National medical advisory structure (British organisations shown in brackets); (bottom) how this system might be applied in Europe

how this system might be applied in Europe. Both diagrams show the lines of communication and the three principal differences from the current European arrangement: a merging of the various directorates at European Commission level into a single medical directorate; separation of the monospecialist committees from the UEMS to form their own specialist organisations; and re-definition of the function of the UEMS and the European Union of General Practitioners (UEMO).

This would represent evolutionary rather than revolutionary change and would have several advantages. It would provide clearly defined channels of communication for the Department of Health, BMA, royal colleges, and specialist societies; allow specialties to develop on the lines of the proposed European Boards but without the constraints of working through the UEMS or UEMO; and allow the UEMS/UEMO to develop on a basis not dissimilar to the BMA. Indeed, its constitution—through nominations of national medical associations—would lend itself to this.

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1 Richards T. Who speaks for whom? *BMJ* 1992;304:103-6. (11 January.)

Public opinion and purchasing

SIR,—Andrew Richardson and colleagues used a postal questionnaire to derive information about public priorities and perceptions of health care provision.¹ In the planning of a cardiovascular strategy for health in South Glamorgan we have embraced community participation.

Representative "focus groups" considered the question of how we could reduce illness and disability due to heart disease and stroke in South Glamorgan. Their discussions resulted in a questionnaire containing 26 answers to this question, randomly paired so that each answer was matched with three others at some point in the questionnaire. Respondents could indicate not only which of the matched answers was more important but approximately how much more important. The

overall priorities of respondents could be tabulated by computer analysis. In this way questionnaires were devised for the use of local residents, patients with cardiac disease, and patients with stroke.

The three groups surveyed responded with slightly different priorities. The cardiac patients were primarily concerned with speed of treatment for both emergency and planned admissions, and preventive measures did not figure highly. Stroke patients also wished to receive speedy attention but were concerned about support provided at home and integrating after care provided by hospital and general practitioners. The local residents advocated banning tobacco advertising and increasing the awareness of the effects of anxiety, poor eating patterns, and the importance of research into cardiovascular disease. Their main priorities, however, also related to speedy treatment.

The priorities identified by these consumers of health care have been merged with the views of health care professionals to form the local strategy for health. In this way the views of local people can help determine the nature of local health services.

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1 Richardson A, Charny M, Hanmer-Lloyd S. Public opinion and purchasing. *BMJ* 1992;304:680-2. (14 March.)

Women in the NHS

SIR,—Elizabeth Shore's letter draws attention to the urgent need to make the best use of trained medical staff.¹ This is likely to mean fundamental changes in specialist training and patterns of work. She refers to the cooperation that now exists between the BMA and the Medical Women's Federation and to former problems. I wish to clarify the history of the relationship of these two organisations.

E Garrett—better known by her married name, Elizabeth Garrett Anderson—joined the BMA in 1874. Probably only her sponsors, a physician at the Middlesex Hospital and a physician at St Mary's Hospital, knew that the E stood for Elizabeth, and of course the rules of the BMA then admitted all British registered medical practitioners. She was the only woman member until 1892, when at the annual general meeting of the association in Nottingham a resolution to revoke a resolution of 1878 excluding women was passed by 297 votes for with four against.

In 1879 the Association of Registered Medical Women, based in London, was formed to give the few women then on the medical register an opportunity to meet to discuss clinical and other matters of professional concern. As more women became registered four other local associations were formed in other parts of the United Kingdom. In 1917, the date to which Shore refers, these five associations formed the Medical Women's Federation (hence the title). Women were not at that time excluded from the BMA. They believed that a national body was needed to study the implications for women patients and women doctors of the Lloyd George National Insurance Act and other medical matters of concern to women and to make recommendations to relevant bodies when necessary.

The Medical Women's Federation is now an educational charity concerned with medical education and medical and related sciences. It has

always been complementary to the BMA, and long may it be so.

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1 Shore E. Women in the NHS. *BMJ* 1992;304:717. (14 March.)

Starting date of house officer posts

SIR,—Can I encourage A Kaiser to make the changes he suggests¹ without waiting for a master plan from the Department of Health or the General Medical Council?

In November 1975 I converted our six paediatric posts into 12 month posts, starting in February, May, August, and November instead of the traditional January and July. They had a three monthly rotation, and for the first time in the United Kingdom training included a three month period in community child health. At some point (certainly before 1979) we also made the appointments begin on a Monday.

