If Drs Lumley and Bell had read our paper carefully they would have seen that we were careful to state that consecutive women in "each gestational group" were interviewed. Prior to the study we defined how many women in each group were needed to make statistical comparison possible. Once this target was reached that group was "closed." An implication of a 37% prematurity rate was not meant.

I must emphasise again that it was those women going to term who had the better recall for subjective rather than objective life events. This is indeed opposite to what one might predict. The most common major life events recalled by the women in the preterm groups were "income decreased substantially—25%," "immediate family member seriously ill," and "prolonged ill health in a close relative." It may be that these particular life events and the others more commonly observed have a predictive quality and a prospective study is required to confirm or refute this.

I agree with Drs Lumley and Bell that the provision of financial and emotional support is difficult but with the widespread breakdown of the extended family it is necessary that someone tries.

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Medical reports not to the lawyers' liking

SIR,—Understanding relationships between lawyers and doctors are essential to the health of society, especially where parents and children are concerned. If Judge Curtis-Raleigh had given any other judgment than that reported (24 November, p 1376) the doctor in the courts, obliging the lawyer by omitting important sentences, would have moved one further step away from his position as an expert assisting the court to the best of his ability. My own practice when asked to prepare a report is to make it plain to the solicitor, particularly in a case involving custody or access, that what I have to say after studying all the data may not be to his liking. If he finds this acceptable we proceed. Although my fees are paid through him I am not his bought man.

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The care of children in hospital

SIR,—I have read with interest the letter from Dr John Wilson (10 November, p 1227) regarding the training of paediatric nurses.

Dr Wilson correctly states that there is no pecuniary reward for those who undertake training for the Registered Sick Children's Nurse qualification. Nor is there a career structure in paediatrics beyond the level of senior nursing officer. It is therefore unfortunate but inevitable that many children's nurses will be lost to this particular field in order to advance their careers. With regard to nurse training, however, I would question the authority on which Dr Wilson makes his comments. I am certain that he would not welcome similar comments from a nurse about medical training. Furthermore, he is not trained as a nurse tutor. But since he has expressed his opinions they deserve a reply.

It is true that there is a strong body of opinion that the three-year training for the children's register should be reintroduced. This would possibly be one solution to the shortage of paediatric nurses, but I would venture to state that this is a rather narrow view to adopt. The care of sick children and their families is emotionally demanding, far more so than that of adults. It is necessary therefore that the nurses engaged in such work should themselves be sufficiently mature to meet these demands. The average student of 18 years has not gained emotional maturity, but during the course of a three-year general training she will acquire this. In the paediatric setting, however, she frequently fails to mature as quickly as others of her own age; and I can assure Dr Wilson from personal experience that the students in his own hospital cannot be compared with their peers in general training schools.

The advocacy of a general basic training, to be followed by one in a specialised field, is not merely to ensure bureaucratic tidiness: it is an attempt to produce nurses who have gained wider experience and are able therefore to give a better standard of care to their patients.

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A do-it-yourself medical centre

SIR,—When doctors who run privately owned surgery premises cannot see their problem how will we ever persuade the DHSS to improve the system?

Drs A N Ganner and A C K Lockie (17 November, p 1269) describe their building a health centre under the cost-rent scheme as "financially rewarding." And I would agree that those using the cost-rent scheme usually do not make a loss, though they themselves admit that "partners 3 and 4 have a short-term cash flow problem" and that "it will probably cost partners 4 and 5 about £600-£700 a year during the first three years" after tax relief—that would be over a £1000 a year before tax relief. But they do not mention the problems in store for their new partner when partner 1 retires, even though the figures are available in their article.

Suppose they suddenly need to replace partner 1. On the assumption that their centre has risen in value to £85 000 (and £17 000 per doctor is a common practice share now), even at 16% the General Practice Finance Corporation interest payable by a new partner would be £2720. But the cost rent payable to the new partner will still be £1860 and the alternative notional rent would certainly not be more. The new partner has a shortfall of £860, plus the same £1000 which partners 4 and 5 already have, so will be going into practice with a deduction from his income of almost £2000 a year—more if interest rates have risen—just when he will be facing mortgage and car purchase problems.

Younger doctors will not willingly opt for privately owned premises in face of this level of commitment. Yet it is important for the independence of the profession that many doctors are in their own buildings and that the premises are satisfactory. I know doctors in several practices who will not improve premises under the cost-rent scheme because they appreciate better than Drs Ganner and Lockie the financial problems they will be storing up for future new partners.

The GMSC is about to negotiate for reimbursement to be based on a percentage of capital value instead of current market rent. It is essential that this negotiation is successful, even if only for those newly entering practice or changing practices within the first few years. Doctors who live in Cloud-cuckoo-land should be wary of talking about "nest eggs." It would be sad if complacent reports such as this one were to make it harder for the GMSC accurately to describe the plight of young GPs when negotiating with the DHSS.

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Medically qualified preclinical academics

SIR,—Once again preclinical teachers are being urged to do clinical sessions to show they are "proper doctors" (Dr E N Glick (24 November, p 1370)). I never cease to be amazed at the attitude of those of our clinical colleagues who assume that the only proper doctors are clinicians, conveniently forgetting that most of the major advances in medicine have been due to laboratory research workers, including many non-medically qualified staff.

As a medically qualified anatomist I can assure Dr Glick that my time is already fully occupied in teaching and research. With the heavy teaching load in most preclinical departments few members of staff can afford to give up any of the already limited time available for research, and to do so would in the long term be detrimental to the academic standards of preclinical departments.

While there may be a plethora of clinical sessions available in London this is not the case in other regions. For example, I have found that my clinical colleagues in Dundee are opposed to sessional work for preclinical teachers on the grounds that there is already a shortage of such posts for married women on the retainer scheme. One possible solution might be for preclinical teachers to do two subconsultant sessions a week while our teaching is taken care of by our consultant colleagues doing two anatomy demonstrator sessions a week, although I fear that this would lead to inadequately treated patients and inadequately taught students.

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Revised consultant contract

SIR,—May I, as a whole-time consultant, comment on Professor Douglas Roy's letter (24 November, p 1371). He states that—"They [our negotiators] seem to have failed to realise that the full-time salary is the touchstone whereby all other salaries will be judged."

Our negotiators have displayed many shortcomings but failure to recognise the depressing effect of a persistently unsatisfactory level of wholtime remuneration on all other salary grades is not one of them; the spin-off has, in fact, been in the reverse direction to that envisaged by Professor Roy. For the whole-time consultant, the decision to support the latest contract amendments cannot be based on the prospect of substantial private practice, although the freedom from total bondage is welcome. The decision must be based, rather, on the improved negotiating stance which derives from this freedom.