Until their morale is restored to a high level there is little prospect of a halt in the steady decline of the service, let alone any possibility of reversal of the trend.

In theory the solution to the problem is simple—namely, the negotiation of a new consultant contract as a matter of urgency to resuscitate the consultant grading. In practice this has proved well-nigh impossible so far because it is at this point that the well-known Achilles heel of the consultants is revealed—our repeatedly demonstrated inability to agree and act in unison for the common good. In saying this we have very much in mind the quality and extent of service to be made available to the public. Unfortunately, our individual consciences and our ethical responsibilities tend to blind us to the ultimate aim to be achieved and preclude us from adopting any course of action which might affect our patients adversely, even if only temporarily.

We are well aware that there is a great deal more to it than the mere financial side of the question. There is, for instance, the eroded status of today's consultants, who are now little more than a relatively small section of "hospital workers" and with considerably less "muscle" than most for the reasons already detailed. The natural reaction has been for them to withdraw more and more into the clinical sphere and to withhold the constructive contributions to the better management of the service that they made in the past, but this is another matter. If we aim to make any real progress it is better to deal with one thing at a time. The consultants' contract must come first; if anyone is in doubt about this we would refer him to Mr P J E Wilson's letter and his two tables (30 April, p 1161).

We were pleased to read in the last *BMA News Review* that discussions on the new contract are proceeding *vigorously*. At the rate at which results are being achieved we are truly thankful that the discussions in question are not simply proceeding. In the meantime the public must presumably resign itself to a deteriorating hospital service.

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SIR,—From recent reports in the *BMJ* it is evident that the National Emergency Service (NES); it is no longer either honest or rational to speak of a National Health Service) is again becoming aware of its gross insufficiencies.

Mr P Dawson-Edwards and Dr M E H Barrow (11 June, p 1531) have brought to the attention of the public and profession the transparent inadequacies of the present surgical services in a famous teaching centre and the lack of interest shown by the local authorities. On the same page Dr C F Scurr clearly demonstrates how other authorities have planned to compensate for the present unfilled posts in the NES by the overproduction of medical graduates. In the same issue (p 1553) Dr Mary White points out that most of these graduates will enter general practice; even if they do not, both she and Dr Scurr are agreed that there will be no improvement of the service. Professor Harold Ellis (28 May, p 1408) reveals that the closure of private beds has not led to their use within the NES. Mr E S Field (11 June, p 1536) endorses this and emphasises his low remuneration compared to that of senior registrars; indeed,

Dr J A K Davies, a recently appointed consultant (28 May, p 1415), advises senior registrars to stay put until forced up the ladder. It is not possible to explain this peculiar situation to those outside the profession.

One way out of the mire has been suggested by a group of general practitioners in Conway (28 May, p 1416). They advocate a private primary health care service. One need pay only scant attention to the media to appreciate the public discontent with the worsening state of the NES and to realise that a return to such a system would receive widespread support. In the senior registrar grade we are members of a group within the profession in Britain who may consider themselves to be adequately paid. Certainly, however, prospects for the future are daunting. We would happily sacrifice our present situation for improved prospects within a private hospital service working with a private primary health care service. We believe that the benefits to patient care from such a service would soon render the present system not only unworkable, as it now is, but totally obsolescent.

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Peers or leaders?

SIR,—The need for doctors to review their work is important but not new. The most famous reviews are the clinicopathological conferences at the Massachusetts General Hospital. Walter Bradford Cannon (1871-1945) headed a group of students who disliked routine teaching in the wards and asked Richard Cabot if he could organise discussions based on the patient's history, physical signs, and investigations and correlate them with the diagnosis and subsequent developments, which sometimes included the necropsy findings. The *New England Journal of Medicine* continues to publish the weekly conferences, which illustrate the value of leadership. It is fair to state that in Massachusetts General Hospital the junior staff have their own conference as a sort of rehearsal and make their own diagnosis. They are uninhibited by their elders, who presumably differ little the world over, with a dislike for being wrong and resenting still more being shown to be wrong by a junior, who in his turn can suffer acute embarrassment. I suspect one of the junior staff is *primus inter pares*. However, in the senior group the chief discussant is usually chosen because he is an expert and may have no peer. Two examples of review in the United Kingdom will suffice. The first is that of a surgical firm who have met regularly for many years to discuss the cause of death in patients, complications which can be avoided, misdiagnosis, etc. A surgeon presides, and his colleagues, the junior staff, including the preregistration house officers, attend. The second example is of a professor who organises similar exercises for his department of medicine. These are referred to as "peer reviews."

The *Concise Oxford Dictionary* defines "Peer" as "Equal in civil standing or rank" and also as "Equal in any respect." It also includes "Peer group" as "Those of the same status as, and associated with a person." In no sense could a meeting of a surgical or a medical firm be called a "peer group." The nearest approach to a "peer group" is when a number of general practitioners get together and discuss

a problem, but even then probably one of them is more expert than all the others. "Peer groups" are otherwise undesirable because very few people are equal and what we need today is leaders.

I consider that the ingredients of a good review are an interesting presentation, frank uninhibited discussion under informed leadership, and active participation of appropriate specialists, the absorption of which should lead to a thirst for further knowledge.

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Risks and rewards

SIR,—The merits and demerits of the Bowring/BMA insurance scheme will no doubt be discussed for some time as their significance for various sections of the profession differs. One clear conclusion, however, is that some groups face greater legal risks than others. Surely, therefore, now that the BMA has established this through an independent financial group, it behoves the Association to take steps to negotiate for appropriate extra rewards for those involved. Risk and responsibility are rewarded in all other professions or trades and this should be so in medicine. If the BMA feels it cannot press the Government nationally, then perhaps we should follow the example of the General Medical Council. They have co-operated with their French equivalent body on professional recognition and status. The same should be done to establish European rates of pay for all medical men from one end of the EEC to the other. I suggest the BMA sends a delegation to Paris to discuss the matter forthwith.

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The cowardice continues

SIR,—Your welcome leading article counter-blast (4 June, p 1428) omits any mention of the need for pregraduate antismoking indoctrination of medical students. Bynner,¹ Brunskill,² and I^{3,4} have published relevant commentaries on this topic, aptly described by Godber⁵ as "a regrettable failure in medical education." One hopes (again) that the third RCP report⁶ will become required reading for finals. And dare one also hope that postgraduate lecture rooms are now universally acknowledged as being among your "public places" which should be "non-smoking areas"? Only a minority of centres were so appropriately enlightened eight years ago.⁷

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¹ Bynner, J M, *Medical Students' Attitudes Towards Smoking*. London, HMSO, 1967.

² Brunskill, A J, *British Medical Journal*, 1977, **1**, 165.

³ Anderson, J P, *Manchester Medical Gazette*, 1961, **40**, 104.

⁴ Anderson, J P, *British Medical Journal*, 1970, **4**, 120.

⁵ Chief Medical Officer, Department of Health and Social Security, *On the State of the Public Health*, p 227. London, HMSO, 1969.

⁶ Royal College of Physicians of London, *Smoking or Health?* London, Pitman Medical, 1977.

⁷ Anderson, J P, *British Medical Journal*, 1971, **1**, 558.