CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Wasted journeys in the NHS

SIR,—The time consuming and expensive experiences of junior staff seeking promotion within the hospital services[1] have prompted the Association of Surgeons in Training to suggest three possible ways of alleviating the problems (I quote with their permission).

(1) If it is decided that all candidates should make a preliminary visit this should be stated clearly and a number of fixed days set aside when consultants are available to meet potential candidates. A proper appointment can then be operated.

(2) No preliminary visits, the shortlist being decided on the curriculum vitae alone and the shortlisted candidates being invited to visit before the interview.

(3) Two shortlists, the first being large with about 15 candidates selected from the curriculum vitae alone. This group could then be invited to visit and as a result the definitive shortlist made.

The Oxford surgeons felt that the third option might be beneficially applied to selecting a shortlist for a recent senior registrar post. There were 48 applicants for the post, of whom 12 had obtained a higher degree in surgery (MS or MD), five had submitted their thesis, and six had completed the work but had not yet submitted it. The average age of applicants was 33·5 years, meaning that these trainees might eventually achieve a consultant post when aged 37 to 38. Such is the situation in general surgery today.

Shortlisting from curricula vitae alone is not easy and may indeed be worrying because the difference between individuals appears so slight. We thought that it would be more just and more economical of candidates' and surgeons' time to make an unofficial "long" shortlist and invite only those individuals to visit the hospital. A tour of the hospital with one of the present senior registrars and meetings with the consultants would be arranged. After this the official shortlist was to be decided.

Seventeen applicants selected on the basis of their curricula vitae were therefore invited to the hospital on a specific day to meet some of the consultants. The letter explained that they had been initially selected to attend this informal visit and that a formal shortlist would be drawn up afterwards. It also said that as the arrangement was informal the region would not allow a claim for expenses.

A brisk response from the regional medical officer followed, stating that this method of selection contravened agreements negotiated between the Hospital Junior Staff Committee of the BMA and the DHSS (HN(PC)(76)5). It apparently also made the regional health authority liable for claims for travel expenses from these 17, as well as a later further claim from those officially shortlisted, and this was unacceptable to the region as the employing authority.

The proposed initial visit of the 17 candidates had therefore to be cancelled. For the surgeons an opportunity to assess personality and enthusiasm before the formal shortlist was made was sadly lost. In the future, to save large numbers of applicants from travelling, visits will probably be limited to the shortlisted candidates only. Should junior staff feel that the present rules are too rigid, perhaps they should reopen negotiations through the HJSC.

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1 Kelly MJ. Wasted journeys in the NHS. *Br Med J* 1984;**288**:1311.

Stagnation and despair in medical research

SIR,—The leading article by Professor C J Dickinson (2 February, p 337) is timely. Threats to academic medicine in Britain originate from many quarters, and many well informed observers believe that deteriorating quantity and quality of research are evident now and likely to continue inexorably and indefinitely. Financial pressures on the Medical Research Council, University Grants Committee, and other patrons of research are producing their predicted effect. This destruction of the seed corn of British medicine is deplorable and must be resisted, but success, certainly over the next four or five years, seems conjectural. One technique, however, is available to encourage academic medicine but it is so innovative, indeed revolutionary, that we fear it may produce some cultural shock among purists and conservatives.

The idea is that we should simply reward researchers roughly according to their ability, responsibility, and output. Ever since the Phoenicians invented money most people have realised they do not have enough of the stuff; this particularly applies to young people with high mortgages and growing families to support. There can be little doubt that there is a greater need for money between the ages of 30 and 40 than thereafter; it is this age group which should be producing, and usually does produce, the most important research in medical subjects. In our view these workers should be given a small percentage, say 2% or 3%, of the gross amount of any research grant which they have worked for, won, and are prepared to supervise. After all, they bear most of the burden of the inception, execution, and final realisation of important research projects. In what other walk of life would such entrepreneurs not be rewarded? It is no good saying

that they are the very people who will deserve and obtain high class distinction awards in the years to come—they need the money now and in any case may not be medically qualified. Neither is it much use promising them a senior lectureship or chair in five or 10 years' time; it is the immediacy of reward and punishment which is the most effective stimulant to most human effort.

We have discussed this idea with a number of senior professors of medicine, who condemned it out of hand as being (*a*) distasteful, (*b*) unworkable, (*c*) unnecessary as high distinction awards or good future prospects plus work satisfaction should be sufficient incentives. If so, why is recruitment to academic medicine falling off? We are unrepentant and would like to expose our idea to a wider public for comment. We would also like to add that neither of us is likely to gain in any way from the implementation of such a plan, though both of us have considerable experience of medical research, both in Britain and abroad. Critics may grumble that in these lean years our timing is wrong; but as optimists we are looking to the future.

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SIR,—I must congratulate Professor C J Dickinson on his leading article of 2 February. To support his conclusion one need only read the *BMJ* and *Lancet* of the same day. In the *BMJ* the only article on clinical research came from abroad, and two out of the eight papers and short reports came from abroad. In the *Lancet* three out of four of the original articles originated outside Britain and the single preliminary communication also came from abroad.

In addition to his complaint of lack of funding for research, he spoke of the rigidity of training programmes inhibiting young hospital doctors from spending time in research. In 1977 I complained about this rigidity and stated, "The establishment of training programmes has been an additional millstone round the neck of our young doctors, for which the medical profession must be held responsible."[1] These really should be abolished, together with the concept of formal accreditation.

