garment has been manufactured" should help these women, many with minor leg vein disorders, make their choice; it should also help their doctors when they have to prescribe hosiery to correct more serious venous dysfunction.

PETER FENTEM

Department of Physiology and Pharmacology,
Queen's Medical Centre,
Nottingham NG7 2UH

SIR,—Messrs Burnand and Laver ask, "What is the optimum ratio of graduated compression for venous disease?" We have recently completed a prospective trial of 80 patients presenting with chronic venous ulcers which had been present for a mean of 2.4 years. All ulcers had previously been treated using standard Elastoplast or Elastocrepe bandages.

We applied a high pressure, below knee, graduated compression bandage to all patients. The bandage consisted of four layers with an inner layer of Velband (Johnson and Johnson) to distribute the high pressure evenly and comfortably. This was kept in place by a crepe bandage, and an Elset bandage (Seaton Products Ltd) was then applied with two thirds overlap at the ankle and one half overlap at the calf. Finally, to prevent movement of the bandage and maintain compression over one week, a layer of cohesive elastic Coban was applied (3M Health Care Ltd).

The pressure under this bandage was measured in 16 people at four points between the medial malleolus and the knee using a medical stocking tester (Saltzman Ltd, Switzerland). The mean pressure (SD) at the medial malleolus was 41.8 (1.4) mm Hg, reducing to 38.6 (2.1) mm Hg at the gaiter area, 34.8 (1.6) mm Hg at the calf, and 16.9 (1.8) mm Hg just below the knee. The pressure under the bandage rose by a mean of 5 mm Hg during the day, presumably due to foot swelling, and returned to the starting pressure overnight.

It has been suggested that, theoretically, a pressure of 35–40 mm Hg is needed to prevent capillary transudation in legs with venous disease,¹ and when we used this degree of continuous graduated compression on an outpatient basis 77% of these longstanding venous ulcers healed within 12 weeks. We would agree with your leading article that there has been inadequate study to determine the optimal pressure, but our results so far suggest that graduated compression with 40 mm Hg pressure at the ankle is the minimum required to gain rapid healing.

S D BLAIR
C M BACKHOUSE
C N MCCOLLUM

Department of Surgery,
Charing Cross Hospital,
London W6 8RF

1 Stemmer R. Ambulatory elasto-compressive treatment of the lower extremities particularly with elastic stockings. *Der Kassenarzt* 1969;9:1–8.

Manpower

SIR,—As a young married woman looking for a reasonable job that would allow me to look after a young family but still have reasonable career prospects I would not touch the new non-training support grade with a bargepole. I am greatly surprised that the proposals for revising the hospital career structure have been accepted with such great enthusiasm by bodies that are meant to protect the interests of both junior and senior hospital staff. Though in future there may be some rationalisation of the career path of those who succeed as hospital consultants, these proposals do little in the short term to help those who are already

in great danger of falling by the wayside and in the long term to prevent the same problems arising but at a lower level.

The 50 new consultant posts in surgery and 50 in medicine will place only a very small proportion of those who are already doomed to become time expired senior registrars or who will have to convert at the last moment to a specialty in which they have no particular interest. The problem of senior registrars who find themselves surplus to requirements has been caused largely by the inflexibility of the present training system. Those who have recently worked their way up through the hospital grades have discovered that by the time they find that they are not going to be top flight consultants at a teaching hospital it is too late to change careers and they have become earmarked as failed gastroenterologists, failed surgeons, and certainly failed hospital doctors in the present competitive climate for GP rotational trainee schemes.

The new career proposals have done nothing to improve the fluidity of movement between careers in medicine; they have merely pushed the problem further down the scale. Careers counselling of senior house officers will make no difference. It will already be too late to advise doctors to change their careers, as after an extended period of SHO training plus a period of research they have been labelled as hospital doctors (failed or otherwise) and will find themselves unable to take advantage of any careers counselling that may be given. I suspect that any consideration of the lengthening of incremental pay scales for SHOs will come secondary to the new availability of a source of cheap labour for the NHS. Under the current system streaming into hospital doctor or GP trainee takes place at entry into SHO jobs, but it is only after this period that doctors realise their true capabilities in the light of the competition that exists (and will continue to exist) for hospital consultant posts. The SHO period of training should be kept to two years, but jobs should not be designated as being for either GP trainees or prospective hospital doctors and there should be fluidity throughout the SHO training period, so that doctors can change their options.

