district general hospitals that teach undergraduates, and a mechanism needs to be set up to ensure that this transfer of funds actually takes place. Unless this happens the quality of services in these hospitals and of undergraduate education is threatened.

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1 Chantler C. Service increment for teaching and research. *BMJ* 1992;305:71-2. (11 July.)
2 Black GB, Bevan G, Peters TJ, Eddleston ALWF. King's model for allocating service increment for teaching and research (SIFTR). *BMJ* 1992;305:95-6. (11 July.)
3 Smith CL. Service increment for teaching and research (SIFTR): the Southampton experience. *BMJ* 1992;305:97-8. (11 July.)
4 Sheldon TA. Service increment for teaching and research. *BMJ* 1992;305:310. (1 August.)
5 Normand C, McKee M. Service increment for teaching and research. *BMJ* 1992;305:310. (1 August.)

Prisoner of conscience in Tibet

EDITOR,—I recently worked for six months with Tibetan refugees in India and heard many accounts of repression in Tibet. I would like to draw attention to the plight of Jampa Ngodrup, a Tibetan doctor who formerly worked at the Lhasa City Barkor Clinic in the capital of the Tibetan Autonomous Region of the People's Republic of China. He was detained by the Chinese authorities in October 1989 and formally arrested in August 1990. He was accused of having "with counter revolutionary aims, collected lists of people detained in the disturbances (asserting Tibetan independence) and passed them on to others, thus undermining the law and violating the laws of secrecy." The verdict at his trial in December 1990 was that "in order to strengthen the unity of the motherland, to strengthen and protect the motherland and to enforce the democratic rights of the people, defendant Jampa Ngodrup, having committed the crime of being a spy, is sentenced to 13 years' imprisonment."

Jampa Ngodrup is reportedly detained in Drapchi prison in Lhasa. Amnesty International considers him to be a prisoner of conscience detained solely because he exercised his right freely to give and receive information. Amnesty calls for his immediate and unconditional release.

Please send appeals urging Dr Jampa Ngodrup's immediate release from Drapchi prison to Gyaltsen Norbu Zhuxi (the chairperson of the government of the Tibetan Autonomous Region), Xizang Zizhiqu Renmin Zhengfu, 1 Kang' andonglu, Lasashi 850000, Xizang Zizhiqu, People's Republic of China; and to Li Peng Zongli (the premier of the state council of the People's Republic of China), Guowuyuan, 9 Xihuangchenggen Beijie, Beijing 100032, People's Republic of China.

For further information write to Amnesty International, 1 Easton Street, London WC1X 8DJ.

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Assessing GP trainees

EDITOR,—We were concerned to read that the General Medical Services Committee thought that the interim report by the Joint Committee on Postgraduate Training for General Practice was "woolly, flawed, and inconsistent."[1] We think that similar sentiments may be applied to some of the suggestions of the GMSC's education and audit subcommittee.

Hospital training for general practice and the problems of the senior house officer grade are already priorities for action in our regional strategy for general practice education in the west midlands. With the support of the regional postgraduate dean we will be endeavouring to improve the education of all senior house officers in the near future. Such improvements will include assessment of the educational and service aspects of each post.

We are puzzled as to how we would recognise fairly those trainess "unlikely at the end of their training to be competent to practice as principals" without assessing all trainees. This already takes place, with our regional assessment package assessing trainees at three, six, and 11 months in the trainee year. This concept of formative assessment should allow us to identify the trainees' strengths and weaknesses so that any shortcomings may be rectified as soon as possible. After all, under the joint committee's guidelines formative assessment is mandatory for all regions from 1 January next year.

We note the recommendation that "trainees should be selected more carefully" but bear in mind paragraph 38·5(h) of the red book, which states that the trainer is responsible for appointing the trainee. There are no restrictions at present concerning age, experience, or suitability for general practice. In this region the regional general practice education committee has included in its criteria for approving trainers that a trainer should be able to select a suitable trainee. In our assessment package candidates are reviewed before employment, which necessitates discussion with the local course organiser for all prospective trainees not on a formal vocational training scheme. The onus for appointment still, however, rests with the trainer, and any further restriction on selection of trainees would require changes in the red book.

