version to A4 folders or computer records easier.

I am in a three-man practice in which we use A4 folders in a health centre and MREs in our other premises. I have therefore been able to compare the two types of record over a five-year period while using a similarly structured form to that of Dr Maycock. My partners and I are so convinced of the value of the A4s that we are willing to pay the increased cost of extra shelving and convert our MREs to A4s. The other 30 GPs in the health centre have stated that they also greatly prefer the A4 though their records are unstructured.

The complicated case with multiple problems is the one in which a structured record is of most benefit and it is these cases that have multiple insert sheets and letters. With MREs unfolding the letters and unshuffling the various insert sheets is more time-consuming than flicking over the pages of an A4. Also, no matter how careful one is using MREs, insert cards get lost or misfiled. Dr Maycock states that brevity is an advantage of the MRE format. I compared our practice entries in both types of record and found no difference in the length of notes, but the entries in the A4 were more legible. This was probably because writing does not need to be so cramped. Portability is also no problem. In fact, because of their size A4s are less likely to be lost in the car or a patient's home.

Like Dr Maycock my experience is that the first priority is some form of structured record, but given a choice between the A4 and MRE the former is vastly superior for helping the management of patients' problems in general practice.

NEIL M MACLEAN

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Wales under the Act

SIR,—The Welsh Council of the BMA recently considered the Wales Act 1978, which, as you will know, remains inoperative until such time as the referendum takes place. This will be on 1 March 1979 and for the Act to become enforceable 40% or more of the people of Wales will have to give approval.

The Welsh Council has taken a lead on the issue of devolved forms of government, having given evidence to the Royal Commission on the Constitution of the United Kingdom early this decade. One aim we had was to ensure that we maintained a United Kingdom profession, and this aim has been achieved. Another was to ensure free movement of doctors within the United Kingdom, not only by the aim expressed above but also by ensuring uniform standards of remuneration and conditions of employment within the NHS.

While the Act confers no powers to modify within the field of remuneration, the same cannot be said of conditions. It may be that the phrase "remuneration and allied matters" used by ministers secures those conditions which have a direct bearing upon remuneration. What does remain extremely uncertain is the power to vary conditions of service, which can be construed as "day-to-day" matters of management. This shows itself particularly when one considers three important statutory instruments. These relate to advisory appointment procedures for consultants, the general medical service regulations, and the regulations governing medical service committee procedures.

One has to accept that certain reserve powers are proposed as being held by the Secretary of State. What concerns the Welsh Council is that these powers are the weakest which can be devised. Thus I, under the instructions of the Welsh Council, wish to record that while the Welsh Council has taken no stand on the principle of devolution, it considers that the Wales Act 1978 contains the seeds of many and diffuse problems for doctors in Wales. The Council wished to find more effective safeguards to the standards of medical services and failed to observe them in this Act.

G MURRAY JONES
Chairman,
Welsh Council, BMA

BMA Welsh Office,
Cardiff

Private practice and the reduction of pay-beds

SIR,—In reply to Mr D E Bolt, chairman of the Subcommittee on Independent Practice (18 November, p 1438), we would emphasise the following points which we hope will vitalise and extend the subcommittee's activities.

It has been accepted politically that where public demand for private facilities cannot be met they should be provided in NHS hospitals. It must be accepted and emphasised that such demands may vary with movements of people, changes in economy, cost of beds and facilities, different times of the year, etc. Irrevocability of decisions where they are spuriously based must be changed: we are unable to accept illogical procedures.

Again, now that three years have elapsed it is obligatory that some effort be made to assess the result of the exercise. If all the procedure has done is to result in separating the two systems, with the attendant costly duplication of services, it is mandatory for those in power to reconsider the decision and cancel it before further harmful effects result.

What compensation is offered to those consultants who, as a result of these enforced closures, have suffered a major loss of income? The unions representing the car workers obtain extra wages for those they represent despite government ruling; some consultants have taken irreparable losses and nothing is done.

We, the part-timers, are of the opinion that small modification of a totally illogical concept is inadequate.

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P J MILLS

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Remuneration of NHS occupational health physicians

SIR,—With reference to the letter from Dr James Gregory (18 November, p 1437) it will be remembered that when the Government accepted in principle the setting up of an occupational health service for the NHS it was made quite clear that there would be no extra money available to do this.

