who suffered all of these emotions—and more—for three centuries, as well as the ravages of poor or no education, housing, nutrition, and health care? Overwhelmingly, black people supported sanctions.

Contrary to the rather silly editorial that Crawshaw quotes from the *Cape Times*, “the campaign” (for sanctions) did not play into the hands of the “destructive right-wing,” which is now an irrelevant force in South Africa. Rather, it led to the emergence of the remarkable Nelson Mandela and his government of reconciliation and the appointment of the able new minister for health, Dr Nkosazana Zuma. Like so many academics and professionals who were opposed to apartheid, she was forced into exile and suffered far more than mere “damaged self esteem.”

Having publicly supported sanctions for over 30 years (even while I was an academic in South Africa), I now take the opposite view and urge the strongest possible links—academic or other—with the country to help repair the damage of the past and build the sort of country free of prejudice that most South Africans wish to see.

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1 Crawshaw R. Out in the cold: academic boycotts and the isolation of South Africa [editorial]. *BMJ* 1995;311:136. (8 July.)

South African Medical Association colluded with apartheid

EDITOR,—The South African Medical Association's apology for its attitude and silence during the years of apartheid must be welcomed.¹ When we look back over those years, however, it is not only sins of commission to which attention should be drawn but also those of omission. One of the saddest aspects of the association's attitude, apart from in relation to the death of Steve Biko while in police custody, was its failure unequivocally to condemn apartheid in medical education. Few people will remember the battle that was fought in 1943 and subsequently to allow non-white medical students to continue their education in the clinical years at Cape Town University and our having to sign a document undertaking not to attend any class, clinic, ward round, tutorial, operation, or postmortem examination involving a white person.

I still look at the press and other reports of my suspension in 1944 for being present at an orthopaedic tutorial at which white patients whose fractures were in plaster of Paris, and their x ray pictures, were used for teaching. The saddest fact among those papers is the absence of any condemnation by the South African Medical Association of that dreadful event and the ensuing controversy over apartheid in medical education. It is pertinent to quote from a contemporary editorial in the *South African Medical Journal*:

This Journal is the mouthpiece of an Association that consists of members some of whom are profoundly shocked by what is taking place today in our ranks, and of others who take an exactly contrary view to that held by Dean Hulme [on medical apartheid]. Both sections are representative of the two conflicting South African schools of thought and both have the right to demand that, until the Association has expressed itself clearly and unequivocally on the points at issue, its official Journal should not commit its members to any policy which is not sanctioned by the authority of Council or Congress. . . . In this matter of the colour bar in medicine our Association has not, as yet, taken up an attitude that supports conflicts with what may be called the liberal and conservative schools of thought in the Union [of South Africa].

The remainder of the editorial fudges the whole issue.

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1 Sidley P. South Africa's doctors apologise for apartheid years. *BMJ* 1995;311:148. (15 July.)
2 The colour bar in medicine [editorial]. *S Afr Med J* 1944;18:221.

Maintaining clinical contact during research

EDITOR,—As a clinician working in research in medical informatics I am concerned that there is no career structure to enable me to maintain clinical training at the same time as pursuing research. Currently, medical informatics has traditional links with epidemiology and general practice, which have arisen both from the use of computers for statistical analysis and from the presence of computers on general practitioners' desks. This will inevitably change as we move towards electronic patient records and an NHS network for communication between disciplines and sites. Skill from all areas of clinical medicine will be required to ensure that accurate and relevant information can be captured, stored, transferred, and received. Little is to be gained by maintaining the current situation, whereby the only way to maintain clinical contact as a researcher is by taking locum posts. This discourages clinicians from committing themselves to research in medical informatics, and those who do this become less valuable as a source of clinical knowledge as they lose their clinical base.

In the United States posts exist that are split between research in medical informatics and true clinical training. Such split posts are available at all levels of training from junior to consultant and provide a career structure appropriate to both medicine and medical informatics.

Nothing similar exists in Britain. This will prove to be a problem when current students being taught medical informatics as an integral part of the practice of medicine find on graduating that, although the use of computers is fundamental to their work, there is no mechanism for them to influence the development and implementation of clinical systems.

I believe that we can anticipate this before it becomes a problem, and I would welcome the opportunity to discuss the practicalities of introducing split posts in all disciplines of medicine. Medical informatics has now been taught in the curriculum for one year, and there are plans for there to be some input throughout the five years of undergraduate training. This means that in five years' time senior house officers will be looking for the opportunity to take up split posts. If a policy and structure can be agreed in the near future, teaching in medical informatics can be directed during the clinical undergraduate years to facilitate a seamless transition into such posts.

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Genetic testing in the classroom

EDITOR,—Audrey Tyler and her colleagues are concerned that students' practical work could lead to genetic screening without pretest counselling.¹ We have run such practicals for four years (for science students) and for two years (for medical students). Students are given the option of testing

whether they are carriers of the defect causing cystic fibrosis (in terms of the $\Delta F-508$ mutation) after an explanatory lecture by one of us (SR), in which the implications of the possible positive results are stated.

