his patients cannot afford a recently marketed drug, which naturally costs more when it is first promoted, at least they may be spared many of the side-effects which only become apparent with widespread use.

The National Health Service is now costing about £2,000m. a year, and the cost of prescriptions has more than doubled between 1959 and 1968; pharmaceutical services account for about 10% of the total cost, and in 1969 were £42m. more expensive than the cost of general medical services (the general practitioner service).

I am fully aware that the great advances in therapeutics in recent years must be paid for, and that the health of the population has benefitted greatly from this progress. My argument is not concerned with those few doctors who are guilty of gross or careless over-prescribing and who can be dealt with by regional medical officers from the Department. I am concerned only with the average doctor whom I know to prescribe with reasonable care.

I contend that because he bases his prescribing on clinical grounds alone he is artificially divorced from the economic effects of his actions. This is ivory tower medicine. Dr. Derek Stevenson, the B.M.A. Secretary, when expressing recently the professions' opposition to cost-related prescription charges, gave as one of the main objections the fact that the doctor would have to have regard to the patient's pocket as well as to the treatment he needed.¹ As the patient in this case is the population of Britain in general and the tax-payer in particular one can see how clearly the leaders of our profession are opposed to economic considerations affecting our prescribing. The N.H.S. is desperately short of money and I fail to understand how 250 million prescriptions a year can be issued without more regard to economic factors.

Every pound saved in prescribing could be used more effectively in those branches of the N.H.S. like the care of the chronically sick, the aged, and the mentally handicapped, which have been starved so cruelly of adequate funds.

I realize I am treading on delicate ground but I ask the profession to give fresh and unemotional consideration to whether the right to prescribe on clinical grounds alone is really a valid one, and whether it is in the best interests of either the public or the profession.—I am, etc.,

P. A. T. WOOD

Ipswich, Suffolk

¹ *Daily Telegraph*, 29 April 1971.

Vocational Training in General Practice

SIR,—Dr. R. Frampton is rightly anxious about the recruitment of able general practitioners into academic medicine (22 May, p. 469). Most medical schools concerned with developing this field of undergraduate education are only too well aware of the problems involved.

In the case of the Southampton practice, and indeed with any appointment of a general practitioner to the staff of the medical school, the university has tried to minimize any fall in income when it considers the point at which the successful applicant should enter the appropriate salary scale. It should also be noted that the practitioner appointed to the practice will not be required

to provide premises, furnishing, or equipment for the practice, will receive an allowance for any personal expenses incurred in the practice, and will retain, where applicable, any seniority award. Moreover, there will be no restrictions other than those which might be reasonably expected by a general practitioner, though he will not be permitted to practise privately.

The alternative to such an arrangement is, as your correspondent suggests, the appointment of a general practitioner, in contract only with the executive council, who would receive a salary from the medical school for part-time teaching duties. On the scale that we propose to incorporate teaching in the community in the curriculum at Southampton, this would prove unworkable. The solution might be for the general practitioner to take in a partner to reduce the service commitment, but in a practice of this size this would not be financially viable. Furthermore, a situation could arise where the general practitioner appointed could, perhaps with good reason, opt out from his teaching commitment, leaving the medical school with a teaching and possibly research commitment which could not be fulfilled.

These are only a few of the points which determined our policy, namely that the Southampton Medical School Teaching Practice should be staffed by full-time university employees. Within five months, two further salaried university lecturers will join the university practice, so that each member of the practice will have ample time for teaching and research in addition to his service commitment. Consequently the university can hardly be said to be making a profit.

So far, at Southampton, there has been no shortage of suitable applicants. Until a better solution is found, it is important that general practitioners contemplating a career in academic medicine should seek advice from colleagues in this field, and if attracted to an advertised post, take steps to ensure that they are fully conversant with any arrangements which have been made. In Southampton, we welcome this step on the part of potential applicants for such a post.—I am, etc.,

J. A. FORBES

Community Medicine,
Southampton Medical School,
University of Southampton,
Southampton

SIR,—Further to Dr. R. Frampton's letter on general practitioner training (22 May, p. 469) may I add two reasons why vocational training is at a low ebb. First, as a trainee who has received excellent instruction and guidance in general practice, it grieves me to learn that even in these enlightened times some unscrupulous practices still use trainees as unpaid assistants. Secondly, I have found that at a few interviews for jobs established principals still consider the trainee scheme worthless and furthermore are not prepared to give credit to one who has completed his trainee year.

May I suggest some improvements. First, trainers should not be selected by local medical committees, who cannot be considered impartial as they often comprise the colleagues and friends of the trainers, but by an impartial committee with whom rotas, hours, and training programmes should be

registered. Secondly, trainees should submit a report on their training to the committee, which should investigate any complaints and in proved cases should have the power to remove the offender from the list of trainers. Lastly, grants to trainers should be greatly increased, as should salaries paid to trainees, to make them comparable to the salaries of junior assistants. In this way experienced trainers will be recruited and junior doctors will be encouraged to complete some vocational training and not be distracted by the financial rewards of immediate entry into practice. This can only result in the raising of standards in family medicine.—I am, etc.,

K. C. HARVEY

Crickhowell,
Brecon

Throat Infection in Glandular Fever

SIR,—In a recent outbreak of glandular fever in our practice area many of the patients were found to have pathogenic bacteria in the throat. When the appropriate antibiotic was given there was a marked improvement in the general well-being of the patient and the temperature fell very quickly. I therefore feel that as well as a Paul-Bunnell test and full blood count in these cases throat swabs should always be taken and if an organism is found it should be treated.

Ampicillin should not be given for sore throats in an outbreak of glandular fever as this can cause a severe skin reaction. It was noted in two of our patients with *Staphylococcus aureus* in the throat which was penicillin-resistant that flucloxacillin (Floxapen) had the most amazing results when given for five days, both patients making a most dramatic recovery. It is always worthwhile repeating the throat swab after one week in glandular fever if the first swab was negative for pathogens and the patient is still ill.—I am, etc.,

R. W. WALLIS

Horncastle, Lincs

Hospital Staffing

SIR,—At one busy obstetric unit in the Windsor Group repeated requests for an additional registrar to ease the load of the existing single-handed registrar and to improve the standard of inpatient care has been repeatedly refused. We are about to open an additional obstetric unit within the group as part of a new district general hospital. The Department of Health has refused to allow a registrar establishment, insisting that the junior staff consists of senior house officers, with consultant cover, offering additional consultant sessions to replace those normally taken by registrars.

Protest at this policy has been met with a bland assurance that no increase in registrar establishment is acceptable, and this policy has been approved by the medical profession. No record of this approval has been found or reference given, and an appeal to the president of one of the royal colleges has proved fruitless. The Department of Health, to the increasing bewilderment of the administrative staff and consultants alike, seems absolutely intent on degrading the role of