These financial constraints are causing considerable difficulty in negotiations with the Department of Health and Social Security. Meanwhile ad hoc appointments are being

made which cause us serious concern. Until negotiations with the DHSS can be successfully concluded occupational medical officers employed by the local authorities are being advised to negotiate their salaries in accordance with addendum No 3 to "The Doctor in Industry." Employing authorities in the NHS are being told by the DHSS that they may appoint such officers on the senior clinical medical officer scale, if appropriate, and that the Department will look favourably on variation orders which would place them at a point of the scale which would reach almost to that of a consultant in the NHS.

JOSEPH KEARNS
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Occupational Health Committee, BMA

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Payment of allowances and back pay

SIR,—The medical profession has rather harshly been regarded as "semiliterate and innumerate." This view is evidently shared by the finance departments of the Department of Health and Social Security.

There must be many doctors (and others) who go without the extra allowances to which they are entitled under agreements made with the profession's negotiators because the onus is on the doctor to claim these allowances and he is often given little or no guidance from his employers. Similarly with back pay following recent pay awards, if the doctor has moved from his hospital arrears are paid only on application, even though he has already earned his money.

We are familiar with this method of saving by "survival of the fittest" in other spheres of Government activity, exemplified by the social security and rate rebate systems. Is it not time that this method of saving was discredited, at least within the NHS, and the employing authority made responsible for informing its employees of their full entitlements? Such would be the only course for any "good" employer and any other would be poorly tolerated outside a "nationalised industry" staffed by workers reluctant to strike.

J N THOMPSON

Rickmansworth, Herts

The Safety Net and preregistration posts

SIR,—Dr G A Mogey's article "The Safety Net and preregistration posts" (21 October, p 1136) has prompted us to write to you.

We are representatives of the medical students at Nottingham University Medical School who will graduate in 1980. In that year, for the first time, the number of preregistration posts in the Trent Region will be less than the anticipated number of graduates from the region's three medical schools. This is mainly due to a doubling of the previous number of Nottingham graduates (from 48 to 96) accompanied by the graduation of the first cohort of Leicester students (48). It follows that competition for the region's preregistration posts will be more severe than in the past.

We are interested in the method of allocation of preregistration posts in the Nottingham area. The mathematics of the situation dictate that if in 1980-1 every Nottingham area post

were to be filled by a Nottingham graduate, then some students would have both their jobs within the area, others only one. At a recent meeting of the students in the year it was evident that, since many wish to have both their junior house jobs in the area and as a simple "one in, one out" policy would not fill all the vacancies, some sort of allocation system would need to operate.

We understand that several other medical schools which annually face this problem have allocation systems. We would be most grateful if anyone responsible for operating any allocation system would write to us directly, giving details of the ease of use, timing, and staff/student acceptability of any system, so that we might decide upon an appropriate system for the Nottingham area.

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Staffing of accident and emergency departments

SIR,—I believe that I am the only doctor in Britain to have worked up through the grades from senior house officer to consultant level in "straight" accident and emergency as such. If there are any other fellow sufferers I salute them; however, I have worked in seven casualty departments as SHO or locum SHO, in three as registrar or locum registrar, and in three as locum consultant, so can claim to have acquired some rudimentary knowledge of the accident services. These are my credentials for commenting on the article about staffing of accident departments (18 November, p 1447).

The most obvious fact is that no encouragement is offered to anyone who might *aspire* to work in accident and emergency. There is to be no higher diploma, there are to be no registrar posts (so that senior registrars will have to have failed to get similar jobs in the specialties of their choice); it is envisaged that "consultants in accident and emergency" will actually be surgeons and it is suggested that small departments will be closed down. None of this is likely to encourage junior doctors to take an interest in accident and emergency work at an early stage in their careers; indeed, it might actively discourage those who might otherwise be attracted.

There are two basic reasons why accident and emergency is an unpopular specialty. The first is that there is no "ladder of advancement" available to a casualty officer. If a doctor takes an SHO post in accident and emergency he must, if he wishes for professional advancement, give up his casualty work and do something else. Alternatively, if he attempts to stay in accident and emergency and gains experience by working as SHO over the years he will eventually be faced with the necessity to work under a consultant who is less experienced than himself. Accident and emergency must be the only specialty in which it is possible to obtain a consultancy without any previous experience at all, and it must be the only specialty in which trainees at senior registrar level are expected to be more highly qualified than the consultants who are supposed to be training them—this can easily be verified by checking the experience and qualifications of those consultants and senior registrars already in post.

