certified claimants. I wonder if he realises that the regional medical service already employs over 200 GPs and ex-GPs on a sessional basis and that to employ more would involve expanding the numbers of supporting civil servants and of existing medical examinations centres.

At the moment the regional medical service only examines claimants for sickness benefit who have been issued with doctors' statements, and about whom the doctor has had the opportunity to report. It would be very difficult and very expensive to devise a new scheme whereby self-certified claimants could be examined in under seven days, and which at the same time was acceptable to the profession.

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The GMC and "warning letters"

SIR,—Could I point out an important omission in your report of the GMC meeting (15 November, p 1368)?

During this meeting, I proposed a motion intended to prevent the secretariat of the GMC from sending out "warning letters" to doctors in respect of "complaints" about purely contractual disputes between doctor and employer. Your report correctly states that I eventually withdrew the motion—but you do not give the vital reason why I did so.

I am pleased to say that—with the valued assistance of various speakers from the BMA and the Overseas Doctors Association—I was eventually able to obtain *an assurance that the GMC will send out no more such "warning letters."*

This undertaking will hold until such time as full consultations have taken place between the relevant GMC committees, Dr Ian McKim Thompson of the BMA, and myself.

D G DELVIN

Chislehurst, Kent

Who services what?

SIR,—Scrutator (11 October, p 1016) comments on the growth of the Association of Scientific and Technical Medical Staff (ASTMS) representation on the Hospital Junior Staff Committee (HJSC) as "a development the BMA must combat or it could find itself funding and servicing an ASTMS junior branch at Tavistock Square."

I must reassure him. ASTMS is perfectly capable of funding and servicing its own juniors, who are quite happy with the facilities at Jamestown Road. We have several times made known our willingness to participate in the servicing of the HJSC, if the necessary constitutional adjustments can be made, and even without those adjustments we have on occasions offered the help of our research department, or our parliamentary committee. The BMA has so far preferred to bear the full burden itself, but it can't then complain of "free riding"—free riding is the natural consequence when the conductor refuses to collect the fare.

But then we know perfectly well that we can't satisfy Scrutator. When we seek independent negotiating rights we are accused of being divisive and told that we must work within the democratic machinery of the profession, and then when we follow that advice, put our ideas to the test of democratic votes, and win we are accused of being subversive.

The Medical Practitioners' Union/Association of Scientific and Technical Medical Staff (MPU/ASTMS) has a legitimate reason for existence. That reason is not only based on medicopolitical differences (although those differences exist, and debate in the HJSC is enriched by them) but also on the desire to belong to a union which includes other health professions, and which is affiliated to the TUC. By participating in the General Medical Services Committee, the Central Committee for Community Medicine, and the HJSC we are able to allow those differences to be expressed in the democratic machinery of the profession, and thereby to maintain our separate existence without fragmenting the negotiating machinery.

That position is absolutely consistent with the traditions of the profession and certainly contrasts favourably with the divisive position taken by groups like the Hospital Doctors' Association, which prefer to stand on the sidelines shouting rude comments and gnashing their gums.

The fact that the BMA hierarchy regards our participation in the craft committee not as an enrichment of the traditional democratic machinery of the profession but rather as a threat to their power demonstrates the difference between the rhetoric of a united profession and the real power game played by the BMA establishment. And that is another reason why we intend to ensure that the craft committee have alternative sources of servicing available to them, as a guarantee of their autonomy.

STEPHEN J WATKINS
Chairman, MPU/ASTMA Junior Doctors' Committee

Chorley, Lancs

Community medicine: a second chance?

SIR,—As a late medical administrator, with strong views on the need for institutional management, may I be allowed to link the main points made by Dr S T H Jenkins, who seeks to restore the medical superintendent (18 October, p 1074), and Dr J A Lee, who favours managerial community physicians (1 November, p 1218)?

My experience in Edinburgh showed that the proper practice of management skills calls for a sound knowledge of clinicians, their back-up staff, and the hospital environment. It is only thus that mutual respect develops, and with it the clinical sanction to practise decision making with that immediacy which the situation so frequently demands in the interests of patient care. It may therefore be that the managerial community physician will have to be institutionally based to function effectively, and so will become a de facto medical superintendent.

A word of warning: those placed in the management situation must not be held accountable to epidemiologists, for the crises of the clinical world will brook no delay. I resigned because of that.

J R WOOD

Auchenblae, By Laurencekirk,
Kincardineshire

SIR,—I was interested to read Dr John Lees's letter (1 November p 1218) on this subject, particularly his opinion that two types of community medicine doctors are needed—that is, epidemiologists and managers.

While agreeing with Dr Lees about the need to establish full-time epidemiologist posts in the NHS, there seems to be little encouragement for community medicine doctors to take up this specialty. As regards the managerial aspects, I confess to being somewhat sceptical. If community medicine is to succeed it must—as in the case of clinical specialties—respond to a felt need by the medical profession as a whole. Whether the profession has felt the need for a whole new cadre of doctors with administrative and managerial functions is open to discussion.

Community medicine opened out exciting prospects for doctors interested in the control and prevention of disease, accidents, and disability. Such prospects seem not to have materialised and in many parts of the country community medicine doctors find themselves engaged in administrative and bureaucratic tasks, which may be attractive to some but offer no real challenge to young men and women surveying the possibilities of the community medicine field.

This brings me to the generalist concept of community medicine. I believe that this should be discouraged. The community medicine field is made up of a group of specialties (including epidemiology) which need clearly defining. A doctor should be able to take up any of these specialties on a career basis and should be known by his function. For example, if he wanted to do epidemiology he should take a specialised training in this on top of the MFCM and should then be known simply as an epidemiologist. The term "community medicine physician/specialist" should be reserved for those working in small communities where a generalist would be appropriate.

If this example was followed in other community medicine specialties all doctors—and others—would know exactly what community medicine doctors do, which is by no means the case at present. Job satisfaction, far from universal, would be assured.

The MFCM should be the basic qualification for specialisation in the community medicine field as the MRCP is in medicine and the FRCS is in surgery. Community medicine doctors would need to accept that, although skills acquired through the MFCM are unique, they are nevertheless basic and serve to lead them, if they wish, into more specialised work within the field.

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The universal language of cats

SIR,—Dr B J Freedman (18 October, p 1060) notes that the conventional sound assigned to cats is "miow" in most countries, and such uniformity is not apparently the case for other species. It is, perhaps, even more remarkable that the Ancient Egyptian hieroglyphs for cat  are, to the best of our knowledge, rendered phonetically as may-oo. They seem to have conformed to their current image for quite a long time.

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