Since 1990 (due to internal cover for holidays) the first week of the appointment has been a study leave week for orientation, training, and teaching procedures such as neonatal resuscitation. The new senior house officer is resident on call alongside the experienced senior house officers. Finally, in 1991 we changed to an 8 am to 4 pm working day to ease the problems of travelling and parking, since most senior house officers can afford their own residence.

There are two problems with a Monday start. Candidates are told the post starts on a Monday and they will have to take bank holidays owed to them in their current post to cover any overlap. If they are too frightened of their consultant to do this, they miss some of their training week but not all of it. Secondly, 365 days is more than 52 weeks. Consequently every so often a senior house officer works for 53 weeks. They have already been paid appropriately and so far nobody seems to have noticed.

I encourage my paediatric colleague to make changes if they seem sensible. Some of those we have made have been widely adopted. For some specialties, where consultants seem unable to work as part of a specialist unit and wish to maintain their own personal retinue, this approach will be more difficult.

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1 Kaiser A. Starting date of house officer posts. *BMJ* 1992;304:917. (4 April.)

Communication between GPs and consultants

SIR,—The recent paper by John Newton and colleagues made a plea for more information from a wider spectrum of doctors regarding the content of discharge letters.¹ We recently conducted a survey of 400 general practitioners in Leeds, who were circulated with a questionnaire regarding the contents of discharge letters from the accident and emergency department, with specific reference to abdominal or chest pain. Accident and emergency departments present special problems of communication to general practitioners. Many patients are self referred without the knowledge of the general practitioner and have treatment provided without reference to primary health care. The volume of work often precludes detailed communication about every patient, and some degree of selectivity is of necessity adopted. It may thus be even more important in this clinical situation to

Proportion of general practitioners indicating their wish for information in discharge letters concerning various aspects of their patients' attendance at accident and emergency departments

Aspect of attendance	No (%) of practitioners requiring information on aspect (n=213)
Mode of referral	194 (91)
General practitioner diagnosis (prior to referral)	134 (63)
Clinical findings in accident and emergency*:	
All positive findings	115 (54)
All negative findings	57 (27)
Only relevant findings	109 (51)
Results of investigations in accident and emergency:	
Haematology	187 (88)
Biochemistry	183 (86)
x Ray	191 (90)
Diagnosis in accident and emergency	208 (98)
Treatment in accident and emergency	202 (95)
Outcome (admit or discharge)	203 (95)
Treatment suggested for general practitioner	192 (90)
Follow up arrangements	200 (94)
Information given to patient	175 (82)
Information to general practitioner**:	
On all patients	160 (75)
Only those sent home	53 (25)

*Actual question: Would you like to know all positive findings? all negative findings? only "relevant" findings? other (please specify)? Some respondents replied to more than one category.
**Actual question: Would you like this information for all patients? for only those sent home? for only those admitted?

identify what information is essential, what is helpful, and what is thought to be less helpful. These circumstances are reflected in the findings of our survey (table), which differ somewhat from those of Newton and colleagues. Of the 400 general practitioners circulated, 213 replied (55% response rate). Over 90% of the respondents wanted to know what investigations had been performed in the accident and emergency department, what diagnoses were made, and what treatment was given. In addition, however, 80% or more of the general practitioners who responded wanted to know what follow up arrangements were made; what the patient had been told; what the practitioner was supposed to do; and how the patient came to be in the accident and emergency department in the first place. Most general practitioners were interested only in positive findings, and few felt that negative findings were relevant.

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1 Newton J, Eccles M, Hutchinson A. Communication between general practitioners and consultants: what should their letters contain? *BMJ* 1992;304:821-4. (28 March.)

Management training for senior registrars

SIR,—E M Gadd and M F Fletcher suggest that senior registrars are inadequately trained in theoretical and practical management.¹ This problem has been addressed in Wales, where each senior registrar is expected to attend two one week courses to develop these skills. We surveyed the 21 senior registrars who completed the most recent course and found that, although they all thought that the course was valuable, 18 were dissatisfied with their theoretical management skills and 16 with their practical management skills. The main problems were the lack of in service training and of experience. Practical management experience was largely limited to routine organisational tasks (devising duty and teaching rotas and running departmental and audit meetings). Few (six) had any formal contact with management,

and only five had attended meetings relevant to budgetary planning. In contrast to Gadd and Fletcher's study, only one of the senior registrars had attended a meeting at district level. Management training courses are important to senior registrars, but we should be given the opportunity to develop our management skills in hospitals before we become consultants.

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1 Gadd EM, Fletcher FM. Do senior registrars have adequate management training? *BMJ* 1992;304:546-7. (29 February.)

