ceeded in solving the recruitment problems of specialties such as pathology and geriatric medicine. Methods must be found to attract young graduates to these specialties alongside any proposals that will result in training times of an appropriate length.

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## Defects in proposed regional advisory machinery

SIR,—The steady progress made over the past decade in the development of postgraduate education and training has greatly enhanced the standing and status of general practice. Morale is high, and recruitment of the best students has never been so good. This has been achieved by the close collaboration between the Royal College of General Practitioners and the General Medical Services Committee, culminating in their joint enterprise, the Joint Committee on Postgraduate Training in General Practice. But central policy has to be complemented by effective local training arrangements in which many specialties and a variety of interests are involved. The excellent arrangements made for regional co-ordination introduced on the recommendation of the Royal Commission on Medical Education (Todd Report)[1] and strongly supported by the Committee of Inquiry into the Medical Profession (Merrison Report)[2] are seriously threatened by the proposals of the second report of the Joint Working Group on Medical Advisory and Representative Machinery (the Yellowlees Report).[3]

The Yellowlees Report is defective in two important respects. The strength of the present regional postgraduate committees is their independence. Although funded through regional health authorities in England and Wales (and directly by the health departments in Scotland and Northern Ireland), the committees directly represent the universities, the royal colleges and faculties, the profession, and the NHS, and enjoy the confidence of each of these independent authorities. That independence and confidence will be lost in the Yellowlees proposals.

The second defect is the proposal for the specialist advisory committees. The general practice "sub" committees of the regional committees have been the effective instruments of change in vocational training, and now in continuing education, but their close relationship to the regional committees has been an essential factor in developing a rapport with the universities' postgraduate deans and the specialist advisers and committees of other disciplines. That relationship has been a unifying force in an era of increasing divisiveness emanating from progressive specialisation within medical practice—a unity which comes more readily in educational debate than in the competitive arena of resource allocation.

The Merrison Committee was the architect of the new General Medical Council. It is worth recalling its perceptiveness in recognising that there was an inevitable, and entirely blameless, conflict between the needs of education and service resources. Problems involving the interaction of standards and resources are particularly difficult in postgraduate education because they arise in a clinical setting—that is, "in circumstances where the prime aim must ever be the immediate care of patients. We believe that the machinery for resolving the problems of the interaction of standards and resources needs to be local, influential, and informal . . . three adjectives which aptly apply to the regional postgraduate committees" (paragraphs 74-75). There must be "an efficient local mechanism concerned with the identification of suitable posts, and with matching posts to training requirements . . . this sort of process can take place only in an atmosphere of co-operation and good will such as we believe to exist within the regional postgraduate committees" (paragraph 146). The Yellowlees proposals would inevitably subjugate educational matters to service considerations and destroy the subtle balance which has been established by the regional committees over the past decade. It is of the first importance to the whole profession that these proposals are reconsidered and the strengths of our existing organisation reassessed.

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[1] Royal Commission on Medical Education. *Report*. London: HMSO, 1968. Cmnd 3569. (Todd Report).
[2] Committee of Inquiry into the Regulation of the Medical Profession. *Report*. London: HMSO, 1975. Cmnd 6018. (Merrison Report).
[3] Joint Working Group on Medical Advisory and Representative Machinery *Report on regional arrangements*. London: DHSS, 1981.

## Part-time training

SIR,—Mr William Russell (13 February, p 524) and Mrs Renée Short were correct. The Medical Women's Federation is indeed delighted that more opportunities for part-time training are being demanded. However, this must not mask the fact that the federation is as deeply concerned that there should be opportunities for the majority of medical women to practise full time on equal terms as consultants and principals in general practice. We do not stand for second-class medical citizenship with diminished responsibilities; but we do wish to help those men, and the more numerous women, who are temporarily unable to work full time.

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## Medicine in South Africa and Britain

SIR,—It is a pity that Dr J N de Klerk (13 February, p 514), chairman of the Medical Association of South Africa, should misinterpret the caustic comments of his countryman Dr C F van der Merwe. Though I have sympathy with Dr van der Merwe's rather overstated comments, I cannot agree with Dr de Klerk's whitewash of the medical profession in South Africa.

Though there are many conscientious and hard-working doctors in South Africa, there is a deafening silence from the profession over the inequalities of health care between the races. When there was an outbreak of poliomyelitis in the area south of Durban in mid-1975 we were admitting about 30 African children a month to Clairwood Hospital in Durban. It was not until three months later that a polio immunisation campaign was mounted. Would this delay—without a murmur from the medical profession—have happened if the children had been white?

Wherever one looks there are gross irregularities. The overcrowded King Edward VIII Hospital, where I worked in 1975, had patients after eye operations sleeping under other patients' beds and a special care baby unit with over 100 babies and seven nurses on duty at night. It compares poorly with the palatial Addington Hospital for whites on the seafront. Yet the African hospital at Umlazi, which would have taken some of the pressure off, has been over 15 years being built and is not yet finished. It is indeed time that the Medical Association of South Africa made an honest appraisal of what efforts are being expended for the less fortunate members of their country and spoke up about them.

RUPERT GUDE

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## Another death in detention in South Africa

SIR,—We write to you as a group of South African doctors strongly opposed to the political system in our country and the methods used to maintain it.

Early on Friday morning, 5 February, Dr Neil Aggett was found hanged in his prison cell in Johannesburg. He had been detained in solitary confinement since last November without trial or charge.

There was considerable correspondence in these columns in the aftermath of Steve Biko's death in detention. We feel that such international attention has had some restraining effects on the authorities. In particular, there has been a notable decrease in the frequency of deaths in detention since that time.

We are especially concerned for the safety of at least 150 people who are still detained under conditions similar to those under which Dr Aggett died, and who do not even have the apparent protection of being white doctors. British health professionals often ask what they as individuals can do to help. We believe that by publicising the conditions of detention and by calling for an open judicial inquiry into the conditions surrounding Dr Aggett's death they will thereby afford the detainees a small measure of protection denied to them by law.

We want to appeal to our medical colleagues to use all available means to bring pressure to bear on the South African authorities to release all political detainees.

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## Correction

### Oestrogen receptors and survival in early breast cancer

In the letter by Mr John M T Howat (20 February, p 597) reference 6 should be: Maynard PV, Blamey RW, Elston CW, Haybrittle JL, Griffiths K. *Cancer Res* 1978;**38**:4292-5.

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