had spent time and effort arranging an anti-smoking clinic. This was advertised well in advance and a time was chosen in the evening when people would be able to attend. However, only three people attended. It is difficult to see how primary health care teams can achieve targets for the reduction of smoking when tobacco products are still widely advertised and smoking is permitted in public places. People turn to smoking when they are under stress and find it easier to give up smoking when things are going well. It is arguable that if the government were able to reduce unemployment and improve housing, people might be under less stress and doctors might find it easier to help people give up smoking. However, the group recognized that it was important to do what we can and a start would be to have an accurate record of the smoking history of all patients.

The group felt that the green paper had overlooked musculoskeletal disorders, which not only cause considerable morbidity in the population, but also result in many days lost from work. We agreed that immediate access to practice based physiotherapy would be likely to make a big impact on the disability caused by musculoskeletal disorders, particularly back pain.[2]

We discussed mental health and felt that this was another area where social problems could be easily disguised as medical problems. Closing mental hospitals has to be matched by more resources in the community, both medical and non-medical, so that former patients have somewhere to go during the day.[3] We would like to see more practice based services with psychologists, counsellors and community psychiatric nurses taking an active part in every primary health care team.

We conceded that primary care is often inward looking, focusing its attention quite naturally on those patients who attend the surgery. It would be useful to have the resources to send members of the team outside the surgery, to talk in schools or work places for example. Family health services authorities could fund an educator who would educate teachers about asthma, diabetes and epilepsy and talk to children about the human immunodeficiency virus, drug abuse and so on, making it clear that they would be treated sympathetically on these matters at the practice. The district health authorities might also consider enhancing the role of the community medical officers in this respect.

The group felt that it was important that trials should be done to ascertain the usefulness of any new interventions.[4-6] The public seem to want screening and check ups (General manager, Cambridgeshire Family Health Services Authority, personal communication) and the government has an interest in providing the public with what they want. However, doctors would like to know that health promotion clinics for example had been shown to be successful in terms of reducing morbidity and mortality as well as being financially rewarding. There is no doubt that we are much happier advocating screening procedures such as mammography[7] which are of proven benefit.

The emphasis on teamwork and preventive care, together with inducements to increase list sizes, places more pressure on general practitioners to become managers and to offer less personal care themselves.[8] If this leads to more and better services for patients, then this is not a bad thing, although it was generally agreed by the group that we enjoy being good doctors. Whether this is an old-fashioned concept, or whether the definition of a good doctor is changing remains to be seen.

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References

1. Secretary of State for Health. *The health of the nation: a consultative document for health in England (Cmnd 1523)* London: HMSO, 1991.
2. Koes BW, Bouter LM, Van Mameren H, *et al.* Randomised clinical trial of manipulative therapy and physiotherapy for persistent back and neck complaints: results of one year follow up. *BMJ* 1992; **304:** 601-605.
3. Down and out and ill in London [news item]. *BMJ* 1992; **304:** 273.
4. Hobbs FDR, Cherry RC, Fielding JWL, *et al.* Acceptability of opportunistic screening for occult gastrointestinal blood loss. *BMJ* 1992; **304:** 483-486.
5. Mant D, Fuller A, Northover J, *et al.* Patient compliance with colorectal cancer screening in general practice. *Br J Gen Pract* 1992; **42:** 18-20.
6. Parle JV, Franklyn JA, Cross KW, *et al.* Assessment of a screening process to detect patients aged 60 years and over at high risk of hypothyroidism. *Br J Gen Pract* 1991; **41:** 414-416.
7. Klemi PJ, Joensuu H, Toikkanen S, *et al.* Aggressiveness of breast cancers found with and without screening. *BMJ* 1992; **304:** 467-469.
8. Marsh GN. The future of general practice: caring for larger lists. *BMJ* 1991; **303:** 1312-1316.

Vocational training

Sir,

Dr Styles' interesting review of the training experience of doctors certificated for general practice (December *Journal,* p.488) relates only to the requisite number of hospital posts that a trainee has to complete in order to gain the Joint Committee on Postgraduate Training for General Practice statement of satisfactory completion. It is possible that some applicants may have had more hospital experience than recorded on the computer. However, the pattern of training has been disappointingly stereotyped and trainees have not taken full advantage of the flexibility offered by the vocational training scheme regulations. The majority do not wish to undertake any more training than is necessary and of course, there may be many reasons for this including the trainee's anxiety regarding the job market, career progression and social or domestic factors.

Too much cannot be read into the apparent rise or fall in the number of trainees gaining experience in a specialty as a particular training post does not predict the trainee's future behaviour as a general practitioner. Despite the staggering rise in the number of trainees acquiring experience in obstetrics, few show a high level of involvement in, for example, intrapartum care.[1] Therefore, a closer examination should be made of the type of training that each post offers, the attitude of the consultants, the core curriculum of training and the effects of training upon the trainee in terms of his/her attitude towards the specialty.

A well designed rotation allowing two-month attachments to a range of specialties with 18 months' training in general practice may be the best way forward. Those wishing to spend longer than two months in a specialty should also be able to do so but, perhaps, outside the scheme and as part of their higher professional training. In addition, assessment should be made of the effectiveness of some of the historical components of vocational training, such as half-day release and trainers' workshops.

Styles' study, in parallel with others[2-4] highlights an urgent need to take a fresh look at vocational training. The changes in society, particularly with regard to the role of general practitioners, give added urgency for such an appraisal.

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References

1. Smith LFP, Jewell D. Contribution of general practitioners to hospital intrapartum care in maternity units in England and Wales in 1988. *BMJ* 1991; **302:** 13-16.
2. Tachakra S. A hospital consultant's perception of vocational training for general practice. *J Postgrad Educ Gen Pract* 1991; **2:** 36-40.
3. Ruscoe M. Education at senior house officer level. *J Postgrad Educ Gen Pract* 1991; **2:** 155-157.
4. Bahrami J. Training problems. In: Hall MS (ed). *A GP training handbook.* Oxford: Blackwell Scientific, 1989.