define the content of primary care. Had we done so Dr John Ball's "new GP charter" might have been more acceptable.

Recently some of us have written a document detailing the content of primary paediatric care for teaching practices, which has been privately circulated and received wide acclaim. Is there any reason why a similar document should not be produced for primary care as a whole?

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The general practitioners' work load

SIR,—I write in support of Dr Michael Hall's comments regarding the Review Body's assessment of work load in general practice (7 July, p 53).

Education for general practice now emphasises the need to identify behavioural factors in patients' feelings of illness. The identification of such factors requires time in the consultation and therefore longer consultations, and its management requires sympathetic counselling, which also requires time. Although the average consultation time is often stated to be 6½ minutes it may well be that we would do better for our patients if the average length of consultation became 13 minutes. This would entail doubling of the work load without any increase in prescribing (possibly even a greater decrease), and without any increase in the number of patients seen.

The Review Body requires better measures of work load than are available to it at present. These can only be supplied by the profession, and the BMA should consider seriously the establishment of an organisation to obtain such information on a continuing basis, though the primary need is to define suitable measures.

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Review Body's award and consultant contract

SIR,—The chairman of the CCHMS Negotiating Subcommittee is quite correct in suggesting that his letter (14 July, p 135) will not in any way affect the Hospital Consultants and Specialists Association's opinion of the manner in which negotiations on both the old and the new contract were conducted or of the results achieved. It is a sad fact that the "understandings" reached between the DHSS and the negotiators led to 8% being withheld from basic salaries to pay for the long promised emergency recall fees. It is certainly no victory to have the 8% restored, quite rightly, to all consultants—it merely corrects the error.

The cost of this error, however, has been the abandonment of emergency recall fees and the HCSEA believes that the CCHMS had no mandate so to instruct the negotiators. Why should more than half the consultants be deprived of emergency recall fees? The letter from eight consultants in Barnstable, published on the same page of the *BMJ*, confirms the feelings of many. The present suggested level of fee is derisory.

If it is not too late, there is another solution to this problem. Since the CCHMS has decided to set aside the new contract, the

HCSEA considers that the extra money set aside for its implementation (£17 million) should be used to meet the additional cost of funding emergency recall fees. In this way some would gain and no one would lose.

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* * The Secretary writes: "The £17m referred to by Dr Shrank was the estimated additional sum necessary to operate the new contract in a full year. As it was assumed by Government that the contract would not be operative before 1 January 1980 a quarter of this sum (£4m) would only be available this year. It was made clear, however, by the Secretary of State that the money was available *only* for the implementation of the new contract and, when the pricing of the new contract was rejected, the offer of this sum of money was withdrawn."—*Ed, BMJ*.

Domesticated doctors

SIR,—Further to my letter "Domesticated doctors" (16 June, p 1632), I should like to comment, firstly, on the Secretary's footnote to the letter and, secondly, on the reply which appeared (7 July, p 53).

The Secretary compared the BMA registration fee for the scientific meeting with the Medical Women's Federation refresher course fee. I should like to make it clear that many of the women doctors, including myself, who attended the course did not pay for it out of their own pocket.

I was interested in the published reply to my letter from a woman doctor who has obviously opted for a more career-orientated life style. The problem, as I see it, of married women doctors with young children boils down to this.

We are a very mixed bag of individuals each trying to do what she sees is best for her family and herself. However, the DHSS at present caters for only two types of doctor: Type I—those who are happy to be half mum and half medic. For these there are part-time training schemes which require a minimum of 20 hours work a week—that is, half a day every day. Type II—those who would rather be at home most of the time to look after their children while they are young. For these we have the Women Doctors' Retainer Scheme, which encourages the doctor to "keep in touch" while giving financial assistance towards membership of a medical defence organisation and subscription to a medical journal, etc. To "keep in touch" means to do approximately one paid session per week or fortnight and to go to a certain number of postgraduate educational sessions a year.

Unfortunately the majority of women doctors with young children fall between those two categories and are faced with the dilemma of choosing between giving up too much of their maternal role, and leaving their children for too much of those important early years, and giving up too much of their career—not just for the time they are at home but also their prospects for the future. On the whole they opt for the latter alternative for the sake of their families. Far from being "handed their career on a plate," domesticated doctors are not even given access to the basic ingredients for making one up for themselves. The machinery to cater for this "deprived group"—this type III—just does not exist.

The reasons for the second alternative being so unsatisfactory are these. Firstly, the work available on the above scale is limited in the most part to

sessions in the unpopular, dead-end fields neglected by the rest of the profession. Fair enough—one cannot expect a marvellous, satisfying job in this competitive world if one is prepared to give only three hours of one's time a week. Secondly, educational sessions available which are likely to be attended by domesticated doctors are evening ones of a sort to be of general interest to a broad spectrum of practising doctors. Very enlightening these are, to be sure, but I strongly suspect that far more knowledge is leaking down the drain than is dripping in from the tap. Together with a recognised medical journal, these are the sum total of our postgraduate education. Somewhat haphazard, I think you will agree. Hence the need for an organised training programme for type III doctors, to concentrate and direct our thoughts and provide a definite framework for continued growth towards an end point which is our eventual emergence from the washing-up bowl to a more active contribution in medicine in, say, five or six years' time.

It is difficult to get across to people the extent to which one's medical knowledge, but more especially one's confidence, is drained during these fallow years when one is needed as the focal point of security in the home. Erstwhile first-rate housewives become convinced that they will never be any good for anything but nappy changing and family planning clinics. In my view, this should never be allowed to happen.

Many of us have never had the chance to find our niche in medicine and what we desperately need to keep us going is some form of continuous refreshing and updating in all fields, with the prospect of further training in such areas which we then find to be of particular interest. I envisage an introductory course on a once-weekly basis covering as many areas as possible and spanning, say, a couple of years. Following this one could perhaps go more deeply into one's chosen field or fields in a more single-specialty-orientated training scheme. Here one might have the opportunity to actively participate in patient care and possibly take a qualification. The whole thing would have to be spread over several years, but if the programme were nationally recognised and adopted it should be possible for a woman doctor to take up where she left off in the event of a move to a different area of the country.

Is this all too much to ask?

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Information about wanted persons and medical ethics

SIR,—The Central Ethical Committee has been approached by a number of doctors who are worried about police requests for assistance. In an apparently new departure, the police appear to be attempting to use the NHS as an additional arm in the tracing of wanted persons. Doctors are being asked to gather information about their patients and to pass on this information in the absence of either their patients' consent or a court order.

While in no way wishing to undermine the efficiency of the police, we are nevertheless extremely concerned about the ethics involved should doctors be persuaded to co-operate in this way. It would be of great help to the Central Ethical Committee if anybody who has been faced with similar problems would contact the committee's secretariat at BMA House.

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