We believe that we have failed a trainee if at the end of the year the first inkling of poor performance is the trainer's refusal to sign the VTR 1 form. Surely the purpose of formative assessment of all trainees is to identify poor performance earlier in the training and to arrange further remedial education and assessment. In this way the hurdle of summative assessment is minimised.

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1 Beecham L. Assessing GP trainees. *BMJ* 1992;305:316-7. (1 August.)

Public health heresy

EDITOR,—Paula Whitty and Ian Jones are right to blow the whistle on the new "purchasingspeak" of "health gain" through health service contracts.[1] We agree that much of the talk about the contribution of district health authorities to the public health has been informed by ideology and ignorance rather than a real understanding of the social and economic determinants of health and disease. In this context our overall objectives in the department of public health of City and Hackney Health Authority can be summarised as threefold: to strengthen our multiagency work; to develop provider programmes (mainly on health promotion and control of communicable diseases); and to involve local agencies in implementing plans for community care and in assessing the health and health care needs of our population.

To assess the extent to which we are actively pursuing these objectives we conducted a three week prospective audit of how we spend our time. Those taking part in the audit were eight medical staff, two senior non-medical staff (a researcher and a planner), and three health promotion staff. Although there are shortcomings in the methods we used—such as agreeing definitions of activities—the table shows that both medical and non-medical staff spend only a small proportion of their time on purchasing activities. Indeed, a much

Percentage of time spent on various activities each week by staff in department of public health of City and Hackney Health Authority

Activity	Medical staff (n=8)	Non-medical staff (n=5)	Total
Multidisciplinary work (eg, joint planning)	21	28	24
Training and teaching (eg, teaching students)	27	16	23
Management and administration (eg, correspondence, interviewing)	17	28	21
Being trained (eg, courses, time with trainers)	15	5	11
Needs assessment	7	15	10
Service provision (eg, advice on infectious disease, health promotion)	7	7	7
Contract advice and purchasing	6	1	4

higher proportion of time was spent on wider public health work (for example, joint planning and preventive services). In our view, the key to maintaining this important perspective lies in integrating health promotion and communicable disease control services within public health departments. Those public health departments most at risk of a narrow purchasing perspective are those that have merged into "megadistricts" or have ceded these vital public roles to provider units.

It is wrong to assume, however, that we should not aim to influence the pattern of health care spending, especially as some of this money might be better spent on health promotion rather than acute care (which currently uses up 99·7% of district funds). We have made a start this year by ensuring that equal proportions of the district's capitation growth money will be spent on health promotion and treatment and care. We see this as a small but essential contribution that every district should make towards fulfilling its wider public health objectives.

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1 Whitty P, Jones I. Public health heresy: a challenge to the purchasing orthodoxy. *BMJ* 1992;304:1039-41. (18 April.)

Treating Jehovah's Witnesses

EDITOR,—The title of a recent news item—"Court says doctors were right to treat Jehovah's Witness"—is inaccurate.[1] As the text makes clear, the patient at the centre of the decision by the Court of Appeal was not, in fact, one of Jehovah's Witnesses.

While declaring that a doctor has a duty to offer appropriate counselling and to point out any risks attendant on a patient's choice, the court affirmed that a mentally competent adult patient "has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."[2] That is all that Jehovah's Witnesses ask for: the right to choose medical management that does not entail blood transfusion, accepting its risks in exchange for its benefits. We thank those doctors who respect our wishes.

