the layman. In this respect it is unfortunate that the health care professionals have constantly stressed the possible implications that can arise from relatively simple and minor injuries—for example, tetanus from untreated wounds—and have contributed to raising public anxiety associated with emergency health care. Even first-aid manuals stress the ignorance of the first-aider in comparison to the health professional, and inevitably the notes end with the phrase "if in *any* doubt do not delay in seeking medical advice." This kind of exhortation will inevitably make the public reach for the telephone and dial 999, whereas if the public had greater confidence in their own diagnostic and prescriptive ability, calls to the ambulance service would be fewer.

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National Health Service reorganisation —community medicine

SIR,—As a firm believer in the importance of words, terms, and designations, I suggest to my community physician colleagues that the opportunity of the impending National Health Service reorganisation should be taken to align ourselves more firmly with our clinical colleagues in other specialties. I recommend that the designation area medical officer should not be replaced by the designation district medical officer, but by specialist in community medicine (SCM) or community medicine specialist (CMS), preferably the latter. I believe that such a designation would help to enhance the specialty, both within medicine and in relation to our consultant colleagues. The designation specialist in community medicine or community medicine specialist, having gained acceptance, is already more meaningful and more descriptive. Confusion with the designation medical officer for environmental health would be avoided by its acceptance, and perpetuation of the medical officer of health image along with the hierarchical one would be avoided by so doing.

I advocate the use of the term "responsibility for" in regard to future SCM/CMS posts and suggest that the proposed term "special interest" or "interest in" should not be applied to such posts. Provision would need to be made in job descriptions for this; it now seems to be widely accepted that labels and "brackets" in relation to our present designations should cease.

I would like to see the Faculty of Community Medicine accept and propagate my advocacy but additionally seek the support of all medical colleagues.

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Cutting the cost of the National Health Service

SIR,—The question put to Dr P V Scott (21 June, p 1535) by Mr N G M Legg in his letter (12 July, p 150) is of wide interest and I should like to present "generic prescribing" as an answer. The *Daily Telegraph* is featuring this currently and a number of community health councils are recommending this solution. Also the point is made, for example, in the DHSS leaflet on antidepressants—showing the prices of the "branded" medicinal products compared with the generic products at June 1980. The balance in the frequency of prescribing equation:

$$\text{Approved name} \rightleftharpoons \text{Brand name}$$

will require to be determined fairly accurately for the family practitioner services. Equilibrium too far to the left will reduce efforts to discover new drugs, and work on improved utilisation of current drugs in the body would be lost. Equilibrium too far to the right takes too much out of the NHS in the current economic position of the UK.

Determining the balance point limits in the equation would show worthwhile savings in the family practitioners' services, which would then be passed on to health authorities. The evidence from the hospital sphere suggests that they have the balance very nearly right. The difference in prescribing and supply of medicinal products in hospitals is that they have: (1) Drug and therapeutic committees. (2) Hospital formulas and pharmacopoeias of rational prescribing which show appropriate drug names, dose intervals, and quantities to be supplied. (3) Administration of the doses to patients recorded on charts.

Additional benefits to the patients would arise from this type of evaluation, such as reduction in overdosage and a fall in the quantities of medicines wasted.

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Pre-employment medical examinations

SIR,—For many years I have enjoyed reading from time to time the incisive comments of Dr J W Todd (19 July, p 232) on the absurdities and injustices that can arise from the insistence of employing authorities on pre-employment medical examinations. It grieves me, therefore, to have to disagree with him when he proclaims that these are never justified unless the safety of other people is in question.

He was commenting on the letter from Dr G H Sylvester (28 June, p 1616), which referred particularly to nursing. Dr Sylvester is surely right to say that there are some conditions which make nursing an unsuitable career—for example, some cases of chronic low back pain, frequent grand mal attacks, sensitivity to penicillin and other medicaments, or the rare case of unstable diabetes. The doctor who after examination and careful consideration advises such applicants against nursing is performing as much of a service to them as to the employing authority. Rejection at the outset is far less traumatic than resignation forced at a later date by practical demonstration of unsuitability.

Dr Todd's crusading zeal springs, I think, from two factors—the bureaucratic insistence of many employers on medical examination where the nature of the job makes it irrelevant and superfluous, and the practice of some examining doctors in rejecting applicants, without sufficient reason, on unjustified assumptions about the demands of the job, the prognosis of the disability, and its effects on working capacity. The examination tends to be regarded by most laymen, including administrators, as an obstacle to be cleared by the job aspirant; but there is no reason why the medical examiner should not treat it rather as a counselling interview, if there is any doubt. Considerations of fitness are seldom easily stated in black-and-white terms.

Like Dr Sylvester, I have for over 30 years been assessing the fitness of people for jobs, and, like him, I blush to recall some of my past decisions. I have learnt that where there is a good reason for the examination and the applicant is highly motivated to do the job the doctor should be consciously biased in favour of finding the applicant fit. Only solid and incontrovertible medical and occupational facts should lead to rejection. This entails the most careful consideration of all the features of the individual case. Where medical examination has been required without good reason, there is nothing to prevent the doctor from finding every applicant fit.

But Dr Todd talks a good deal of sense. We need people who throw out bath water, but enthusiasm should not blind us to the occasional presence of a baby in it.

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Changes in MRCP (UK) examination

SIR,—Plus ça change, plus c'est la même chose. The letter from the College Presidents makes disappointing reading, in particular that part which disallows a candidate who fails his written paper to proceed further. This is, indeed, turning the clock back, for it was the practice of the old MRCP London.

The increasing number of candidates is a symptom not a cause. Many of these come from abroad. Does the MRCP (UK) have any relevance for them? If not, would it not be better to exclude them or to provide separate special conditions for them, even if this means a loss of revenue?

Ability to take a good history and to carry out a competent physical examination are stressed as central requirements. Surely these are basic skills that should have been inculcated in undergraduate schools. To insist that they are prerequisites for a major postgraduate examination is a reflection on the standard of undergraduate teaching today.

Is it not putting the cart before the horse by recommending that the examination should be taken before proceeding to higher medical training. Proof of the adequacy of such training should not depend upon the candidate, but rather upon specific requirements, preferably laid down and administered by the GMC such as it does in undergraduate teaching.

The public rightly expect nowadays that prospective doctors be properly educated and subsequently registered as such. They have an equal right, in this regard, for those who wish to become physicians and surgeons.

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Correction

Unanswered questions about ectopic pregnancy

We regret that an error occurred in the letter by Mr E G Jonas (19 July, p 228): "aberrant" in line 14 of the fourth paragraph should be "abeyant."