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