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1 Oleesky S. Training programmes. *Br Med J* 1977;ii: 579.

SIR,—Professor C J Dickinson is right to sound a warning about the economic consequences of a decline in British medical science. This is particularly obvious in relation to the government's present policy of reducing the funds available for investment in the British pharmaceutical industry. In a report which the Office of Health Economics will be publishing shortly we show that in addition to investing over £400m a year on research, the industry recorded a net capital investment of over £200m in 1982 in respect of its NHS medicine business. A threatened cutback of £100m in the industry's profits could be expected to halve that figure in 1985, with a corresponding reduction in subsequent years. Other more profitable markets such as West Germany and the United States will probably attract the investment instead.

At present Britain is one of the top five nations developing new medicines (with Japan, Switzerland, West Germany, and the USA). It will not maintain that position if present government policies towards the industry continue to drive down its profitability in Britain.

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SIR,—Professor C J Dickinson cogently outlined some of the problems facing medical research. I would like to emphasise a further way in which the present policy of reducing support for medical research will be counterproductive.

A major reason for the escalating costs of the health service is the increasing expenditure on new expensive drugs and technologies. The health service is inundated with new and often expensive technologies and management methods. New techniques for treating and preventing diseases are being developed continuously. If their introduction is to be achieved rationally the temptation among clinicians, service managers, and lay individuals to accept at face value the claims made for new technologies must be resisted. As I have discussed elsewhere academic departments and research units are uniquely placed to undertake evaluation of new technologies.[1] Thus it can be expected that the further undermining of research resources will lead to a diminishing ability to assess the benefit and costs as well as the ineffectiveness of new methods. Health service planners will as a consequence find it harder to consider rationally any proposed new technologies or resist demands for their introduction even where claims have not been substantiated.

Unless it is appreciated that the critical scrutiny academics normally apply is of vital importance in making an unbiased assessment of cost effectiveness, then the health service will be doomed inexorably to spending more and more without necessarily improving the services provided.

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1 Holland WW. Teaching hospital in crisis: expensive luxury or vital asset? *Lancet* 1984;ii:742-3.

SIR,—Professor C J Dickinson's leading article has been given an authority which a feature so long on rhetoric and so short on fact does not deserve. The pips are certainly squeaking, as witnessed by this biased commentary and the recent refusal of the Oxford dons to grant the prime minister an honorary degree. I find it difficult to comprehend how an informed medical person who has witnessed the same part of this century from a similar position as myself can use such phrases as "relentless attrition" when describing our educational and scientific base. My own area is regarded as impoverished by most statistics, yet the comparison in educational and research facilities in Manchester between 1955 and 1985 indicates an expansion that few would have considered possible in 1955.

National medical manpower in the hospital service has expanded by 168% between 1949 and 1980 (1949, 11 735; 1980, 31 421)[1] and this is mirrored in new capital expansion both in university building and in basic research facilities, hardly suggesting the action of a backward medical nation, and this expansion is still proceeding. My own medical school (Manchester) now produces 270 new graduates a year compared with 100 in 1955. It is interesting to compare the university and polytechnic expansion in our city with the decline in our industrial base over the same period. That industrial base gave birth to our university, but our expensively expanded educational platform appears to have done little to sustain our industry and seems totally indifferent to its plight.

Those who seek more and more funds for our traditional educational establishments must wrestle with this paradox. Perhaps there are other more fruitful means of providing education and research than the ones we have traditionally used. It is difficult to accept Professor Dickinson's views when we examine the massive expansion in medical writing,[2] much of which is hardly worth the paper it is printed on and which is clearly indulged in for reasons far from genuine scientific research interests. His comments about the senior registrar situation are a significant exaggeration of the facts when compared with a similar situation in the 1950s. Regarding overseas visitors, I find no falling off in demand for either temporary or permanent visits, and I suspect that his pessimistic view of our medical scene is not shared by the worthwhile overseas person. In this respect Glenister's comments on medical education are relevant[3] and provide a much more worthy cause to espouse.

The distress the various levels of academia are feeling is not due to any lack of facility for any genuine research, but the fact that the academics have been rumbled. The facts show that they are neither using what they have efficiently nor producing the results that will keep Britain "Great." My advice to academia and your leader writer in particular is to stop whining and do the pruning that is clearly needed for a really strong growth in the future.

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1 Department of Health and Social Security. *Inequalities in health: report of a research working group*. Black Report. London: DHSS, 1980.
2 Colman V. *Paper doctors: a critical assessment of medical research*. London: Temple Smith, 1977.
3 Glenister TW, Richards P, Kilpatrick GS, Wood DR. Stemming tide in medical schools. (Letter.) *The Times* 1985 Feb 6:13.

Young suicides

SIR,—I read with interest Dr Greg Wilkinson's review of *Suicide in the Young* (26 January, p 309), in which he outlines the England and Wales statistics for suicide in young adults. Suicide is a very distressing event for all left behind and all who have been involved. Some acts of suicide have a personal target; many are carried out with agents prescribed in quantity for the best of reasons and not necessarily for the deceased himself. Many of the causes suggested for increasing suicide—unemployment, colour, mobility, broken homes, etc—are quite beyond any individual's control, and we may feel powerless. But amid this generally depressing picture there is one ray of light.

Comparing teenage suicides for 1973-5 with those for 1981-3 shows an increase among boys from 153 in the first three year period to 260 in the second, but a decrease among girls from 106 to 84. There is a similar comparison, though less marked, to be