service management, but their own credibility would not be enhanced by their seeking to assume a part-time community physician role. I should begin to wonder why they had that amount of time to spare, what their motives were in so doing, and whether they were operating effectively in their own clinical practice. It works both ways.

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[1] *What Should Community Physicians Be Doing?* Occasional Papers No 2. Manchester, Unit for Continuing Education, 1979.

SIR,—I read with interest the results and conclusions of Professor E D Acheson's survey of the views of community medicine trainees with regard to combining clinical practice and community medicine (6 October, p 880).

Expanding this survey to include the views of well-established specialists in community medicine with consultant status in the NHS and academic posts, etc, would not only be useful to trainees and aspiring trainees but is also necessary to validate the conclusions reached, as the commitment of trainees to community medicine may not be as complete as those of consultant status. The important points are which specialties can be successfully combined, whether in the NHS or in medical schools, etc, and at which level —including the implications of a clinical assistant appointment if a consultant one is not feasible. Some community physicians already have practical experience of combining or attempting to combine two specialties and knowledge of their experience could be invaluable to trainees.

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Boycott of tertiary examination in orthopaedics?

SIR,—The Edinburgh College of Surgeons has now set up a third-stage examination in orthopaedics. Competition for consultant posts being severe, no registrar in the specialty can baulk this further hurdle if it becomes established. It will inevitably commit all present registrars and their successors permanently. Do we accept that it is humane and wise to impose on young men this extra obstacle? When consultant posts are scarce, the rewards moderate, the responsibilities excessive, is it fair to expect would-be surgeons to sustain yet another burden and obstacle in their climb?

Some would argue that an additional challenge must enhance the standard of training achieved. Whatever the proper place of examinations in advanced medical training, this is not necessarily so. I believe firmly that, where I have had a comparison, a recent higher examination has proved counterproductive in terms of service. The content of examinations is determined by the convenience of examiners and by prestige considerations. The subject as examined becomes the subject as taught, and thence soon the subject as practised. Examinations permit the coercion of trainees into attitudes and opinions which are merely fashionable. They excuse diversion of time and energy from provision of service and accumulation of experience. These last are the most important aspects of the work we should require from registrars.

Popularity of specialty careers in the hospital service has understandably fallen, so unkindly have we dealt with our registrars. Academic misconceptions have long since made an abuse of research, probably of training systems—and now, surely of examinations. The prospect of following the low-pass-rate primary and final fellowship with another such test, in a system liberally provided with additional opportunities for failure, will alienate many young people who should join us.

It is long past time to call a halt to the abuses of the system by which we staff our senior hospital positions. Simple humanity, as well as every consideration that is not facile, requires that this false step by the Edinburgh college should be annulled. I can see only one way in which this can occur. Action is urgent and imperative. The junior staff, for their own sake and that of their successors and for the potential well-being of surgical services, should ensure a 100% boycott of this tertiary examination at Edinburgh.

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Postgraduate dental general anaesthesia

SIR,—The undergraduate teaching of general anaesthesia has been a topic of conversation for a number of years. Ever since 1965, when a joint subcommittee on dental anaesthesia led by the Standing Medical and Dental Advisory Committee reported that a need existed for a training scheme to be available for dental graduates, little has been done to fulfill this need, although a few organisations and individual practitioners scattered throughout the United Kingdom have contributed much in the educational field.

The working party set up by request of the deans of the faculties of dental surgery and of anaesthesia under the chairmanship of Dr W D Wylie again endorsed this recommendation. I was fortunate to be the first postgraduate appointed as house officer in anaesthesia at the Sheffield University Dental School. The full-time post uses the guidelines laid down by the Wylie report to provide experience in general anaesthesia in the hospital environment, together with outpatient anaesthesia and sedation in general practices in and around the Sheffield area.

I found these six months of such benefit that I would like to add my voice in encouraging those who are considering the implementation of the recommendation of the Wylie report.

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Ethics in occupational health

SIR,—I have been very interested in the correspondence initiated by Dr J W Todd's letter (11 August, p 391).

I am not at all sure that it is unethical for an occupational health physician to advise management that a prospective employee is a worse-than-normal risk medically, even if the risk is in the future (and maybe concerning a general medical condition) rather than an actual (and perhaps obviously job-related) present incapacity. If disability should develop, possibly prolonged or recurrent periods of sickness absence may result; and this is obviously uneconomical to the organisation, and likely to impose added strain on the disabled employee's workmates.

It is not unethical for an insurance company medical officer to act in this way, and I do not see why it should be so regarded in respect of an occupational health physician. His allegance is primarily to his organisation and to the people already employed; and taking on a bad risk is likely only to increase the problems of work and health for existing employees, both workmates and management.

In conclusion, let me say that in practice it must be only very exceptionally that a man found medically unfit for the particular job for which he is applying can be easily offered alternative employment within the organisation, and I do not think that this is a viable answer to the problem.

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Secrecy and the health of Soviet prisoners

SIR,—Dr Michael Ryan, in his "Letters from the USSR" (25 August, p 480, 8 September, p 585, and 15 September, p 648) has performed a valuable service in describing the pressures that are exerted on the individual doctor when he practises in the Soviet Union. The intense secrecy surrounding all activities of the monolithic state inevitably causes distrust of any statements it may make regarding the state of the public health, or in the case of those in its closer charge.

I refer to the case of Anatoly Sharansky, the Jewish human rights leader, who is now in Christopol Prison serving a 13-year sentence for alleged spying for the USA. There is now grave concern for his health, particularly after the prison visit by his mother, the only one after 12 months of incarceration. His general condition was described as appalling and he told her that he was suffering from severe pain in his eyes and sinuses on attempting to read or write, and that he had been refused a consultation with an ophthalmologist. This confirms the report of similar symptoms in previous letters from Sharansky from prison, and also reports from a fellow prisoner.

Bland assurances from the authorities that Sharansky is in good health cannot be accepted, and there is no possibility of obtaining, inside or outside the prison, any medical opinion on his real state of health. Unfortunately it is not possible to accept the word of the Soviet authorities, including that of their medical establishment, so long as they maintain their wall of silence, and give information to serve only political ends.

In the meantime Sharansky's friends, inside and outside the Soviet Union, will continue to make every effort to see that his health is preserved in captivity, and that every step is taken to ensure that he receives all medical treatment that may be indicated.

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