The second reason why casualty is so unpopular is the attitude of the nursing profession. Nurses traditionally "give guidance" to casualty officers

and it seems to be a nurse's duty to report on the competence of doctors to a consultant or up the Salmon ladder; this can undermine a doctor's self-confidence to the point where he becomes dangerous. This conventional authority of nurses over doctors is always upheld because casualty officers are assumed to lack experience; however, it is the more experienced doctors who are penalised by the discipline which nurses seek to impose. There have been discussions between the Casualty Surgeons' Association and the Royal College of Nursing to consider this problem, and even my own medical defence organisation advised in answer to a telephone inquiry in 1975 that "it is now generally accepted that casualty officers work under the clinical supervision of nursing staff."

None of the current proposals for organising the accident and emergency service attempts to solve the central problem of how to get doctors to work in the service at all, and most of these proposals are actually counter-productive. It is possible that since "consultants in accident and emergency" and "higher professional training" have been introduced the service has actually declined. This is certainly the impression gained by my observations over seven years in all parts of the country, and should be capable of verification or refutation by considering how many departments have been closed since these proposals were first made. In at least one hospital to my knowledge, and I suspect others, staff shortages are artificially created to justify the closure of departments which the public would like to see kept open.

There are really only two ways in which the accident and emergency service can be improved. One is to recognise it as a specialty, with its own higher diploma and a massive expansion of the registrar grade so that there will be a "career structure" to which doctors can aspire. The other method would be to introduce permanent non-consultant posts in accident and emergency, which in effect would mean the restoration of the archaic medical assistant and senior hospital medical officer grades. Neither is seriously contemplated in any of the current proposals and it is unlikely that there will be any improvement in the service at any time in the foreseeable future.

DONALD M BOWERS

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Clinical medical officers

SIR,—Paediatricians are concerned about the delay in clarifying the administrative base and career structure of community health doctors (senior clinical medical officers and clinical medical officers). We can ill afford the loss of these skilled clinicians, the majority of whom work in the child health services. For many of these doctors the sense of insecurity engendered by reorganisation of the NHS in 1974 was partially alleviated by "waiting for Court," but the appearance of this important document¹ and the negative reaction to it have merely added a sense of disillusionment and further loss of morale.

At a recent meeting of the Central Committee Community Medicine, Dr J R Preston, chairman of the Working Party on Community Health Doctors, is reported to have said (7 October, p 1039): "We have now to decide whether health doctors are to move steadily in a direction compatible with the profession of community medicine or to head off elsewhere." We recognise the difficult task faced by this working party, but we believe that any

solution must take account of the following points:

(1) *Clinical base.* These doctors are *clinicians* and should become or remain members of the appropriate clinical departments or divisions based on the hospital although their work may be wholly or partly in the community.

(2) *Training.* At present there are no specific training requirements and doctors enter this service from a wide variety of backgrounds. Advancement from clinical medical officer to senior clinical medical officer appears to be arbitrary and inconsistent from region to region. Properly organised training programmes are urgently needed. These must be interlinked with, and seen to be equivalent to, the hospital training grades so that a planned programme of training and advancement to clear career goals is apparent. For example, clinical medical officers might participate in the hospital service while hospital registrars rotate through the community services. Depending on interest, training, experience, and qualifications, there would be progression to senior clinical medical officer or senior registrar within a certain defined period.

(3) *Prospects.* Any change in the career structure should be based on the important principle that there would be accessibility of the consultant grade to all who enter the training programme and pass the necessary higher qualifications, including the MRCP. A consultant paediatrician might then work both in the hospital and in the community or wholly in one of these spheres.

It will obviously take time for such proposals to be implemented. Meantime, we strongly urge that doctors already working in the community health services should become fully integrated into clinical departments at a grade consistent with their training, experience, and present duties. Generous grants and training allowances for doctors wishing to take advantage of further training opportunities would be necessary.

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¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

SIR,—The British Paediatric Association welcomes the interest shown in your columns in the training, functions, and career structure of clinical medical officers. Probably the majority of these doctors spend most, if not all, of their professional time in the child health services, where they have their greatest expertise. One of the main recommendations of the Court Report, which was accepted by Government and has the full support of this association, was the integration of the curative and preventive health services for children. Those clinical medical officers whose work is with children have an essential part to play in the prevention and early detection of disability and also contribute to the curative services. Like most doctors they have certain administrative tasks, but their main con-