consultations per hour in the afternoon). By contrast, the potential consultation time for one of the doctors who held walk in surgeries was eight minutes per patient.[3] The nurses' fee for service work earned about one third of the salary costs borne by the practice.[2] Most of the tasks that the nurses carried out were simple, such as changing dressings, taking blood pressure, and testing urine; some of them could be delegated to staff who were not nurses, freeing resources for more difficult work such as giving advice on health. Mark R Williamson has argued that venepuncture should be delegated to receptionists.[4] In the study by Fallon *et al* 9·2% of tasks were venepuncture. Delegating this task would free substantial time.

Fallon *et al*'s study supports the argument for rethinking skill mix in primary care, offers the hypothesis that nurses are popular with patients because they have more time than doctors to spend with patients, and provides further data on the relative costs in relation to consultations undertaken. Policymakers cannot assume that changing skill mix will save money as the advent of practice nurses has shown. With a massive iceberg of unmet need in the population,[5] changing the skill mix is a way of providing a broader and more appropriate range of services, of freeing highly trained staff for the most demanding tasks, and of enriching the work experience of those who accept the delegated work.

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Database on clinical negligence

EDITOR,—Little interest has been shown in the steps that the Department of Health is taking to set up a central fund to spread the burden of indemnity payments and legal costs borne by trusts in connection with damage done by clinical negligence. Eventually, as the availability of legal aid becomes increasingly restricted, only the very poor and the very rich will be able to afford to take action in respect of clinical negligence. But trusts will have to bear the burden of past years for some time yet: claims will continue to arise from decisions made and actions taken since April 1991.

Another consideration is much more important than that of spreading the financial burden. When Mrs Bottomley's predecessor destroyed the mechanism operated by the defence organisations for spreading that burden in the hospital and community services he also destroyed the mechanism for collecting, analysing, and retrieving data on damage done by medical negligence in those services. Risk management is probably the only way of lessening the toll of medical negligence; to be effective it requires the formation and preservation of such a database. The defence organisations do their best with information from past years and from private and general practice, but they no longer have access to the vast fund of experience gained in the hospital and community services.

I hope that the department will combine the institution of a central fund with the creation of a central collection agency that would store and analyse records of clinical negligence in the hospital and community services. The present arrangements for dealing with claims in respect of clinical negligence are sadly defective; they are damaging to patients and clinicians and are of benefit principally to lawyers. The benefit of risk management would be greatly enhanced by the institution of a central store of information about this continuing problem.

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Hospital vocational training

Local audits are helpful

EDITOR,—As a general practitioner, course organiser, and former senior house officer in Wessex, I am keenly aware of the problems in training for senior house officers.[1,2] Paul Little's survey provides an overview of the situation in Wessex but hides the variation among hospitals and posts.[1] Since the senior house officers who were questioned were in post it has become regional policy for course organisers in general practice to review hospital vocational training.

In Portsmouth we send a questionnaire to all senior house officers on vocational training schemes in the final month of each of their posts. Anecdotal reports about a post may be misleading as they may reflect a poor senior house officer or a poor post. Cumulative data from a series of senior house officers in post provide a better base from which to argue for improvements.

In Portsmouth all doctors on general practice vocational training schemes spend two months in general practice before their hospital training and 10 months in general practice after it; as Little mentions, a quarter (four) of our hospital posts are three months long. Ten of the 12 senior house officers in post replied to our questionnaire in February this year. All stated that they received weekly teaching, and seven thought that it was relevant to general practice. They were not asked the standard of teaching or degree of relevance. Only half had applied for study leave, but all the applications had been successful. Asked how many months into the post it was before they felt competent, one replied never; one, four months; two, three months; two, two months; and two, one month; two did not answer. Problems identified were doing non-medical tasks (eight), lack of appraisal (nine), absence of education targets (eight), no clear source of careers advice (six), and not knowing where to go for support when suffering from stress (seven).

The "lost tribe" of senior house officers has many problems, but Wessex is starting to tackle them. Local educational audit is one way to facilitate improvements in hospital training.

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1 Little P. What do Wessex general practitioners think about the structure of hospital vocational training? *BMJ* 1994;**308**: 1337-9. (21 May.)
2 Bayley TJ. The hospital component of vocational training for general practice. *BMJ* 1994;**308**:1339-40. (21 May.)

New post addresses deficiencies

EDITOR,—Vocational training is one success of British general practice. Paul Little rightly states that the hospital component needs reviewing as it does not reflect the views and training needs of those participating.[1] The general practice component has been criticised for not preparing practitioners for their business role. Changes in general practice emphasising the management of chronic disease, health promotion, and survival in the marketplace highlight the need for an understanding of issues concerning public health and purchasing.

The general practice regional adviser for North West Thames and the medical adviser to Kensington and Chelsea and Westminster Family Health Services Authority have developed a post at the family health services authority that aims at addressing these inadequacies. A general practitioner who has just finished his or her vocational training is attached for one year to the family health services authority and department of public health with opportunities for training in public health medicine, NHS organisation and management, and the authority's role and responsibilities, emphasising their application to general practice. Through supervision and teaching the general practitioner develops an understanding of issues including the provision of health care related to needs, preventive medicine, planning, evaluation, and the management of services and how to put these skills into practice. He or she is actively involved in the planning and provision of health care as work undertaken contributes to the development of local services. Weekly sessions are set aside for clinical work to extend training in general practice, which is arguably too short.

The health service gains through the knowledge and skills acquired being carried into general practice, enabling the provision of better care. We hope that similar posts will become commonplace and no more curious than any other on the route to a career in general practice.

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1 Little P. What do Wessex general practitioners think about the structure of hospital vocational training? *BMJ* 1994;**308**: 1337-9. (21 May.)

Prevention of suicide

EDITOR,—David Gunnell and Stephen Frankel's review of the literature on the prevention of suicide highlights the difficulties for psychiatric services in identifying those at greatest risk.[1] This point is further illustrated by data from a follow up study conducted in Nottingham. Consecutive first admissions to Saxondale Hospital (the Nottinghamshire County Asylum) were identified for the years 1974 and 1975. A cohort of 91 patients, comprising all those aged between 16 and 65 who were admitted from the borough of Broxtowe (total population roughly 100 000), was followed up 16 years later. Case notes of index admissions were examined to establish a diagnosis (according to the *Diagnostic and Statistical Manual of Mental Disorders,* third edition, revised[2]) and obtain other relevant clinical and demographic data. All 91 subjects were traced either up to their death or to their current general practitioner. Death certificates were obtained for all of those who had died.

The index diagnoses ranged widely, but 41 patients met the criteria for a major depressive disorder and nine met the criteria for schizophrenia. A suicidal act relating to the admission was recorded for 28, and 36 were noted to have reported suicidal ideation. Sixteen patients had died. All of these deaths had been due to natural causes: none had been due to accidents or suicide and no open verdicts had been recorded.

Such a cohort reflects the social and diagnostic mixture of many psychiatric caseloads and should represent a high risk group in both the short and the long term. Gunnell and Frankel report that in