better qualifications as "they should have a true knowledge of the type of life ahead."

Many students whose parents are doctors enter the profession after some gentle persuasion to follow in father's footsteps, rather than genuinely desiring to become medical practitioners. Their knowledge in these circumstances is hardly likely to promote a "sense of vocation and kindness." Those who join medicine without such compelling influences are more likely to have a vocation.

For too long the medical profession barred many for reasons other than academic attainment. The change in attitude in recent years is a most welcome one.—I am, etc.,

ALAN D. SHROOT

Glasgow University Union,
Glasgow W.2

Pensions

SIR,—Those of us approaching retirement must be dismayed by the rapidly diminishing purchasing power of the pensions we hope to receive from the N.H.S. Not only is each increment earned during the past two decades depreciated year by year, but the total sum after it is determined can be expected to depreciate after retirement.

The only way I can see to correct this is an adjustment proportional to a suitable cost of living index both before and after retirement. I wonder if our negotiators are showing sufficient determination to obtain such a result, or whether those who have passed their prime are to be left to pass into oblivion in penury.—I am, etc.,

R. S. SAXTON

Port Talbot,
Glam

Superannuation and Substandard Lives

SIR,—I am taking up the challenge of Dr. P. H. Sutton (8 May, p. 342) when he asked you to find an actuary to write a short article on this subject. I believe that both Dr. Sutton and Dr. K. D. Allardyce (17 April, p. 165) are confusing two separate things: (1) fitness for employment, coupled with entry into a firm's superannuation scheme, and (2) life assurance for substandard lives.

(1) The primary consideration for an employer is whether a prospective employee is fit for the work he has in mind. A secondary question of less importance is the acceptability of the man for superannuation and other benefits. Speaking generally, if he is fit for work, then he is acceptable for superannuation and other benefits. The most important question facing an employer is "Has this man the ability to do the work I have in mind for him?" When we refer to ability we naturally take into account a man's physical and mental health, bearing in mind what type of work is being considered. Some men, who are not of robust health or muscular in stature may nevertheless be excellent employees for light work. Indeed, in these days of mechanization, there is less and less need for muscle. An employer still requires a certain degree of fitness in his employees; he wishes them to work on the whole continuously, without more than occasional absences for sickness, and he wishes to be able to rely on their remaining fit for work in the future. There may be

special work to be done, such as travelling, which does impose an exceptional strain so that physical toughness may be necessary. However, if an employer considers that a man is suitable for his purposes, he can also accept him for superannuation and other benefits. This is likely to be the case whether or not the benefits are provided by a private fund or by an insured scheme underwritten by a life office. Within wide limits, a life office granting death benefits under group life and pension schemes will be prepared to accept all employees who are actively at work; the life office can afford to relax its standards of selection for group schemes of a variety of kinds, because a large number of people are involved and only a small proportion is likely to be impaired. Moreover, there is little possibility of deliberate selection against the life office because the benefits are usually related to earnings.

(2) Life assurance for substandard lives is an altogether different subject. Although Dr. Allardyce referred to Dr. K. Shirley Smith's presidential address to the Assurance Medical Society (2 March 1957, p. 513), I do not believe that either of your correspondents really has this subject in mind. Let me therefore content myself with saying that the underwriting standards of life offices in the United Kingdom are broad enough to enable all except a comparatively small proportion of proposers to be included at standard rates. Where individual life assurance is concerned, the life offices cannot afford to be as generous as they are with superannuation benefits, because life assurance is dependent on the initiative of the individual proposer and there is always the possibility of selection against the life office by a proposer who knows himself to be impaired. After all, an individual has an unlimited insurable interest in his own life. Those lives who cannot obtain life assurance at standard rates can usually obtain life cover on special terms. The number which is declined is extremely small.

I hope that these remarks are helpful.—I am, etc.,

A. J. STEEDS

London E.C.2

Vocational Training for General Practice

SIR,—Vocational training for general practice can only be planned in the context of the medical curriculum and must also take account of the future role of the general practitioner. As far as the first point is concerned it is appreciated that the curriculum like everything else in the medical world is in a state of ferment and transition, but there are certain basic principles which are constant. One of these is that there should be far greater involvement of the medical student in the community—that is, in general practice. This should take place at the start of the medical course and continue all the way through so that every student will be made aware of what goes on in the medical world outside the hospital system.

There should be in the medical school a department of general practice concerned with the organization of the general practitioners who will take part in this teaching and with the vocational training for general practice. This department should be the responsibility of a senior member of the teaching faculty who would be advised by a committee of general practitioners nomin-

ated by the local medical committee with representatives of the Royal College of General Practitioners. I mention the L.M.C. advisedly because this body represents all general practitioners in the N.H.S. and by its regular meetings is kept fully informed as to what is going on at the grass roots of general practice. Through this department each student, on qualifying, will have a fairly good idea of what general practice involves and so be able to choose his career with some knowledge of the possibilities.

