point blank, thereby triggering off the Section 70 inquiry, speaks for itself.

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Clinical medical officers

SIR,—Your correspondence columns (9 December, p 1648) carried inspiring encouragement for clinical medical officers (CMOs); but in view of the nebulous nature of planning by imperfect prediction a scheme worthy of at least interim consideration would be the attachment of suitably trained CMOs to appropriately structured group practices, as tentatively suggested in the DHSS post-Court circular.¹

It is difficult to understand the lukewarm reception given to this suggestion, because by taking clinical responsibility for developmental and educational medicine in a given number of schools attached to a general practice the CMO would bring to his GP colleagues a better awareness of the medical aspects of children's educational difficulties, while simultaneously learning to understand the problems besetting family doctors. A scheme of this kind would certainly be the quickest way of implementing the spirit of the Court Report,² the benefits in terms of family-orientated paediatric care being considerable.

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¹ DHSS Health Circular HC(78)5, January 1978, p 2.
² Committee on Child Health Services, *Fir for the Future*. London, HMSO, 1976. (Court Report.)

Staffing of accident and emergency departments

SIR,—Your resumé of Mr Walpole Lewin's inquiry into the medical staffing of accident and emergency services (18 November, p 1447) did set some puzzles—hence Dr Richard Hardy's letter (23-30 December, p 1791). I am convinced that Mr Walpole Lewin does not need a champion to defend his personal recommendations on the subject, though there will be some who do not agree with him.

His report prepared at the request of JCC is a very well-thought-out document, which I am sure took a very long time to prepare and involved quite a lot of work, although I preferred to read the summary in the *BMJ* to his original document, in which there are all the answers to Dr Hardy's puzzles.

"A grade of registrar on the establishment is not recommended at present, but secondment within the training programme of other specialties should be encouraged." By that I understand that Mr Lewin, as Vice-president of the Royal College of Surgeons, is making a personal recommendation for a rotating surgical registrar to work during part of his training in an accident and emergency department. This proposal would be even more welcome if the Royal College of Physicians were of the same mind. Dr Hardy is correct in saying that many A/E consultants are always on call, but it is up to them to arrange a rota with other consultants to cover the A/E department.

The general practitioners should make a

contribution to accident and emergency work, as quite a number of them are interested in this field and some could teach Dr Hardy and myself a lot. Naturally they should be remunerated accordingly.

The treatment, the follow-up, and research are missing, so your correspondent said. But are they? "... and arrange for further care if necessary"—it definitely means a follow-up; "provide emergency resuscitation"—naturally this means providing treatment; "provide teaching"—is not research a part of teaching?

I am surprised that accident and emergency consultants did not flood the *BMJ* with their letters, but if they do I hope they will read at least the summary of Mr Lewin's report carefully.

I am only sorry that the word "accident" was not cut out from the name "Accident and Emergency Department," as it is often confused by many with accident units run by the orthopaedic department. Alas, the "dead hand of the orthopaedic Galen" still hangs over our heads. It would be so simple to call ourselves emergency departments only.

There is a lot of material to discuss in Mr Lewin's report, but I do welcome it as it is the first positive step towards trying to put our house in order.

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Peripheral hospitals and the new career structure

SIR,—I saw with concern the advertisement for a "five-year appointment designed to provide a basic training for persons wishing to specialise in Obstetrics and Gynaecology" at Guy's and regional hospitals (16 December, p xxxii).

Obviously the vexacious problem of equating career posts with service posts, which has exercised the profession for many years, appears to have been solved, at least at that teaching hospital, and for the chosen few it has done away with competition. Presumably those of us in peripheral hospitals not directly linked to teaching hospitals will be left to accept any "rejects" who previously thought that they might get back to a teaching hospital registrar post having had some training and experience in the rough outside world. Some of these doctors actually made it on the old system and returned to their teaching hospital, often with a postgraduate qualification.

This new career structure will now ensure two types of hospitals: the self-styled "centres of excellence" with their own graduates safely ensconced for five years, and those other hospitals where a majority of the staff from overseas keep the service viable. Luckily with cuts in acute services there will be fewer posts at registrar level in acute disciplines and with the third-world doctors staying at home or returning home we should be able to keep the career structure as we would wish it for our own graduates. Presumably to enable a few peripheral hospitals to remain we will rely on conscription, now euphemistically known as the vocational training scheme. Incidentally, I had always thought that posts at all levels had to be advertised and competed for, but I suppose that this system saves money and in the name of career prospects the rules can be bent a little. I have every sympathy with the juniors—I have even been one myself; but this superficial solution of a problem will help

nobody. We live in an increasingly bureaucratic system where competition, which admittedly had faults, is being stifled; but to replace it with patronage will not help.

To many of us trying to run dangerously understaffed units this attitude will add to the resentment building up against these teaching hospitals which, already having made a mockery of redistribution, have now shown themselves incapable of comprehending the problems of the service requirements of peripheral hospitals. No doubt I shall be accused of peripheral paranoia, and then told that this is a "one-off" experiment approved of by the juniors in principle, etc; but I very much doubt this. Certainly there will be an evaporation of what little sympathy there was remaining for our colleagues suffering from RAWP, from whom there has been such a flood of crocodile tears.

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Part-time contracts for women doctors

SIR,—I hope that Dr Eva Lester's challenge to the DHSS to take steps which will lead to the publication of guidance on employment of women doctors at consultant level (23-30 December, p 1805) will not be ignored. Solutions are not going to be easy to achieve, but here are some clues.

The unpopularity of part-time contracts among those concerned about the expansion of private practice could surely be overcome by some contractual limitation imposed on those accepting part-time employment by virtue of their domestic commitments. Area health authorities could be positively encouraged to submit schemes for part-time posts in certain shortage specialties. AHAs could also be encouraged to advertise full-time posts as suitable for two married women, but they are unlikely to do this until the DHSS works out ways of dealing with situations which might arise when one woman leaves or wishes to increase her work. Any new consultant contract needs to be carefully examined for its suitability to the needs of doctors with children.

Women doctors should provide models to the community of ways in which family lives can be combined with rewarding and contributing careers. They should not continue to be required to make tension-producing arrangements both at home and at work which benefit neither their families nor their patients. Nor should their concern for their families debar them from work in hospitals because of inflexible attitudes on the part of professional organisations or DHSS inactivity.

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Taxation of car and telephone expenses

SIR,—A recent DHSS circular, HC(78)39, gives instructions to health authorities about taxation of these allowances. *Regular users* travelling under 3000 miles per year will have fixed amounts under these instructions which will be subject to tax. Over 3000 miles there will, however, be no tax liability. The circular also states that employees paid allowances at the *standard and public transport rates* will not have to pay the tax on these, as these are not