		
	29	14		

over this issue. Perhaps the most interesting information came from the comments added by almost every respondent, some of whom wrote accompanying letters. Many expressed concern for the future of general practice, some fearing that the situation reflects a perception of low morale dating from the introduction of the new contract in 1990. There was a suggestion that newly qualified doctors previously keen on a career in general practice are taking time out until "new general practice is sorted out." Two practices were to have no trainee for the first time in 10 and 14 years, while another, having advertised unsuccessfully in the *BMJ* twice, eventually received applications through a European journal.

Whatever the reasons, this simple survey provides objective evidence of an impending dearth of vocationally trained general practitioners, which requires urgent attention.

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NHS medical card

Still sexist after all these years

EDITOR,—On receiving my new NHS card I was puzzled to see printed on the front of the envelope the statement that, should I require a home visit, I should "help my doctor by asking him before 10 am." My current doctor is female, as was my previous doctor. I am told by the BMA that almost one third of all general practitioners in Britain are female, and I understand that the proportion of new medical students who are female is even higher.

The appearance of biased assumptions like this on official NHS correspondence is outdated (the first female doctor in Britain began practising in 1870) if not dismissive of the existence and value of female doctors. Is a small printing correction—perhaps when stocks are renewed—too much to ask of the NHS in carrying out its equal opportunities policy?

Some might call this nitpicking; others might see it as a slight, and welcome, correction on the path to true equality.

PAIGE SINKLER

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NHS Executive's reply

EDITOR,—We try to ensure that any such wording is amended, but this particular form seems to have been overlooked. I shall ensure that the form of words is amended at the next reprint, and I apologise to Paige Sinkler for any offence caused.

JENNY SMITH
Executive officer

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Pacific nuclear tests should not go ahead

EDITOR,—On behalf of the Medical Action for Global Security (MEDACT), I am writing in support of the protest by Australian doctors over French nuclear testing.¹ No relevant official medical data exist owing to the secrecy that has shrouded past tests, but it seems likely that outbreaks and the rise in incidence of ciguatera, which is widespread in the Pacific, arise from nuclear testing together with the activities needed for the supporting infrastructure.²

The geology of the two atolls that have been used

renders them unsuitable as repositories of highly radioactive waste, for reasons such as their tendency to natural fissuring. Caesium-134 has been found in samples of water obtained locally and, with a high degree of probability, in plankton obtained 19-22 km downstream from Mururoa.³ This suggests strongly that radioactive material is already seeping from the test sites, with the risk that it will enter the food chain.

MEDACT shares the Australian doctors' hope that the French government will take note of the widespread concern over the tests and abandon them. It will be contributing to the Australian doctors' advertisements in the French press; any doctor wishing to be associated with this is asked to contact MEDACT's office.

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- 2 Ruff TA. Ciguatera in the Pacific: A link with military activities. *Lancet* 1989;i:201-4.
- 3 Buske N. Radioactivity in plankton outside the 12-mile exclusion zone of the French nuclear test site. Report of the 1990 scientific mission of the Rainbow Warrior. Davenport, WA: SEARCH Technical Services, 1991.

Misleading drug packaging

EDITOR,—There is always scope for dangerous errors to occur when drugs are given, especially if they are injected.¹ To ensure that the correct drug is given, one school of thought argues that ampoules of drugs should be distinguishable only by the writing on their labels and not by any other characteristic such as shape or colour.² The opposing view states that ampoules should have a distinctive appearance and should be colour coded so that products look as different as possible.³

The worst possible scenario is happening: some manufacturers supply their different products in distinctive forms, while others catch out the unwary by supplying different products in containers that are identical except for the lettering. The lettering in the example in the figure is 1.5 mm high and is difficult for someone with modest presbyopia to read. If the person giving the drug is unaware of the existence of a similarly packaged preparation the patient may be put at risk.

Labels (for two different products) which are identical apart from lettering

Distributing medicines in standard ampoules of standard format can work only if the system is adopted widely. Otherwise we should encourage diversity: it could make the difference between life and death.

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- 1 Ferner RE. Errors in prescribing and giving medicines. *Journal of the Medical Defence Union* 1992;3:60-4.
- 2 Nunn DS. Ampoule labelling—the way forward. *Pharmaceutical Journal* 1992 March 14:361.
- 3 Orser BA, Oxorn DC. An anaesthetic drug error: minimizing the risks. *Can J Anaesth* 1994;41:120-4.