harmful,[1-3] and the Department of Health and Social Security has been called on to take action to limit smoking in hospitals (25 July, p 308).

Hospitals are institutions for the promotion of health, and it might seem that smoking on hospital premises is incongruous. Many hospitals, however, have a main entrance hall where smoking is permitted, thus subjecting staff and visitors to passive smoking. The magnitude of this problem has not apparently been quantified recently, and a brief study was carried out to remedy this.

Addenbrooke's Hospital (new site) is a teaching hospital in Cambridge with a large entrance hall. There are three main entrances, leading to the main ward block, the main hospital entrance, and the canteen and residences. Three shops, a bank, a coffee room, the post room, and the chapel all open on to this main hall. There is a seating area with a well signposted no-smoking zone.

During half-hour study periods all smokers and a fixed proportion of all entrants to the hall were counted. Over six weeks, a total of 11 half-hour periods were sampled on weekdays only, between 09 00 and 19 00 hours. Study periods were chosen to coincide with maximum use of the hall (for example, lunchtime and visiting time). The number of seated smokers was used to calculate the percentage of hall-users who smoked. Wherever possible, smokers were categorised as to whether staff, patient, or unidentifiable.

There was an average of 8·6 smokers seated in the hall during study periods (range:1-16). At no time was there not a smoker in the no-smoking zone. Total users of the hall varied from 180 to 705 a half-hour study period, with an average of 413·6. The average proportion of smokers was 2·25%. The majority of smokers were unidentifiable (56%). Forty one per cent, however, were members of the domestic cleaning staff of the hospital. No patients were seen to use the hall for smoking.

Only a very small proportion of the users of the main hall at Addenbrooke's are smokers, but they inflict themselves on all hall users and oblige them to smoke passively. They do not permit a no-smoking seating area within the hall to function.

This evidence has been presented to suggest that the main hall of hospitals should be a strictly no-smoking zone and that this should be enforced. Ashtrays should not be available. A voluntary no-smoking zone would appear to be impracticable. Alternative smoking areas should perhaps be available for staff who wish to smoke, and for patients.

I thank Dr N Olsen, district community physician, for his suggestions and encouragement. Fuller details of this study are available on receipt of a stamped addressed envelope.

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[1] White JR, Froeb HF. *N Engl J Med* 1980;**302**:720-3.
[2] Hivayama T. *Br Med J* 1981;**282**:183-5.
[3] Trichopoulos D, Kalandidi A, Sparros C, MacMahon B. *Int J Cancer* 1981;**27**:1-4.

Planning to work in the USA?

SIR,—Your contributors Drs J M Connor and R A C Connor (16 May, p 1645) are incorrect in their statements that "A spouse can enter on his or her partner's immigrant visa, but will require the VQE if he or she intends to work as a doctor."

The visa qualifying examination is no more than a visa qualifying examination—it is a prerequisite for physicians applying for certain types of immigrant visa, and is an attempt to limit the number of potential visa applicants. It is not a requirement for medical licensure. However, there is a much easier examination called the FLEX (federal licensing examination), which is usually needed by British graduates who wish to practise. This is held twice a year throughout the United States.

If a physician can claim a right to live in the United States—for example, by having relatives, being sponsored by friends, having a net worth of £20 000 or by being the spouse of a person who has a needed skill (such as teaching, nursing, engineering), the VQE is not required as the physician will automatically get an immigrant visa when the spouse applicant gets his or hers. This is also the best way for a physician to undertake a period of postgraduate training in the United States, as it allows the physician to earn extra income, and also to extend the visit if so desired (perhaps permanently).

Finally, a new regulation was introduced in December 1980 waiving the requirement of the VQE for physicians intending to practise in less desirable areas of the country.

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Training of pathologists

SIR,—There have been several letters in the *BMJ* during the last few months commenting on the unpopularity of pathology (14 February, p 569; 7 March, p 826; 4 April, p 1160; and 24 April, p 1401) arising from the article "Staffing crisis in pathology" by Drs J R Anderson and J R Tighe (15 November, p 1370). I have entered pathology in my 30s after working in several branches of medicine, including a year in general practice and over a year in an African mission hospital. I feel that I have a fairly wide experience of medicine and I am writing this letter on the training of pathologists as a basis for discussion.

There is general agreement that pathology is an unpopular specialty. However, little seems to have been done to remedy the situation. I should like to consider the current situation before discussing how it might be improved. Most laboratory work is performed by technicians. A doctor entering pathology straight from clinical medicine suddenly finds that he has little work to do. Unlike his clinical counterpart he has no responsibility for patients or running the laboratory. He is in no position to advise technicians until he has worked in the laboratory for several months and acquired some expertise in the interpretation of results. This sense of isolation is often most marked in teaching hospitals, where each department has its full complement of experienced doctors.

Teaching is completely haphazard. Lecture schedules may be made but these are rarely adhered to; the person responsible is either away or dealing with more urgent matters. Consequently the SHO receives practically no tuition. There is no equivalent to the consultant ward round in pathology. It is usually difficult for the doctor to learn the practical aspects of the work as these are carried out by technicians, who are usually too busy to teach.

The aspiring pathologist is then faced with the primary MRCPath examination after two years. Unfortunately the present examination produces two grades of pathologist—those who have worked in all four major branches of pathology and supposedly have a good general knowledge and those who gain exemption from the primary because of the MRCP or a degree in one subject. The latter will obviously lack the breadth of knowledge possessed by the first group.

I offer the following possible solutions to these problems. (1) Recognised teaching laboratories should be so organised that the trainee pathologist is taught basic laboratory skills by a senior technician. (2) One consultant (if there are several in that laboratory) should be responsible for organising the training of all junior pathologists. (3) There should be a weekly day-release course organised by the Royal College of Pathologists on a regional basis. This would include lectures and demonstrations on the major specialties. (4) The primary multiple-choice question paper should be compulsory for all candidates for the MRCPath. Those with the MRCP, or an MSc in biochemistry or microbiology, would be exempt from the practical and viva voce examination.

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Will doctors miss out again?

SIR,—I was disappointed to note that an article by Mr Norman Ellis (4 July, p 84), senior industrial relations officer of the BMA, contained no reference to the effects of reorganisation on community physicians.

I fully appreciate the possible effects on other crafts within the Association, but I am sure that Mr Ellis and his staff realise only too well that the major effects at the present time are on the careers, and indeed on the health and wellbeing, of community physicians. This is the second time in eight years that their jobs have been at risk through political action, and I would have expected Mr Ellis to have made specific reference to the serious implications not only for the specialty as a whole but for individuals.

It may, of course, be that Mr Ellis intends to write a further article referring to community medicine specifically, and if this is so I shall be pleased to see it published in the very near future. If this is not the case then serious consideration should be given to publication in your columns of the views of the senior industrial relations officer on the specific problems faced by community medicine at the present time.

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SIR,—Your "Talking Point" article by Mr Norman Ellis (4 July, p 84) entitled "Will doctors miss out again?" makes no reference to the future of doctors practising community medicine but concerns itself with the management arrangements for other National Health Service professions at unit and district level. How refreshing it would be to see some acknowledgement in your columns of the effect that the reorganisation will have on the only doctors whose jobs are directly affected by it. Please note that community physicians are BMA members as well as their colleagues in clinical practice.