The recent studies increasingly suggest that smoking, in addition to its undoubted connexion with lung cancer, plays some part in the development of cancer of the mouth, larynx, oesophagus, and possibly pancreas. But no association with cancer of the stomach has been found despite investigations into the question. Epidemiological, clinical, and experimental data also point to a relationship between smoking and cancer of the bladder, though whether it is causal remains so far uncertain. Evidence continues to accumulate showing that cigarette smokers, both men and women, are much more liable to coronary artery disease than are non-smokers. Moreover, a reduction in the risk follows cessation of smoking. According to the report, too, additional evidence strengthens the association between cigarette smoking and cerebrovascular disease.

The smoking of tobacco, and especially of cigarettes, is surely the greatest menace to the public health of our time, causing death and disability on a scale reminiscent of the epidemic diseases of earlier centuries. But a dilemma faces any Government that attempts to diminish the scourge of smoking, for it is not, like the epidemics, a communicable disease—except by example—so that the general public might not be as willing to accept compulsory measures of restriction as they were in the case of infectious diseases. Moreover, special difficulty in educating the public comes from the long interval between a man's beginning to smoke and his death from lung cancer—usually some decades. If the chances of a smoker contracting cancer were the same as now but the interval before death was only some months it is scarcely conceivable that cigarettes would be marketed at all, or, if they were, that legislation would be long delayed to prohibit them altogether. Since the Government is unlikely to adopt that course at present, it must consider others. The measure most often canvassed is a complete ban on the advertising of cigarettes. If this and other restrictions are imposed they will need to be supplemented by much more thorough educational campaigns than have been carried out so far, directed especially to young people[5] and with a skill that will communicate firm conviction rather than mere knowledge of the harm that follows smoking.

Good General Practice

As reported in the *Supplement,* the General Medical Services Committee has in the main approved its advisory committee's report on vocational training for general practice. Any criticism was mostly of details and not of principles. The report has been sent with the G.M.S. Committee's blessing to the Royal Commission on Medical Education and to the Central Committee on Postgraduate Medical Education, set up in June, under the chairmanship of Sir Robert Aitken, by the universities with medical schools and the medical colleges of England and Wales and Scotland.[1] This Committee, which has now incorporated " (Great Britain) " in its title[2] in recognition of its concern with Scotland as well as with England and Wales, has already discussed the organization of medical training in the first three years after registration. Also published early this month were the Royal College of General Practitioners' views[3] on how its earlier proposals for vocational training should be implemented.

There is no longer any real dispute about the need for vocational training for general practice in the same way as it is needed for other specialized branches of medical practice. The only remaining questions are on how it should be done and when it should begin. Vocational training must be seen as part of the whole of medical education, and it cannot be considered separately from postgraduate education. Further events must await the report of the Royal Commission on Medical Education, expected early next year. It may be supposed that the Commission has had the benefit of the views of the Central Committee on Postgraduate Medical Education in addition to those of the General Medical Council, the colleges, the B.M.A., and the other bodies that have given evidence to it. Those who are anxious for progress will therefore be looking to the Royal Commission's recommendations to provide the impetus that is needed.

Not surprisingly, the views of the Royal College of General Practitioners and of the G.M.S. Committee's Advisory Committee on Vocational Training and Continuing Education for General Practice were very similar. They shared many members in common, and also vocational training for general practice is now so old a concept that ideas on it have had plenty of time to crystallize out. If the trainee practitioner scheme has not been the success that was hoped for it has certainly provided a source of valuable experience on which to build. So also have some other schemes, notably the Wessex experiment in training for general practice. Against this background of general agreement some cautionary notes sounded in the G.M.S. Committee's debate should be heeded. The demands on, in some cases, seriously overworked doctors to provide medical care for patients are certain to conflict with what those who have to administer the Health Service are bound to consider as the less pressing needs of medical education. The essence of traineeship is to be a learner first and a doer—a pair of hands—second. The urgent need of the Health Service is for more and more pairs of hands. For this reason the responsibility for vocational and for all postgraduate training must surely be with educational committees. An organization with the Central Committee on Postgraduate Medical Education (Great Britain) at its head seems ideal for the purpose. Likewise, it would be better to regard vocational training as a university responsibility and not a Health Service one. This implies that the money for it should come mostly from the University Grants Committee and not from the Ministry of Health. This is something the medical profession should lay stress on.

Short of making vocational training compulsory—and the wisdom of taking so big a step to begin with is questionable—participation in any scheme must depend on the incentives which prospective general practitioners are offered. They will not enter a scheme if they suffer disadvantage from their keenness. They must be paid properly while they train, and afterwards their added skills must be rewarded. The current vocational training payments in general practice are derisory. In this, as in other respects, the country must be prepared to pay for a good medical service or to have a poorer one. But there will be no inducement to young doctors to add three to four years to their training if they cannot use their skills when they go into practice. Vocational training is important, but it would be putting the cart before the horse to train first-class doctors for third-class working conditions. Emigration would increase, not decrease. If general practice is to attract recruits it must offer them the facilities for practising good medicine.

[1] *Brit. med. J.,* 1967, 2, 833.
[2] Ibid., 1967, 3, 687.
[3] *Implementation of Vocational Training,* Reports from General Practice No. VI, Royal College of General Practitioners, 1967.

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