In east Gwent a project was designed around this philosophy.

The Bridges Community Centre was opened in 1987 in what had been a derelict factory canteen on a large industrial site in Monmouth. Joint funding by the Welsh Office and Gwent Health Authority provides a day hospital on two days a week and a day centre, run by volunteers, on three days a week; the day centre has about 90 clients a week. From the start the project incorporated a screening nurse, who has competent administrative help.

Like my colleagues in Newport, I have been dismayed by the checks for people over 75: it is not just the collection of medical facts but the appreciation of the social and personal difficulties of elderly people. If we screen intelligently how do we satisfy their uncovered needs? The answer must be to have a community based resource that unites medical and social health professionals.

The project awaits community care funding with some trepidation. Its five year funding has finished, and the family health services authority and health authority are making encouraging supporting moves. I fear, however, that the project will become lost in the confusion and enormity of the changes in community care funding.

The family health services authority and health authority met with social services at the end of January to explain community care funding, but will this have come in time to save this local initiative? Clearly, the community care fund will require the active participation of both social service departments and the family health services authority and health authority in these community ventures.

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- 1 Robinson R. Moving ahead—community care in Gwent. *BMJ* 1993;306:44-7. (2 January.)
- 2 Welsh Office. *A good old age*. Cardiff: Welsh Office, 1985.

Consultant episodes

EDITOR,—Allyson M Pollock and Azeem Majeed's arguments¹ in response to our editorial on consultant episodes² could perhaps be summarised as "the internal market is intrinsically flawed and we should not do anything that would delay its demise." That is a valid view, but we believe that the internal market is likely to exist for the foreseeable future and that we should try to make it work as well as possible.

When we wrote the editorial it was true that most, but not all,³ of the evidence of opportunism had been reported from the United States. This was inevitable as the American market based system has been in place longer than the British, but there is increasing evidence of it in Britain as well.⁴ Pollock and Majeed argue that this behaviour is somehow different in the two countries as the motive is profit in the United States but survival in the internal market here. This argument is untenable as some of the most dramatic changes in behaviour by American hospitals occurred at the time that the prospective payment system was introduced, when only 10% of hospitals were private, for profit institutions,⁵ and there is considerable evidence that, especially for rural hospitals in the United States, the threat has indeed been to survival.⁶ A somewhat more complex issue that has not received adequate attention in Britain is the meaning of the word "profit" in the context of trusts, and some of the ideas being discussed resemble the strategies that have caused the Internal Revenue Service to question the tax exempt status of some American not for profit hospitals.⁷

The thesis underlying our editorial is that if purchasing authorities are to base their activities on meeting epidemiologically defined need they

should use epidemiological principles. This means that they should use data that are based on people and defined events. We cannot see how the continued use of inappropriate information can enhance equity of health care.

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- 1 Pollock AM, Majeed A. Consultant episodes. *BMJ* 1993;306:141-2. (9 January.)
- 2 Clarke A, McKee M. The consultant episode: an unhelpful measure. *BMJ* 1992;305:1307-8. (28 November.)
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Junior doctors' hours

EDITOR,—Ellis Field suggests that increasing the number of consultants to help reduce junior doctors' hours would alter the nature of senior posts for the worse and advocates a substantial increase in junior staff.¹ While a corollary of the new deal may be that some consultants will have to take a more direct role in the acute management of patients, this in no way diminishes the attraction of a senior post. The thought of spending another five years in training to achieve that goal does. Field describes the increase in the number of junior doctors as temporary but fails to offer any mechanism to phase out these posts in the absence of appreciable expansion in the number of consultants. Had we been as free from the fetters of manpower planning as Field when we negotiated the new deal the problem could have been solved overnight.

An increase in the number of seniors is only one option proposed by the signatories to the new deal, who included consultant representatives. Changes in the working patterns of juniors are necessary. In addition, consultant firms are no longer appropriate in many settings and a team based approach will often result in better care for patients and improved experience for juniors, who will be sufficiently awake to benefit from the "apprenticeship method of transmitting skills and knowledge" that Field advocates. Where a rota system remains the most appropriate form of out of hours cover a consultant may have to be directly on call to an experienced senior house officer. None of these could be regarded as solutions in themselves, but taken together, and in combination with other measures outlined in the new deal, they can make a substantial improvement.

The Department of Health must accept that without a substantial increase in the consultant body and rationalisation of acute services the new deal will undoubtedly fail. If it does the alternative of a statutory limit on hours of work similar to that proposed by the European Commission would destroy any semblance of manpower control just as surely as Field's proposals.

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- 1 Field E. Junior doctors' hours. *BMJ* 1992;306:68. (2 January.)

EDITOR,—I have no solution to the problem of junior doctors' hours, but Jeremy Wight's allega-

tion that the Junior Doctors Committee was duped by "the hierarchy of the BMA" requires comment.¹ As long ago as the "work to contract" juniors were negotiating and acting independently, although they needed the sanction of the BMA council to make their action legal, as did the consultants. They submitted their evidence to the Short committee separately despite the protests of the other craft committees and council.

At last year's annual representative meeting we were informed by the chairman of the Junior Doctors Committee that he was engaged in secret talks with the chief medical officer on the future of training and specialist recognition, without the knowledge of the seniors. He told the representative body that the talks were too confidential for us to be let into the secret. He was followed in the same debate by a junior who informed the representative body that even if we did not vote for the juniors' motion a solution would be imposed by the Department of Health in conjunction with the juniors whether we liked it or not. I was present at and involved in all these events. The image of the juniors as passive dupes of the BMA machine is a myth.

We have been asked over the years to vote for a freeze on medical school places when juniors were unemployed, for more manpower when they were overworked, and for more consultants when they were having problems with their careers. Every time the juniors have been supported.

The equation may be insoluble. It may be because the juniors act independently with equal quantities of youthful enthusiasm and historical ignorance that they get themselves into situations that the dinosaurs have seen before. It is usual for frustrated youth to protest that "it's not fair" and to look around for bogymen to blame. Looking for them in BMA House only emphasises the juniors' ignorance of the enormous amount of work put in on their behalf by all sections of the profession.

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- 1 Wight J. Junior doctors' hours. *BMJ* 1993;306:67. (2 January.)

Umbilical cord clamping in horses

EDITOR,—It is interesting that obstetricians have just realised what has been known to veterinary practitioners for many years.¹ In equine practice it is mandatory for the stud groom to wait until the umbilical cord has stopped pulsating before clamping it; this takes 30-60 seconds. If the cord breaks—for example, if the mare is standing when she delivers—then the foal is at risk of infection as well as anaemia, for as much blood as possible should be passed to the foal. Whenever I have conducted a human delivery I have always insisted that the cord is not clamped too soon, and I am interested that my belief has now been scientifically verified.

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- 1 Kinmond S, Aitchison TC, Holland BM, Jones JG, Turner TL, Wardrop CAJ. Umbilical cord clamping and preterm infants: a randomised trial. *BMJ* 1993;306:172-5. (16 January.)

Correction

Alternative allergy and the GMC

Stephen Davies and Damien Downing (30 January, pp 328-9) mistakenly stated that Caroline Richmond handed over a draft report from the Royal College of Physicians to the high court. The court obtained this report by subpoena.