The supraregional assay service

SIR,—The NHS reforms associated with the provision of the supraregional assay services came into effect this month, bringing the prospect of a more fragmented, less cohesive, less cost effective, and considerably more expensive service, not to mention the masses of associated paperwork.¹ Worse still is that the money required by the individual laboratories to pay for these services has not been clearly identified in all cases. As a result, what used to be funded centrally will now have to come locally from existing laboratory budgets (at least for this year). This is not unlike the problems that many laboratories are facing with the changes in funding for national external quality assessment schemes, which also came into operation this month. Money supposedly top sliced at regional level for allocation to this scheme has failed to trickle down to individual units in most cases. Once again, it will have to come from local funds (that is, laboratory budgets), and I can only hope that regional money will eventually find its way to individual laboratories.

Are all these examples just underfunding by a different name—reform? Yet this is just the beginning of the reforms, and we can expect more of the same in other areas of the NHS. Could someone please enlighten us as to the benefits to the patient or the clinician, or indeed even individual laboratories, in all these changes?

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1 Lester E. The supraregional assay service. *BMJ* 1992;304:790-1. (28 March.)

SIR,—I have beside me a file, which was once slim and concise but is now bulging with a plethora of documents from each of the laboratories in the supraregional assay service, comprising letters of intent, tentative and definitive price lists, "advertising" leaflets, and so on. Disturbingly, one such letter demands that payment must accompany each sample sent. Should I continue to use these services the administrative time required to process the extra paperwork will add considerably to the overall cost (a situation presumably duplicated throughout Britain)—as Eva Lester forecasts in her editorial.¹

Accordingly, I have examined the in house costs of all but the most esoteric or technically complex assays and have concluded that many tests done by the supraregional assay service could be adequately handled locally, thus benefiting my budget. Mine, however, is a "bread and butter" laboratory, and though we are competent enough both technically and in interpretation, our skill will of necessity be diluted by the needs of other aspects of the service and will be inferior to that of the specialist

laboratories. Nevertheless, managerial pressure to introduce cost savings is strong and may well overcome such professional misgivings. If other heads of department follow the same reasoning laboratories in the supraregional assay service, with all their skill, research, and training facilities, will be in jeopardy. As a consequence a short term financial gain for individual departments will risk the destruction of a valuable asset to the NHS. The ultimate loser will be the patient.

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1 Lester E. The supraregional assay service. *BMJ* 1992;304:790-1. (28 March.)

Seat belts in pregnancy

SIR,—Deborah Moncrieff and Jayne Cockburn's letter¹ seeks to modify the advice given in my editorial on the use of seat belts in pregnancy.² The three point harness dissipates crash energy through the skeleton. The addition of a small cushion under the lap strap is therefore positively dangerous as not only is it likely to slip during the accident but by holding the belt away from the skeleton it defeats the purpose of the restraint. This is likely to lead to an increase in soft tissue injuries of the pelvic organs. If the belt rides up to lie over the symphysis it will still effectively act through the skeleton. The woman who still needs to travel by car in late pregnancy should therefore be advised to put up with the discomfort and to reduce the journeys to the absolute minimum.

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1 Moncrieff D, Cockburn J. Seat belts in pregnancy. *BMJ* 1992;304:986. (11 April.)
2 Pearce M. Seat belts in pregnancy. *BMJ* 1992;304:586-7. (7 March.)

Hype in the BMJ

SIR,—One of the ordeals facing a doctor involved as a defendant in litigation is that of publicity. Having been recently involved thus, I found that in press reporting it is the headline which, as well as being the most eye catching, is liable to the most inaccuracy.

The brief national press coverage of the case was restrained and responsible in its headlining, so I was extremely perturbed to see that the headline in the news section of the *BMJ*¹ indulged in the journalistic hype, referred to in Richard Smith's editorial,² characterised by the sensational "excesses of Sunday's papers." Clare Dyer makes it clear that the case was complex and required some five days' argument in the High Court between medical experts.

In the event the issue was settled out of court, undebated and without judgment. Despite this the headline, "Chilblain medicine gives woman brain damage," is uncompromising. If the causal relation is unproved it should not be stated as fact—not in a journal that surely takes pride in scientific accuracy.

I believe that the headline has, on this occasion, let down both legal and journalistic professions in that it was misleading, judgmental, and hostage to sensationalism.

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1 Dyer C. Chilblain medicine gives woman brain damage. *BMJ* 1992;304:799. (28 March.)
2 Smith R. Hype from journalists and scientists. *BMJ* 1992;304:730. (21 March.)