Confidentiality is assured because students pick a unique number out of a hat; after producing a saliva sample they use that number to label their tube. Anonymous samples are available for students who do not wish to test themselves; these are similarly labelled. Tests are then performed under supervision. Results can be obtained only by students who know their number and whether the sample is their own. The class knows that students found to be positive can have a fast track genetic consultation (with SR and colleagues). All who take up this offer are relieved to know their status and keen for their families to be given information and offered carrier testing.

Anonymous questionnaires have sampled the students' views, and the practicals have been found to be popular. Most students (over 90%) have chosen to test their own status. One student said that the pretest counselling lecture was “over the top” (in indicating the dangers of being tested); most welcomed the opportunity that the lecture gave them, before testing, to have discussions with their peers and teachers about the pros and cons.

In practicals of this type, peer pressure might cause unwilling individuals to follow the group,² but we would expect such difficulties to be shown by our questionnaires or the counselling after the test. The practicals have, on the contrary, proved a highly popular part of our biochemistry course and have extended the work of Grody *et al.*²

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1 Tyler A, Ball D, Clarke A. Genetic testing in the classroom. *BMJ* 1995;311:330. (29 July.)

2 Grody WW, Kronquist KE, Lee EU, Edmond J, Rome LH. PCR-based cystic fibrosis (CF) carrier screening in a first-year medical student biochemistry laboratory. *Am J Hum Genet* 1993;53:1352-5.

Extracontractual referrals

Budgets need to be increased to realistic level

EDITOR,—Barbara Ghodse highlights both the administrative workload and the financial pressures imposed on health authorities by the extracontractual referral system.¹ I have analysed the extracontractual referrals processed by Rotherham Health Authority (population 250 000) during the three months April to June 1994. I found a similar number of extracontractual referrals per 1000 population and a similar ratio of emergency to non-emergency referrals to those given by Ghodse.

Because of the perception that an increasing number of extracontractual referrals were consuming increasing resources above the figure set for them in the budget I tried to identify referrals where reductions could be made. I assumed that emergencies were not amenable to modification and that forensic psychiatric cases (with the most expensive procedures) were also unlikely to be influenced.

Among the non-emergency referrals, trauma-orthopaedics and ophthalmology accounted for 45%. Trauma-orthopaedics cases were difficult to analyse by problem, but almost all were tertiary

referrals and therefore presumably could not be treated at the local hospital. All of the ophthalmology referrals were for conditions not treatable at the local hospital. The other procedures were spread fairly evenly across all other specialties. These numbers were too small to warrant individual case definition. The money to be saved on any of these referrals would not repay the effort of tracking them down or confronting clinicians about their clinical judgment.

I agree with Ghodse that one way of reducing workload is to limit the number of extracontractual referrals per provider and develop contracts if this number is exceeded. Another way is to develop contracts by specialty if a number of cases are being referred for a particular condition. Such contracts would also save money. Setting clear guidelines for extracontractual referrals and circulating them to all relevant clinicians, including general practitioners, may help this process. Good systems for collecting, recording, retrieving, and analysing the data by specialty, procedure, and referrer are also required for audit.

The fundamental point about increasing numbers of extracontractual referrals outstripping the budget nevertheless remains. This is addressed by Auplish and Shires.² An analysis of budgets for extracontractual referrals showed that all those authorities with a budget of less than 2.5% of their total budget experienced similar difficulties of perceived overspend. Those authorities with around 2.5% of their total budget allocated to extracontractual referrals did not overspend. Thus the problem is really one of underfunding. As extracontractual referrals did not exist until the NHS reforms, the figure to be allocated to such referrals was difficult to quantify, and therefore most health authorities probably underestimated initially. Monitoring is important, but the fundamental need is to increase the budget for extracontractual referrals.

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- 1 Ghodse B. Extracontractual referrals: safety valve or administrative paperchase? *BMJ* 1995;310:1573-6. (17 June.)
- 2 Auplish S, Shires L. Who goes where? *Health Service Journal* 1994;104:24-5.

Panel has reduced inappropriate requests

EDITOR,—We endorse Barbara Ghodse's recommendation that extracontractual referrals could be handled more efficiently.¹ We would emphasise more strongly the central importance of involving general practitioners both in assessing the justification for extracontractual referrals and through giving them feedback on decisions made.

In Lambeth, Southwark, and Lewisham extracontractual referrals are considered by a panel chaired by a contract manager, which includes two local general practitioners (one a fundholder), the director of quality, and a public health doctor. The views of general practitioners are thus incorporated into the decision making process. The panel feeds back to referring general practitioners both the decisions reached and an explicit statement of the underlying principles. This has had the beneficial effect of reducing the number of inappropriate requests for extracontractual referral of patients who could be managed within existing contracts and has supported the general practitioners' ability to resist pressure by patients to make a referral that is not justified by clinical need. The panel has evolved policies for handling the commoner types of requests for extracontractual referrals, and many requests can now be dealt with by managers, when necessary with advice from local clinicians. The panel has been able to reduce the frequency of meetings from weekly to monthly.

