theory endorsed the rationalisation of resource allocation, they have imposed a system in which every hospital believes that, to survive, it must continue to provide the fullest range of services regardless of their suitability. Let us hope that common sense will eventually prevail.

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1 Bayley TJ. Unified training grade. *BMJ* 1995;310:1020-1. (22 April.)

Vocational training for GPs should be community based

EDITOR,—Trevor J Bayley's editorial on the unified training grade leaves the impression that, after nearly three years of lengthy debate, countless meetings, and working parties, we are still no nearer a solution than we were in 1992.[1] Although undoubtedly an expansion in the number of consultants is a prerequisite for the successful implementation of the grade, I believe that the main obstacle is our traditional habit of trying to introduce change without upsetting the status quo. For instance, the assumption that all those with a certificate of completion of specialist training will seek employment only in NHS hospitals or will want full time employment is open to debate. Furthermore, many of the expected difficulties would be overcome if we were to grasp the nettle of knowing staffing requirements in each specialty. The widely held view that this is impossible needs to be challenged.

The question of doctors who qualified overseas and want specialist training in Britain, though important, in reality is a red herring. It should be possible to create appropriate educational opportunities for such doctors without necessarily interfering with the implementation of the new grade. I also suspect that in many hard pressed specialties such doctors would be very welcome.

Bayley's comment about securing specific hospital posts for those in vocational training in general practice is important. Indeed, since the publication of the Calman report serious concerns have been expressed about the possible impact of the scheme on vocational training. A consensus is now emerging, however, that vocational training might become more community based, with a greater flexibility of educational opportunities than previously envisaged.[2]

It is now time to implement the scheme and modify it in the light of experience. After all, the European medical directive was agreed in 1975.

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1 Bayley TJ. Unified training grade. *BMJ* 1995;310:1020-1. (22 April.)
2 Royal College of General Practitioners. *Education and training for general practice.* London: RCGP, 1994.

Deprivation payments to general practitioners

EDITOR,—The Department of Health has recently announced that in the 1995-6 financial year deprivation payments to general practitioners will be made using 1991 census data instead of 1981 census data.[1] To determine what impact this change will have on local practices, I used data from Merton, Sutton and Wandsworth Family Health Services Authority's age-sex register and census data to calculate both current (based on 1981 census data) and revised (based on 1991 census data) deprivation payments to the 131 practices within the authority. Eighty nine per cent (601 330/672 872) of the people registered with these 131 practices lived in Merton, Sutton, and Wandsworth; no data were available on the 11% of patients registered with these practices who lived outside the authority.

Differences in deprivation payments based on 1991 census data and current deprivation payments based on 1981 census data for general practices in Merton, Sutton, and Wandsworth Family Health Services Authority (only patients living in the authority included in calculations)

Difference (£)	No of practices	Difference (£)	No of practices
≤ −32 500	1	To 2500	94
To −27 500	1	To 7500	13
To −22 500	0	To 12 500	2
To −17 500	1	To 17 500	4
To −12 500	3	To 22 500	1
To −7500	1	>22 500	1
To −2500	9		

In 1994-5, the 131 practices received a total of £411 874 in deprivation payments for patients living in Merton, Sutton, and Wandsworth. If Jarman scores derived from the 1991 census had been used to allocate payments, they would have received £402 410 in deprivation payments, £9464 (2·3%) less than now. Ninety four (72%) practices would have received from between £2500 more to £2500 less than now in deprivation payments (table). However, differences for some practices were large; one practice would have received £22 961 more and another practice £33 051 less in deprivation payments if these payments had been made on the basis of 1991 census data.

This study has shown that, for many practices, changes between the 1981 and 1991 censuses will not alter greatly the amount they receive in deprivation payments, but for some practices the differences will be large. In part, the larger differences occur because of the "all or nothing" method of allocating payments; a small change in the Jarman score for an electoral ward between the two censuses—for example, a change in the score from 29 to 31—leads to large changes in the deprivation payments allocated to practices with patients in that ward. To prevent such anomalies, the Department of Health should consider altering the method of allocating deprivation payments. For example, the current system could be replaced by a more graduated system of payments.[2] There is also evidence that patients are more representative of their enumeration district than their electoral ward,[3] and a system of deprivation payments based on enumeration districts may therefore be fairer than one based on electoral wards.

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Hospital doctors' work

EDITOR,—Peter Jackson emphasises that doctors should be well supported by managers, who must share responsibility for patient care and medical training.[1] Results of a survey which we conducted on British trained preregistration house officers in West Midlands in 1993 lend further weight to Jackson's comments. Of 196 respondents (an 84% response rate) only 36% of preregistration house officers reported that they felt supported by managers.

Before a universal move to shift systems can be recommended, we must look at the consequences of these work patterns. Our work, based on small numbers, suggests that a partial shift system may be worse for preregistration house officers' physical health (as shown by stress) than is a full shift system, but a partial shift system may lead to better job satisfaction among senior house officers than a rota system.

The Doctors Tale also reported that doctors are unclear of what is expected of them, that they perform tasks which could be undertaken by other staff, and that junior doctors frequently work unsupervised.[2] Again our results support this: 94% stated that their skills were underutilised, and many commented on the number of "menial tasks" required of them. Additionally, feedback from consultants was for the most part minimal; 28% reported no feedback, indicating a poor level of supervision.

Suggestions about improving postgraduate training are welcome, but our work shows the need to ensure that undergraduate training is also adequate. Nearly three quarters of respondents felt ill prepared for their role as a preregistration house officer, with lack of training in practical procedures being the major bone of contention. This dissatisfaction with training in practical procedures persisted through to senior house officer level. Similar numbers felt ill prepared for working within the NHS; most wanted training in self management techniques such as time management.

Finally, *The Doctors Tale* makes reference to the need for part time training. Our work suggests that only 40% of preregistration house officers are aware of the possibility of part time training and that it is mostly women who would take advantage of the scheme. Undoubtedly this type of training must be better advertised.

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1 Jackson P. Hospital doctors' work. *BMJ* 1995;310:952-3. (15 April.)
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BMJ on the internet

Will be useful for isolated general practitioners

EDITOR,—The release of the *BMJ* on the internet is a landmark development.[1] It is a particularly heartening example of the idealism of wanting to share knowledge being more powerful than the need to maximise the commercial return.

As an educator who helps general practitioners, I am only too aware of the professional isolation that so easily engulfs my general practitioner colleagues, and as an Australian I am aware of the geographical isolation that presents such a challenge for many of our rural general practitioners. Access to the most relevant current medical information through the internet is an important weapon in fighting this isolation. Already doctors in isolated areas are beginning to acquire access to the internet as a means of communicating with each other, and the *BMJ*'s page will be a powerful additional motivation for more doctors to do so.

I encourage the *BMJ* to continue experimenting with the best use of this new medium. I am particularly impressed with the use of hypertext in the article on medical informatics. Although I am sure that the computer screen will never replace the written page (I for one will continue to read the hard copy of the *BMJ*), the internet can offer something unique. Immediate and direct communication with the authors of articles and an easy