All three lords justices cited with approval the Canadian case of Mallette *v* Shulman, which confirmed the validity of the advance medical directive or release customarily carried by bona fide Jehovah's Witnesses, executed of their own free will as an expression of deeply and sincerely held religious scruples.[3] "Doctors who treat such a patient against his known wishes do so at their peril."[4]

In an effort to be helpful and avoid confrontations Jehovah's Witnesses maintain a network of

800 hospital liaison committees internationally, of which 36 are in Britain; these committees assist in linking both patient and doctor with specialists prepared to manage the patient in harmony with the patient's conscience. We hope that doctors will use these contacts as we have no wish either to pressure or to be pressured. Cooperation is always better than confrontation.

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1 Dyer C. Court says doctors were right to treat Jehovah's Witness. *BMJ* 1992;305:272. (1 August.)
2 Lord Donaldson of Lymington re T. Page 2 of judgment released to press by Court of Appeal.
3 Mallette *v* Shulman *et al*, Supreme Court of Ontario. (1991) 2 Med L R 162.
4 Lord Justice Butler-Sloss re T. Page 1 of judgment released to press by Court of Appeal.

Laboratory animals and recognition

EDITOR,—Writing about coincidences and vivisection, N H Naqvi quotes his young questioner as arguing that "all medical labs should erect dogs' statues and pay due respect to the animals who lose their lives during experiments." I agree wholeheartedly that laboratory animals deserve recognition, and in Japan they get it. Near the Kiso River, where a research laboratory of a large pharmaceutical company discharges water so clean that fish and other aquatic life are abundant, stands a stone memorial to laboratory animals. Each year many people attend the celebration of a Buddhist rite in this beautiful garden setting.

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1 Naqvi NH. Coincidences. *BMJ* 1992;305:94. (11 July.)

Advance directive bill

EDITOR,—Alison Tonks's report on the advance directive bill makes a strong case, albeit unwittingly, for legislation to give advance directives legal status.[1] On the one hand, both the BMA's representative, Anne Sommerville, and Simmy Viinikka of the Terrence Higgins Trust seem confident that doctors follow patients' wishes as expressed in advance directives. On the other hand, Tony Hope argues the case for ignoring them, and I am sure he is not alone in this view.

This is typical of the confusion that now exists over decisions regarding non-treatment. Nor can we seek help from the law. The reason that so many doctors feel compelled to practise so called passive euthanasia furtively is the uncertainty of the legal position.

In some small way the Medical Treatment (Advance Directive) Bill will help to clarify the situation for the benefit of both patients and doctors.

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1 Tonks A. Advance directive bill. *BMJ* 1992;305:139. (18 July.)

Plight of singlehanded consultants in A and E

EDITOR,—At long last it is recognised that consultants in accident and emergency medicine work longer hours, excluding time on call, than any other consultants.[1] This is especially so for the single handed. I know. For five years I worked single handed, and the cost was high: my now ex-wife went on to marry a farmer, having herself given up a promising medical career. I am now in the relatively fortunate position of having not only an excellent business manager but also a first class consultant partner.

But St Mary's Hospital is still the only hospital in North West Thames region to have two consultants in accident and emergency medicine. The problem is not just finance (though this is a problem, especially as most non-teaching hospital departments are understaffed at all levels); there are not sufficient suitable applicants available, especially in London (because of the cost of housing and spouses' dislike of the city). Harley Street is not an attraction as there is no private practice in accident and emergency medicine. In autumn last year 20 posts for consultants in the specialty were unfilled.[2]

At least two colleagues in my region would advertise tomorrow if they thought that senior registrars were available and would apply. It will take five years for the increased numbers of registrars to work through their training programmes to accreditation. Some might say it is easier to find a spouse than a consultant partner in accident and emergency medicine. What hope, then, for my 17 singlehanded colleagues (and their families) in the region, or the patients they serve, for in reality no immediate relief is in sight? Perhaps consultants in accident and emergency medicine should be able to retire at 55 as psychiatrists can, especially as many long term psychiatric patients are now cared for in the community (often attending accident and emergency departments).

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1 Smith R. Understaffing in accident and emergency departments. *BMJ* 1992;305:329-30. (8 August.)
2 National Audit Office. *NHS accident and emergency departments in England.* London: HMSO, 1992.