The present six year course is long enough and I would suggest that entry into general practice could start after the pre-registration year of six months in general medical and six months in general surgical house posts. For those intending to engage in general practice obstetrics, a further post of six months in obstetrics and gynaecology would be obligatory, with a view to taking the D.R.C.O.G. Further house posts in any of the other specialties would be on a purely voluntary basis.

The young doctor, qualified and registered, is now ready to begin his period of vocational training for general practice. Except for sparsely populated areas which require special arrangements, the future of general practice in the N.H.S. lies undoubtedly in health centres. In Bristol there are at present six with several more in the planning stage and it is worth mentioning that a conservative estimate suggests that there will be more than 300 throughout the country by the end of 1971. It is within the health centre that vocational training for general practice should take place and not in the hospital.

Training, which would not necessarily be restricted to one centre, would be for a period of not less than three years as an assistant or apprentice, at a salary appropriate to the position. This is not the place to present a detailed programme of training nor how the health centres or trainers should be chosen, but these matters would need full discussion with all concerned. It is important to realize that the best way to gain experience of a job is to be in the job, to learn as each problem presents itself, and have frequent recourse to text books and consultations with the health centre general practitioners who will be responsible for the training. One should also recognize the stimulating effect of the early assumption of responsibility, limited though it would be at the beginning. There would also be regular day releases or attendance at hospital outpatient departments and full participation in the greatly expanded postgraduate activities now available to general practitioners. At the end of this three-year period, the assistant would be ready to become a general practitioner. There would be no examination and no extra degree though some sort of certificate may be thought advisable.

With regard to my second point, general practice is also in a state of flux though certain trends can be observed, such as the increasing number of group practices and health centres. There is also the increasing effort to bridge the gap between the general practitioner and hospital by offering clinical assistantships and sessional posts as casualty officers to general practitioners. Actual working conditions have greatly changed since the days of the Collings¹ and Taylor² reports. There is now almost complete freedom of

access to hospital diagnostic facilities, and great improvements in the supporting services within the community such as home helps, nursing assistance, and other social services. There is nowadays much greater emphasis on preventive work than formerly, and such a vast expansion of knowledge that some degree of specialization within a group practice is inevitable.

It is a valid criticism that the medical curriculum is mainly hospital orientated and does not prepare doctors for work within the community. In the past general practice has been regarded as a sort of second best to a hospital career. With all the changes already mentioned this is no longer the case, but we shall not make it more attractive by an extension of hospital training. If we accept that the intention of the reformed curriculum is to produce a basic doctor who will then go on to further study in whichever branch of medicine he chooses, then we must ensure that the vocational training will be relevant to that branch. As far as general practice is concerned, this means within the community, in group practice, and in health centres.—I am, etc.,

JOSEPH SLUGLETT

Bristol

¹ Collings, J. S., *Lancet*, 1950, 1, 555.

² Taylor, S., *Good General Practice*, Oxford University Press, 1954.

Hospital Staff Appointments

SIR,—Dr. J. de Swiet (22 May, p. 470) draws attention to the scandalous practices that go on in the hospital staff appointments. It should be welcome by all as it seeks to rectify one of them.

May I point out another of these? Quite often the advertisements for hospital appointments carefully omit the mention of some important details, to the advantage of the employers. For example, a candidate of a post in "General Medicine," after a long and tiring journey for the interview may discover that the post also entails a regular casualty work, or a geriatric unit, even another hospital at a good distance. "Good library and postgraduate centre" may turn out to be in another town. Similarly, "Good accommodation available" may only mean single accommodation. Faced with these situations in an interview the candidate finds it very difficult to decide, as turning down the post means not only losing the expenses but also wasting all the time and effort involved.

I completely agree with Dr. de Swiet that all the scandalous practices in hospital appointments should be stopped.—I am, etc.,

M. A. ARIF

High Carley Hospital,
Ulverston, Lancs

Hospital Medical Staffs' Defence Trust

SIR,—We thank you for the Secretary's reply to our earlier letter (15 May, p. 406), which goes some way to show how the money from the Hospitals Medical Staffs' Defence Trust has been spent. However, no figures have been mentioned, and the reality of the situation emerges only when they are.

