sizes: fewer than 1500 patients per doctor. This has major implications for our resourcing, worse since the new contract's encouragement of higher list sizes. We serve one of the two most deprived areas in Bristol, but UPA(8) anomalies mean we receive no deprivation payments at all. Talbot[2] and Carr-Hill and Sheldon[1] have clearly shown this range of issues.

We foresaw the problems the use of UPA(8) scoring would generate for situtations like ours.[3] Our deprivation is diluted within a huge, relatively affluent electoral ward.[1] Out of date (1981) census data[2] do not reflect the major demographic shift that has marginalised the most deprived people to the least desirable areas because of the "right to buy" policy reducing council housing stock (a nationwide factor). The level for starting deprivation payments is too high: the political difficulties of admitting the true extent of relative deprivation are self evident.

If the UPA(8) system is to be used there must be a mechanism for appeal and renegotiation when a practice can show that the deprivation it serves has not been recognised. Local knowledge and local objective data in our area leave no doubt about where the real deprivation is. UPA(8) scores for individual practices, as suggested by Chase and Davies,[4] is one possibility. As there is a clear link between poor health and poverty an index based on material deprivation, such as the Townsend score, may be more appropriate, though still not ideal.[5,6] The concept of allocating additional resources to deprived areas is excellent and is much needed to address the problem of health inequalities—probably the most important issue facing government, with regard to health care, in Britain today.

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DIY microbiology

SIR,—One of our local general practitioner colleagues has recently drawn our attention to the developing market in general practitioners' surgery laboratory investigations. He had, in fact, acquired a mini-incubator and a supply of media and had proceeded to plate out a variety of swabs. Unfortunately, he was unable to identify the organisms growing on his plates and asked for our help.

The particular incubator had recently been featured in an article in the magazine *GP*, which had suggested that general practitioners could save money by setting up their own mini-laboratories. No mention was made of the appropriate safety measures required, the problems of disposal of plates and specimens, or the importance of quality control. The Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health (COSHH) Regulations apply to work in which there may be exposure to pathogens. Current assessments of the hazards facing microbiology laboratory workers are based on the guidance of the Advisory Committee on Dangerous Pathogens, which "while it has no legal force, its standing as agreed practical guidance means that it may be referred to in a court or tribunal to demonstrate the standards that need to be met under the law."[1] We suggest that all general practitioners contemplating a mini-laboratory should take note.

Besides safety, there are much wider issues. Organisms may be misidentified or fail to grow, with grave clinical (and medicolegal) implications; sensitivity data may be misinterpreted, resulting in treatment failure or the unnecessary use of toxic drugs; and a large amount of epidemiological data may be lost. There would also be the loss of the interpretative and clinical input from the medical microbiologist, who would be unlikely to wish to discuss the management of a patient based on the isolation of organisms in a general practitioner's mini-laboratory.

In the forthcoming market led health service, if patients are to be given more choice they need to be aware of the quality of microbiological investigations being provided. It is not difficult to imagine which sort of laboratory they would choose to perform these. Surely this is one instance in which small is NOT beautiful?

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GMC specialist register

SIR,—The procedure by which the General Medical Council proposes to set up a de facto specialist register is unfair, unnecessary, and discriminatory. By according specialist status only to those who have been accredited by the appropriate training bodies the GMC has done a signal disservice to many doctors who work in NHS hospitals as registrars or clinical assistants, whose only crime is that they have fallen foul of a system of training in which numbers are limited by staffing controls.

In many countries in Europe specialist status is achieved merely by pursuing a postgraduate course lasting three to five years. There is nothing like the senior registrar post, and the concept of higher medical training does not exist. As a result a consultant in the United Kingdom is, on first appointment, much better trained and more highly qualified than a specialist in, say, The Netherlands or Italy. For these consultants and senior registrars the GMC's scheme has nothing new to offer, unless they desire a few more letters after their names.

Many in the "junior" grades, particularly overseas doctors in the hospital service have, however, been hard done by. Up and down the country there are many exceedingly good doctors working in key specialties like surgery, orthopaedics, obstetrics, general medicine, paediatrics, and ear, nose, and throat medicine who are better trained and better able independently to handle the full range of clinical problems in their specialties than are "specialists" on the continent. Except in teaching centres most of this silent army of middle grade staff are overseas doctors. In most district hospitals the consultants in these specialties would be unable to work without the able support of these highly trained and qualified specialists. It is an open secret that only in name are these posts designated training jobs; in reality they are 100% service posts.

These doctors believe that they have been sold down the Rhine. The GMC will not recognise their work and their worth by granting them registration as specialists. It is through no fault of theirs that they have not become senior registrars and gained accreditation. But surely it is possible for the GMC, itself under no staffing restrictions, to recognise their skills by adopting a different criterion from that of accreditation to register specialist status. I suggest the criterion of possession of the MRCP, FRCS, etc, and four years' work in the specialty, two at registrar level.

The present proposals are irrelevant to doctors who are already accredited; they are unfair to the many who do the same work as those who can register; they are discriminatory in that doctors in Europe with lesser skills will be specialists. This discriminatory effect will be felt disproportionately by overseas doctors working in NHS hospitals. The proposals offer nothing more to employers than the accreditation process already does. I submit that as they stand they are a waste of time.

Many will also think that, had the ethnic mix of middle grade staff who neither have hope of obtaining accreditation in their chosen specialty nor wish to enter general practice been different then the GMC would have come up with a different set of proposals.

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Unnecessary hospital referral data

SIR,—The latest edict from the Welsh Office, specifically designed to increase the administrative burden of "paperwork fatigued" general practitioners, sets out the minimum data required in the referral of each patient to both inpatient and outpatient hospital care after 1 April 1991.

Nineteen separate pieces of information are required for each patient. These range from the district health authority contract identification number through to name, address, and code number of both the referring doctor and the patient's "registered" practitioner. These data are in addition to, and separate from, all the pointless (and probably inaccurate) data that have to be recorded for the family health services authority in the practice's annual report. At the same time the Department of Health has set up a committee to investigate unnecessary paperwork in the NHS!

I envisage that there will be problems with so much additional time spent on data collection. There will be less time available for patient care. There is clearly a breach of patient confidentiality as this information will be required in order to process invoices between providers' and procurers' treasurers. It requires information that many general practitioners and patients are unable to provide—for example, postcodes and the "name of the patient's registered general practitioner." Many records are incorrectly stamped with the names of general practitioners long since retired.

I understand that hospital consultants will have similar data problems. Requests for payment from their hospital will require them to record their GMC code number, with suffixes attached, according to the exact ward, hospital building, or department in which the patient was treated.

As a non-budget holding general practitioner through choice, I regard the whole budget exercise as a Whitehall farce, dreamed up as someone's bright idea and formulated, without thought of its full implications, on the back of an envelope. This data collecting will be regarded by many as a low priority procedure, will be performed half heartedly and inaccurately, and will produce meaningless statistics. It may result in computers choking on inaccurate data while they search for non-existent patients referred by long dead general practitioners.

These "budgets" are a problem for the hospital and the district health authorities. It is up to the hospitals to have adequate computer systems to generate invoices and bills to the authority. It is not up to general practitioners to put the care of their patients at risk while this crazy system goes through its birth and death pains. I suspect that the