Ashworth Hospital

EDITOR,—In his editorial on the special hospitals Robert Bluglass merely jumps on the bandwagon when he states, "Proper value should be given to civil rights, to abandoning oppressive methods of control (including the excessive use of seclusion), and to recognising the patient's autonomy."[1] How can he assume that most of the staff do not do this? No one mentions the majority of staff in these hospitals who do a good job under difficult circumstances, who treat patients with dignity, and who go to work facing the threat of violence and criticism every day.

As an occupational physician at Ashworth Hospital I see the physical and mental scars of staff who have been violently assaulted by patients and whose careers have ended prematurely.

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1 Bluglass R. The special hospitals. *BMJ* 1992;305:323-4. (8 August.)

EDITOR,—As Dr Eileen Bell has been a colleague and friend of mine for over 20 years I know her to be both a conscientious and capable psychiatrist and a caring and sensitive woman. In the news article on the inquiry into Ashworth Hospital Luisa Dillner quotes Dr Bell as saying that the patients are "not just dangerous and often criminal but most are very nearly impossible to diagnose and therefore to treat," with the implication that this statement is unreasonable or incorrect.[1] Having visited Ashworth Hospital many times during the past 15 years to examine patients for mental health review tribunals, I am well aware of the complex psychiatric problems presented by the patients. Most of them are in Ashworth Hospital because other psychiatrists have failed in their efforts to diagnose and treat them.

In my opinion the problems at Ashworth Hospital are due to the criminal and indefensible behaviour of a small number of staff and to a poor and antiquated system of psychiatric care that has proved resistant to change. The authors of the report on the inquiry do no one a service in underestimating the management problems and dangers presented by many of the patients in Ashworth Hospital.[2] It is also sad that they undervalue the considerable efforts made by most of the medical and nursing staff to help and care for these unfortunate and challenging patients.

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1 Dillner L. Ashworth inquiry suspends staff. *BMJ* 1992;305:385-6. (15 August.)
2 Department of Health. *Report of the committee of inquiry into complaints about Ashworth Hospital.* London: HMSO, 1992. (Chairman Sir Louis Blom-Cooper QC.)

The doctor's right to choose

EDITOR,—Trisha Greenhalgh is disarmingly frank, but she is wrong.[1] There is no point in fighting for a woman's right to choose abortion if you then unilaterally invent criteria for rationing that so called right. Because her patient failed to conform to her cultural stereotype of a woman seeking abortion Greenhalgh arbitrarily imposed her own inverse poor law concept of "the undeserving rich." I, too, was affronted by her patient's presumption—but, unlike Greenhalgh, I would have placed principle before prejudice.

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1 Greenhalgh T. The doctor's right to choose. *BMJ* 1992;305:371. (8 August.)

EDITOR,—Many readers will sympathise with Trisha Greenhalgh over her problem in being asked to endorse a patient's wish to have an abortion to allow her family holiday and subsequent pregnancy to be arranged at times convenient for her.[1] I suggest that doctors would not need to be confronted with difficult decisions of this type if the British abortion law was amended to match the law in most developed countries. Most applications for terminations for these rather difficult social reasons occur during early pregnancy, before 12 weeks' gestation. Most developed countries allow women free choice of abortion during the first 12 weeks of pregnancy, and a reason does not have to be stated; thus doctors are spared embarrassing situations of the type Greenhalgh describes. Of course, for terminations after 12 weeks the regulations that obtain in Britain at present would apply, but few, if any, women would ask for a late termination to allow a skiing holiday.

The Pro-Choice Alliance is an organisation that aims to give British women free choice during the first 12 weeks of pregnancy; it includes members of parliament in all parties, surgeons, gynaecologists, general practitioners, and members of the general public. Readers may like to join and support the Pro-Choice Alliance in its efforts to bring an amendment before parliament that would bring British abortion law into line with that of other countries in the European Community.

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1 Greenhalgh T. The doctor's right to choose. *BMJ* 1992;305:371. (8 August.)