We believe that this is an efficient way of handling the sometimes complex ethical and clinical issues

raised by requests for extracontractual referrals. We are also examining the possibility that the panel might be able to act as an informal route of appeal for patients of fundholding practices who disagree with their fundholder's decision on which providers to contract with.

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- 1 Ghodse B. Extracontractual referrals: safety valve or administrative paperchase? *BMJ* 1995;310:1573-6. (17 June.)

Classified advertisements in the *BMJ*

EDITOR,—I wish to comment on a decline in the standards of the appointments section of the *BMJ*'s classified supplement. Not long ago, all advertisements for jobs were identical in layout; alas, no more. At first I viewed the change in format with amusement, but now I believe that this nonsense should not be allowed to progress further. I do not believe that the trusts placing these new advertisements have done any research among customers into what attracts a doctor to a job.

Within the past month I have seen an advertisement for a consultant psychiatrist that did not state where the job was located or the name of the prospective employer (the prospective applicant had to contact a recruitment agency) and full page spreads offering top financial rewards the nature of which the advertisers are too embarrassed to mention. The final straw is a half page colour advertisement placed by a trust in Essex; 30% of it is devoted to a photograph of some rowers on a river with the headline "Be part of a winning team." Who is the trust trying to kid? Nothing is going to disguise the fact that the job is in Basildon.

I am part of a cohort that will soon be seeking a consultant's job. My friends and I have drawn up a list of jobs that we will not apply for. We will ignore posts for which the advertisement is anything other than normal format; for which the advertisement does not mention the location of the job; in trusts where the chairperson is a grandee in the Tory party who has never worked in the NHS before; or in trusts that delude themselves by believing that they are dynamic, caring, or at the cutting edge of health care.

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Colleges and trusts are blocking humanitarian service

EDITOR,—I was pleased to read of the Princess Royal's support for the release of medical staff from health authorities and trusts for voluntary work overseas.¹ The princess is quoted as saying: "People returning [from working overseas] report negative attitudes and a lack of interest. Working in other countries appears to give a negative signal to employers." This has been the experience of the British Red Cross Society.

There are two main difficulties. Firstly, as indicated in the article,¹ trusts are unwilling to release staff. This is largely for understandable commercial reasons, but the staff's loyalty towards their trusts has also been questioned. Secondly, doctors in training have been told that any interruptions to their training scheme not only fail to count in their favour but may also result in their losing their numbered place, so that three months spent away may result in the loss of a year's accreditation.

Many areas throughout the world require humanitarian aid. Medical staff are in much demand, and the International Committee of the Red Cross currently faces a crisis due to a shortage of surgeons and anaesthetists. The British Red Cross, on behalf of the international committee, is trawling for volunteers, who would be paid on a contract basis. We require general surgeons, preferably with orthopaedic and trauma experience. Anaesthetists should be prepared to work in conditions where modern technology may not be available.

Medical staff who dedicate some of their time towards providing humanitarian aid learn enormously from their experience. They enlarge their perspectives on both life and medicine, gain from making decisions in difficult circumstances, and handle situations with greater understanding and humanity. Such overseas work should be recognised officially towards their training, and certainly should not be counted against it. Trusts are fortunate to have staff who have seen the world. Therefore, while taking this opportunity to ask for surgeons and anaesthetists to come forward to meet the present crisis, I would like to plead for greater understanding from the colleges and trusts towards those medical staff who wish to contribute to the wider practice of medicine and the interests of humanity. Anyone interested in helping the Red Cross should contact Anne Kerr, care of the address given below (telephone (0)171 201 5122).

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- 1 Christie B. NHS staff should work in developing world, says princess. *BMJ* 1995;311:77-8. (8 July.)

General practice at night

New agreement penalises doctors who do their own on call

EDITOR,—The title of a recent news item "GPs accept out of hours offer unanimously" would be humorous if it was not so tragically untrue.¹ General practitioners have done no such thing. We have not even been asked if we accept the offer. A few months ago I was amazed at the response to a ballot, which showed that a huge majority of general practitioners were ready finally to unite against the laissez faire attitude of a government that cares nothing for their morale and good will.

How has the offer changed since it was last rejected? We can now devolve our responsibility to another general practitioner. A good joke perhaps—the problem is that general practitioners are sick of this work. How many will want to take on any more of it? Now all vocationally trained doctors will receive the paltry night visit fee. How generous once again to bribe us with our own money. I never fail to be amazed at how we fall for the government's outrageous trick of moving parts of our pay around by changing its name, only to claw it back a year later.

The most delicious irony of all is that the general practitioners who lose most from this debacle are the ones who are dedicated (or unfortunate) enough to do all their own on call work. They will