If the top two figures on the accounts for 1969 refer, as they do for 1970, to expenditure on the Joint Consultants Committee (J.C.C.) then taking the two years together £10,628 was spent on the J.C.C., £15,350

on the Review Body, and £131 on the Regional Committees. We do not know the figures for previous years but if expenditure on the J.C.C. ran at a similar level then between 1956 and 1970 Trust funds spent on supporting that committee would amount to something in the region of £70,000. Is this true? If it is not, what are the true figures?—We are, etc.,

N. A. SIMMONS
C. C. CRAMPTON
D. ZUCK

K. W. LAVERS
J. D. KINLOCH
B. HELAL

Postgraduate Medical Centre,
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** The Secretary states: In the 15 years from 1956 to 1970 a total of £45,600 was contributed by the Trust towards the costs of the Joint Consultants Committee. During most of that period the J.C.C. provided all or most of the Staff Side of Committee B of the Medical Whitley Council, whose functions are now discharged by the Negotiating Subcommittee of the C.C.H.M.S.—ED., *B.M.J.*

Medical Assistants, S.H.M.O.s, and 1971 Salary Review

SIR,—*B.M.A. News* (No. 28, March/April) announces the preparations for the 1971 salary review. Medical assistants and S.H.M.O.s hope that they will not be as ill-served by the profession's negotiators on this occasion as they have been in all previous negotiations—and particularly those of 1970.

Earlier this year a case was presented to the Group Medical Staff Committee, County and City of Perth, pointing out that:

(1) Of all hospital medical staff grades, only to the medical assistants and S.H.M.O.s was the increase frozen throughout the entire pay-scale at 20% of the Review Body's recommendation;

(2) all junior grades received the full 30% award. In granting this the government explicitly accepted the obvious fact that it is the actual amount of cash that is all-important at lower income-levels. (To paraphrase—£5 is worth more to a pauper than £50 to a millionaire.)

(3) the award to the consultants ranged up to 30% and was at no point in the scale—or in the superscales (Merit Award)—less than 20%;

(4) unlike the junior doctors, many medical assistants and S.H.M.O.s were in their career grade without the future prospect of high consultant salaries;

(5) many medical assistants and S.H.M.O.s were older (67% of S.H.M.O.s are over the age of 50, for example) than both the juniors and the younger consultants so that their financial commitments were necessarily likely to be heavier, and thus the hardship caused by the loss of 10% of their award could be expected to be greater than the hardship which would have been caused to either of the other two groups;

(6) for the eldest, the reduction would have a particularly deleterious effect on their already relatively poor pension; and having had a relatively low salary during his working career, such a doctor would have been less well able to provide savings to supplement it.

The Committee agreed that a letter should be written and that the Eastern Regional

Committee for Hospital Medical Services be requested to draw the situation to the notice of the Scottish Committee for Hospital Medical Services for the attention of the next Review Body.

If medical assistants and S.H.M.O.s in all hospital groups were to ask for, and to receive, an equally generous gesture of support from their local committees it would surely help to ensure that they did not once again become the sacrificial lambs on the combined altars of false economy and face-saving and that the gross anomaly of 1970 would be corrected in 1971.—I am, etc.,

T. B. RANKINE

Perth

** The Secretary states: "The 'tapering' scale imposed by the Government on the consultant scale following the Twelfth Review Body Report had the following effect on consultants in England and Wales: Nearly two-thirds of all consultants were at the top of their scale and received only 20%. Less than 2% of all consultants received 30%, and only 12% received more than 25%. The average increase received by all consultants was only 21.5%. The

	Salary prior to 1 April 1966	Salary under Government decision on 12th Review	Percentage Increase
Consultant	£4,445	£6,330	42.4%
S.H.M.O.	£3,080	£4,572	48.4%
Medical Assistant	£2,910	£4,572	57.1%

Table sets out the increases received by medical assistants, S.H.M.O.s, and consultants, respectively, at the top of their salary scales, since immediately before the last major Review (the Seventh Report of 1966).—ED., *B.M.J.*

Economy Drive on Drug Prescriptions?

SIR,—The Medical Staff Committee of Dudley Road Hospital wishes to comment on recent misleading statements in the national and local press^{1,2} about instructions to pharmacists to substitute cheaper alternative drugs to those prescribed. These arose from a resolution by a subcommittee of the Hospital Management Committee intended to be sent to the Medical Staff Committee for discussion. It was released to the press by the administration in error before discussions had taken place.

Drug costs have been under frequent study by the Medical Staff Committee over a number of years and these efforts have led to a considerable abatement in the ever-increasing cost of drugs. However the Medical Staff Committee wishes to make it absolutely clear that, contrary to the impression given in the press reports, it has not taken any action over prescribing which would be of doubtful legality or which would infringe the doctor's right to prescribe as he thinks fit in the interests of his patient.—I am, etc.,

J. G. L. COLE

Chairman, Dudley Road Hospital
Medical Staff Committee

Dudley Road Hospital,
Birmingham 18

¹ *Daily Telegraph*, 17 May 1971.
² *Birmingham Post*, 17 May 1971.