help of videotape. This is followed-up in the practice by regular videotaping of the trainee's consultations which are then analysed during protected teaching sessions. Helpful feedback allows trainees to gain insight into their own performance and identifies the areas which need improvement. The development of communication and consultation skills is seen by the trainees as one of the most important benefits of the general practice post and useful in their future careers.

Patients deserve doctors who see the importance of communication and who have been shown to have acquired the appropriate skills. Our experience confirms that opportunities exist for the education and training of doctors in hospital specialties and general practice to be combined in a complementary manner to the ultimate benefit of patients[4,5].

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Continuing professional development in public health medicine

Editor – We read with interest the paper by Doyle and colleagues discussing the professional development of public health physicians (July/August 1997, pages 405–9). The authors unfortunately limit their work to the needs of public health personnel who have a medical background, and omit to include in their evaluation the needs of other workers who did not attend medical school but work within public health departments throughout the country.

After graduation, on deciding to re-direct a medical career and become a public health doctor, a trainee has to develop a completely new set of skills to those taught in medical school, accepting that most medical students touch upon medical statistics, epidemiology and so on as undergraduates. Public health trainees are then shepherded through their education in these new skills in a very structured way. In our experience, public health trainees quickly achieve consultant status, quicker than most medical disciplines. This pattern probably reflects supply.

The flavour of this article in only representing the needs of public health medicine employees with medical backgrounds may illustrate the ethos of public health doctors and the Faculty of Public Health Medicine (FPHM) in protecting jobs and salaries for only medical graduates. The FPHM does not routinely allow others with suitable backgrounds and qualifications into its rank and file and there is little support for any attempt to broaden membership[1]. This protective attitude, although perhaps slowly changing, is reflected in the lack of public health consultant posts advertised where non-medical staff are allowed to apply.

Interestingly, the notion of equity was the fifth highest priority for continued professional development in Doyle and colleagues' survey. The FPHM and public health doctors in the NHS should perhaps seize on the notion of equity and achieve the following objectives:

- To allow anyone with suitable experience and qualifications to become a Member of the FPHM
- To give everyone within existing public health departments access to the same level of resources currently available only to those with medical backgrounds.
- A defined career structure for the development of those in public health departments who do not have a medical degree.
- Award others with similar levels of skill and experience within their departments the same financial rewards.

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Medication for older people

Editor – We read with interest the summary of the College report *Medication for older people* (May/June 1997, pages 254–7). We agree completely with the emphasis of the report on evidence of polypharmacy and iatrogenic disease in the elderly but feel there is another aspect of medication for older people that is worth highlighting, namely missed medication. Poor compliance at home may account for treatable morbidity and has been addressed

in the report. However, medication is also missed in hospitals, where ideally 100% of prescribed medication should be administered successfully. A clinical audit showed that 10% of regularly prescribed medication doses in all specialties were missed in a busy general hospital[1].

We audited drug charts of 122 elderly patients admitted to our acute wards. Of 8,904 doses of medication prescribed, 678 (7.6%) were omitted. The type of drug missed – bronchodilators (11.3%), antibiotics (8.5%), diuretics (6.1%) and analgesics (9.5%) – could significantly affect a patient's health. Although the reason for missed dose was not recorded in 45% cases, 87% of missed doses were outside normal pharmacy opening hours, suggesting these drugs may not be in the hospital formulary. We are currently looking at ways to minimise missed medication by using patients' own medications on admission to hospital, educating staff to consider alternative routes of administering drugs, and moving towards a district-wide formulary.

It is important to rationalise and minimise medication in the elderly but once this is done, it is equally important to ensure that essential medications are taken.

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Elderly vs older

Editor – I was disappointed to read that the RCP report is entitled *Medication for older people.* An adjective has a basic version: big, small, fat, old. It then has a comparative version and a superlative. In big, small, fat the person who is bigger, smaller or fatter is more so than the big, small, fat person.

I am elderly now, but back when I was about 50, many a young Canadian would have described me as an 'older man' but would not have dreamt of calling me an 'old man'. 'Older' is not as old as 'old'! Thus *Medication for older people* could well be for adolescents, who are older than pre-pubescent children.

I am sorry to discover that RCP – at 450 an older College than RCP&SC but younger than Clare College (1232) or Bethlehem Royal Hospital (1247) – clearly needs a language police force.

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(An older man than Professor Alberti, but younger than Arnold Palmer or Jack Kramer).

In response

I accept Dr McCormick's general thesis that use of language should be maintained at an appropriate level. However, language is not a static phenomenon, it evolves to meet the needs of its users and we all draw the line at a different point. Thus whilst I abhor the verb to ambulate, I use the verb to bin. Similarly, whilst I did not coin the term 'older people' nor was I responsible for its recent use in association with the Royal College of Physicians' report, it is nevertheless in general usage.

I suspect many Victorian writers would similarly take offence at some of the language that Dr McCormick feels would pass the 'language police' test. In summary, like it or not, language responds to its users' needs and what Dr McCormick describes is this dynamic process.

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Editorial note

Page vi of *Medication for Older People* states 'The term 'older people' is broadly used to indicate people aged 65 and over'. The next sentence defines the elderly as '...women aged 60 and over, and men aged 65 and over...' so 'older' is older than 'elderly'. The authors of the report included consultants/professors of geriatric medicine, clinical geratology and psychiatry for elderly people, but no doctors for older people. Professor Jackson is right: language is made by people and is constantly changing but fashions and political correctness come and go and I would be happier if those caring for my age group could agree on a label. However, when quoting from other publications, we use their terminology.

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Specialist paediatric health services

Editor – I read Dr TL Chambers' personal statement with interest (July/August 1997, pages 389–91). It reflects a discussion which has been taking place for many years on the need to maintain strong links between paediatrics and the medicine of adulthood while strengthening clinical and academic paediatrics. The issues raised are central to the future health and provision of high quality and accessible medical services for children. The Bristol example with adult specialist services and a number of paediatric specialist services on different sites highlights a problem that is common to many urban areas in the UK and which requires action. Breaking up paediatric services and placing them on multiple sites is a recipe for disaster as far as paediatric services are concerned. Academic and clinical leadership in paediatrics and child health, certainly in the specialist tertiary