the first part before they complete the questions in the appendix.

What is a matter for concern is the wording of some of the questions, particularly questions 13 and 17, which are among those set out in Dr. Hayes's letter, and we have, of course, made strong representations to the Home Office about these. On the other hand, I do not consider it unrealistic to ask whether there are any puncture marks which are not consistent with the treatment of the deceased. There have been a number of cases where murder has been committed by injection, and it is important that the examining doctor should be aware of this possibility. As for construing this question to mean that the sites of all injections given two weeks before death should be marked and charted, I feel that common sense will dictate to the doctor the nature of the examination which should be made to satisfy himself on this point.—I am, etc.,

I. M. JONES,
Chairman, Private Practice Committee.

Sunderland, Co. Durham.

Longer Training for Radiographers

SIR,—The Council of the Faculty of Radiologists have given their view on radiography training requirements. Dr. P. Jacobs (20 June, p. 1640) has pointed to practical difficulties which could follow a change from a two- to a three-year course, and I do not question the validity of either. Radiographers have their point of view, however, and—this being a medical and not a radiography journal—may I, in the interests of justice, present the case for a lengthened radiography course as some radiographers see it?

The view that three years are required to train a radiographer may be questionable, but—in parallel with radiology training and partly because of it—more has been, and more still could be, added to the syllabus than can be subtracted from it. Radiographers too make another point: that they now compete for recruits against occupations with a length of training (and thus status and reward) that has increased—school teachers in particular; that it is necessary to accommodate to a society with this trend to better education, longer training; that unless this is done recruitment will certainly fall in the long run, and the hospital service be let down in the end.

Some radiographers say that if, as now, an apprenticeship system continued to operate (they say that, not I), then the third-year student would perform much of the work of the present first-year radiographers in the training-school hospital; that radiographers would be thus displaced to the non-training radiography department; that there would thus be neither staffing nor accommodation problems—just a better-trained product.—I am, etc.,

A. W. ROBINSON.

Knowle, Warwickshire.

SIR,—I share the anxiety of Dr. Philip Jacobs (20 June, p. 1640) as to the possible consequences of an increase in the length of a radiographer's training from two years to three, and his belief that it is not necessary. We find it difficult enough to keep most of our vacancies filled under present conditions. It will be impossible with fewer students qualifying each year, as will be the case on account of shortage of training accommodation and tutors. The longer course will hinder recruitment; some of our radiographers would not have taken up radiography had the course lasted three years. The girl who leaves radiography on account of marriage will have given one year less of useful service after qualification.

We find that newly qualified radiographers need little further experience before they become useful members of a general department. If there is too much to learn in two years there is scope for lessening the contents of the present course—for example, in physics. If it is hoped to attract students from among those leaving school at 17—an argument used when the shortage was at its worst—the starting age could be lowered to 17 without lengthening the course. We are always being told how much more rapidly girls are maturing. Nineteen is not too young for qualification.—I am, etc.,

G. OSBORNE.

Whittington Hospital, London N.19.

Different Methods of Payment

SIR,—I am sure that the Manchester A.R.M. will hear a great deal about new systems of payment for general practitioners, for despite the Fraser Committee it is up to the profession itself to decide by which method it is paid.

I hope that the representatives will remember that many general practitioners have a great sense of vocation and wish to attend their patients 24 hours a day 7 days per week, while many others, although they have a sense of vocation, consider the practice of medicine a way of making a living and would prefer a 9 to 5 working day with an emergency call service for nights and weekends.

To me it is obvious that no one system will suit everyone, and therefore let us have a choice of systems. Let those who wish to retain the capitation system do so and keep on "head-hunting." Let those who wish to go looking for items of service be paid for those items they find. Let those who wish to sell their professional souls be full-time salaried, and let those who wish to be paid by the hours they work be paid on the sessional basis.

Surely then all the profession will be content and no one section can be accused of forcing its views on the other.—I am, etc.,

A. A. BRAND.

Richmond, Yorks.

General Practice in Scotland

SIR,—Inspired by Dr. J. S. K. Stevenson's article (23 May, p. 1370), I worked out the figures for our practice. The practice is one of three doctors, the third doctor coming in 1962, working from two surgeries. There are a number of new estates being built round us, about half-and-half council and private housing. We have had an appointment system in operation throughout the period analysed.

The figures were analysed in the same way as Stevenson's so as to be comparable.

These figures would suggest not only that the work is increasing, but that with an average of 5.1 consultations rate over the five years we on Tees-side are more like Scotland than England in regard to the morbidity rate.—I am, etc.,

CHRISTOPHER GILLIE.

Redcar, Yorks.

Self-made Martyrdom?

SIR,—The letter from Dr. H. W. Ashworth (6 June, p. 1511) with its somewhat sweeping assertions regarding the behaviour patterns of general practitioners will surely evoke some protest, especially from those of us in the older age groups. To suggest that over-visiting and over-consulting are done in order to create a gratifying public image is unfair and attributes a very unworthy motive. General practitioners are an individualist body, but the common denominator of all satisfactory general practice is a good doctor–patient relationship whatever the type and size of the practice.

This relationship is admittedly capable of wide interpretation, for it is compounded of many things which are difficult to assess. These include professional skill, willingness to visit, kindness, mutual respect, and confidence on the part of the patient, often leading to a real affection built up over the years. The number of times and the reasons for seeing any given patient are such individual and personal matters depending partly on the temperament of the doctor that nobody can possibly presume to tell another how many or how few times a patient should be seen. Reassurance is worth a very great deal and sometimes it is to bring that, and that alone, that a special visit or consultation is made.

Omitting to see a second case of measles in the same family can be dangerous. Twice in my memory in this practice we accepted a message from a patient that a second child had contracted measles, and a visit was not made; but on both occasions within two or three days one of us was called urgently to find in one case a roaring otitis media and in the other bronchopneumonia.—I am, etc.,

W. B. MUMFORD.

London S.E.16.

Salaried Service

SIR,—Dr. J. P. Ommer's letter (30 May, p. 1444) deserves the largest print, not the

Year	Practice Size	Calls	Surgery Attendances	Total Consultations	Consult. Rate per Patient	Growth Rate of Practice (% of Previous Year)
1960	3,930	6,717	13,890	20,607	5·2	10·5
1961	4,371	6,965	15,644	22,609	5·2	11·2
1962	4,860	7,819	16,677	24,496	5·0	11·2
1963	5,348	11,604	20,443	32,047	6·0	10

1963—Night calls (6 p.m.—8 a.m.), 516 = 92 per 1,000 patients per annum.