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