and offers support and information to newly diagnosed families through 14 support groups in the United Kingdom. It also provides a database for investigators interested in research into the cause and treatment of the syndrome. Marfan's syndrome should be diagnosed as all aspects of it are now treatable although not yet curable.

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3 Child AH. Joint hypermobility syndrome: inherited disorder of collagen synthesis. *J Rheumatol* 1986;**13**:239-43.
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Vocational training in general practice

SIR,—In her letter (28 May, p 1534) Dr Dorothy M B Ward has ignored our questioning of the strategy of the Joint Committee on Postgraduate Training in dealing with the allegedly recalcitrant behaviour of the North East Thames region in favour of a discourse on the grounds on which the decision was based. As Dr John Sinson also calls for the evidence to be examined we would be happy to clarify this aspect.

As Dr Ward states, the decision was not based solely on the 1987 report but on the region's alleged failure to implement stricter criteria for selecting trainers after criticisms made in the 1985 visit. In 1987 two practices failed to meet the required criteria. These facts are not in dispute.

In the 1987 report this sentence appears: "We are very much aware that we have only seen five out of the fifteen practices . . . and that these were deliberately chosen, *as the visitors had requested*, to include those about which the regional adviser was particularly concerned" (our italics).

The report then states that of these five practices, two were above average, one was approved with reservations, and two should not be reappointed. Unsurprisingly, these were the two specifically selected as giving cause for concern.

Neither of these trainers had, however, undergone the reselection process within the preceding three or four years. It therefore seems quite illogical to use them to exemplify the region's compliance or otherwise with the recommendations made in 1985. If, as Dr Ward implies in her final paragraph, the Joint Committee on Postgraduate Training thought that this was the main point at issue and that the 1987 visit was in the nature of a final test, with disciplinary rather than "advisory and educational" connotations, then (*a*) this fact should have been made explicit, in advance and in writing, to those being visited and (*b*) rather than taking a small, deliberately biased sample the committee should have insisted on examining a significant number of training practices approved or reapproved *since 1985* to determine whether these conformed to the required criteria. There could then have been no argument about the fairness of the procedure or the verdict.

Instead, the adopted strategy—of first inviting the district to identify its most problematic training practices and then using these as the basis for a judgment on the entire region—might appear to a cynical observer to be a deliberate set up, into which the region's officers were naïve enough to walk. More charitably, it could be regarded as just one further instance of the failure of communication that has characterised the entire episode.

Until this time visits by the committee had, indeed, been regarded as "advisory and educational." The committee must now choose whether its visitors are to be educational advisers or policemen—they cannot simultaneously be both. And those on the receiving end are entitled to know which of the two they are entertaining.

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Breast milk and HIV infection

SIR,—We have received a letter from the chief medical officer at the DHSS to all doctors on the subject of human immunodeficiency virus infection, breast feeding, and human milk banking. He advises a number of specific steps that should be taken before using bank milk. He states his "confidence that future mothers will accept the need to safeguard the vulnerable newborn in every way possible and that they will continue to respond generously to the needs of these babies."

We cannot see how we can continue to run a milk bank if we obey his specific steps. The relation among our special care unit, the local health visitors, and the mothers who help us has created an enormous amount of goodwill. We believe it would be thrown away if we had to ask women who wished to help with breast milk donations whether their husband, or any other man they might have had sex with in the past 10 years, might have had sexual partners who lived in an African country.

We cannot see the logic in having to screen those women who wish to donate milk while not screening all women who book in for maternity care. Blood is often spilled in maternity units, and it seems out of proportion to test those who are offering a secretion which has only a theoretical risk of passing on infection while avoiding testing those who may be a real risk to members of staff and other patients. We have asked the chief medical officer if he will publish the scientific evidence on which he bases his advice.

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Disciplining doctors

SIR,—While welcoming Dr Malcolm Forsythe's article (21 May, p 1421) we disagree with his statement: "As the charge is serious it is usually necessary to suspend a doctor on full pay."

All but one of us have been suspended. We do not know whether we are typical of the 40 doctors each year who are disciplined using HM(61)112, but we think that suspension was neither necessary nor just in our cases, and probably in many more.

Two of us have accepted premature retirement at age 55, and we know of another doctor who has done so at an even earlier age because of ill health precipitated by the attack on his professional position. We think that the extension of the HM(61)112 provisions to community medicine in 1987 has serious implications for public health.

Two of us went to the high court in an attempt to have our suspension lifted. For one of us this did help to decrease the duration of suspension to 15 months. In another case the high court was used to overturn the decision to dismiss the doctor.[1] Another of us was not suspended but has had her post whittled away after allegations of incompetence in 1979 and now faces redundancy. Her appeal against this to the secretary of state will be heard soon.

The joint Joint Consultants' Committee and DHSS committee reviewing HM(61)112 is taking evidence until the middle of June. Doctors who know of inappropriate or unjust use of this procedure or have suggestions for improvements should write to Mrs K James, Eileen House, 80-94 Newington Causeway SE1.

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1 Dyer C. A "sad and disturbing" case of dismissal of a consultant: DHSS overruled. *Br Med J* 1986;**293**:322-3.

Allocating resources

SIR,—Many of our patients are on waiting lists which operate on a first come first served basis. This is an unfair strategy which ignores severity of disease, disability, and urgency. I recently tried to arrange urgent investigations for a 44 year old obese mother of four children who had a recent onset of angina with a normal electrocardiogram. I was told by the senior registrar that the cardiology department was overwhelmed so general practitioners were being asked to treat patients with nitrates and β blockers, advise about diet, measure lipid concentrations, and reassess over the next two months. This is a potentially dangerous delaying tactic and not a sound way to ration exercise electrocardiographic tests.

It would be better if hospital specialists, general practitioners, representatives of community health councils, and local self help groups could come together to select criteria which could be used to allocate priority. In this case relevant factors to consider include family history, duration and severity of symptoms, results of investigations, blood pressure, coexisting diseases, age, dependants, willingness to stop smoking, and so on. A consensus could identify the most relevant factors and these could be weighted to obtain a final score. General practitioners could then be circulated about the need for and use of such a priority system to identify those patients in need of urgent investigation.

The same approach could be used for patients on waiting lists for other investigations and those waiting for bath aids, surgery, and so on. In each case appropriate social, psychological, medical, functional, and epidemiological factors should be identified and agreed by all concerned. There is a danger that if such criteria are drawn up only by hospital staff important factors will be overlooked or incorrectly weighted.

Criteria for allocation of priorities based on needs and risks would have to be regularly reviewed as resource constraints change and new information becomes available. A priority waiting list does not mean that those on the routine list are ignored. Each week a certain percentage of patients could be taken from each list. To have a waiting list policy based on the first come first served principle should be considered unethical. We must develop priorities jointly with consumers and other health professionals which are seen to be fair and explicit in the way that they deal with the allocation of scarce resources.

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