Though the package as a whole has certain good points—for example, the optional early retirement of consultants and the apparent restriction of registrar posts—I believe it does little to solve either the short term or the long term problems of medical staffing and feel a sense of betrayal that my representatives should have agreed to it so wholeheartedly.

J E BRIGGS

General Hospital,
Hereford HR1 2PA

SIR,—I was pained to read Dr Kurri Reddi's letter (2 August, p 334). The sentence which offended me was: "The new intermediate level service grade will be welcomed by junior doctors, especially overseas doctors who have the right to stay in Britain and may wish to seek a career here." This view is not shared by others.

I agree that a number of junior doctors from overseas will, after years of frustration, eventually yield to the soft option. However, there are others, well trained, highly motivated, ambitious, and dedicated to their specialties, to whom such an offer would be an intellectual insult. They are in Britain primarily for the professional opportunities and challenges offered—the ability to pursue clinical practice of a high order and, equally important, the ability to influence such practice by their individual research interests.

That they have the right to stay here is already acknowledged by the working group. These

doctors would like to believe that they can do so with dignity and self respect.

G DAS

London Lithotripter Centre,
London W1M 7PG

SIR,—We write to express our serious concern at the proposed new hospital medical manpower structure, recently hastily endorsed by the DHSS, the Joint Consultants Committee, the Central Committee for Hospital Medical Staff, and the Hospital Junior Staff Committee. Unfortunately the proposals seem merely to institutionalise the problems inherent in the present unsatisfactory career structure.

Currently many doctors are caught in a career bottleneck at senior house officer level; the solution proposed is to extend officially the length of time spent in this grade. Owing to the shortage of consultant vacancies many doctors become caught in unsatisfactory career traps; the proposed manpower structure invents a new name for these career traps, dignifying them as a grade. Many registrar posts are presently occupied by doctors with no hope of career advancement; in future it is proposed that most registrar posts will be based at district level with no possibility of career advancement. Most of these posts are held by black doctors, but some white doctors also find their way into them; in this area at least there is a positive proposal—in future only black doctors will be eligible to be exploited in this way. Currently there is a serious imbalance between teaching hospitals and district general hospitals; the proposed new career structure seeks to embody this disparity in contractual form.

If the solutions proposed as the "new career structure" are adopted, the frustrations, injustices, and wastes of the present system will become deliberately instituted, instead of accidental. What is most appalling is that such an absurd set of proposals should be approved with so little discussion by the profession at large. Previous indications were that most junior doctors did not want a subconsultant grade; why is it assumed they have suddenly changed minds?

We understand that some BMA divisions will be demanding a special representative meeting, and hope that the requisite number of such requests are obtained.

S J WATKINS
and 6 consultants,
8 registrars, 21 SHOs,
and 4 house officers

Oldham and District General Hospital,
Oldham, Lancs

SIR,—The report of the working group on hospital medical staffing (12 July, p 147) made welcome reading for us as newly appointed consultant general physicians at a peripheral hospital where there has been a rapid increase in service commitment over the past three years—without any concomitant increase in junior medical staff.

Our medical registrars work a 1 in 2, 24 hour emergency rota, and recently we have had increasing difficulty in obtaining locum cover for holidays and sick leave. Thus 1 in 1 rotas are not uncommonly worked. Even when national agency locums are available their clinical competence is unpredictable and very variable.

We believe our registrar staffing problem is also exacerbated by the fact that in our region general medical registrars and senior registrars in the teaching hospitals do not generally rotate through our district hospitals as part of their general medical training.

We hope that peripheral hospitals such as ours will benefit on both these counts from the pro-