pean Community in particular. There would then have to be a considerable increase in career registrars and senior registrars, which would negate the intention of *Achieving a Balance* just as it was beginning to become really effective, or there would be many senior house officers in the system with no prospects of promotion.

The staff grade and other non-training grades are not the answer: they cannot be expected to solve the on call commitment in any appreciable way as the number of such posts is limited to a maximum of 10% of the consultant establishment. The alternative is for an increase in consultant numbers without a commensurate increase in junior staff and for a change in consultants' working practice. In many disciplines consultants would have to work in larger teams and accept being on call, often with only one level of cover. They would be involved in much more day to day care. This message has not yet been made clear to the consultant body, but I suggest that this is the only way in which the aims of both the agreement on junior doctors' hours and *Achieving a Balance* can be reconciled.

JOHN G TEMPLE

Board of Postgraduate Medical and Dental Education,
Birmingham University Medical School,
Birmingham B15 2TT

1 Carney A. Patterns of hospital medical staffing. *BMJ* 1992;304:1197-8. (9 May.)

EDITOR,—Andrew Carney's article on patterns of hospital medical staffing does not address the main problem—namely, the lack of a career grade equivalent to the army rank of major.¹ *Achieving a Balance* has always been unrealistic—demonstrably so in the light of the recent heads of agreement and the new restrictions on juniors' working hours.

The medical career structure in hospitals suffers from several main defects, among which are that everyone has to reach the top; that clinical responsibility is equated with the top grade; a failure to accept at junior level the need for both career and training posts, to the detriment of both; the false concept of a fully trained, rather than adequately competent doctor; and that a consultant's job has too many facets, with inevitable professional and geographical conflicts.

In the services the bottom three ranks are roughly equivalent to preregistration house officer, senior house officer, and registrar (including senior registrar). Once initial regimental training is complete officers spend periods at these levels in regimental work and training work—for example, attending staff college courses. All are guaranteed promotion to regimental officer at field rank; at this rank they are fully professionally competent but are able to take advice from above. The competent move upwards to the general ranks and the less competent sideways to less taxing jobs. In the health service there is no career grade that everyone must achieve, and through which everyone must go, but is not the top. Promotion from senior registrar to consultant is the equivalent of promotion direct from captain to general. Until there is an equivalent to field officer in the health service the career structure will inevitably result in overwork for junior staff and violent fluctuations in supply of, and demand for, consultants.

A middle buffer to smoothe these problems out is essential for a successful career structure. On promotion to this specialist grade doctors would be competent specialists with clinical responsibility but able to take advice from consultants in the same way that general practitioners do. Those good enough would be promoted to do true consultant work, while the less competent would move sideways to do less taxing, but nevertheless essential, sessional work. This would give those responsible for acute emergencies and the very ill, including the new specialists, time to concentrate

on this work with some relief of the routine workload. Consultants would contribute to clinical medicine, management, research, and national advisory machinery, for which they would be paid, and would tend to specialise more in one type of work than at present.

C K CONNOLLY

Friarage Hospital,
Northallerton,
North Yorkshire DL6 1JG

1 Carney A. Patterns of hospital medical staffing. *BMJ* 1992;304:1197-8. (9 May.)

Racial discrimination in registrar appointments

EDITOR,—The proposed investigation by the Commission for Racial Equality into alleged discrimination against ethnic minorities in the appointment of consultants, though most welcome, is not likely to come up with the full facts.¹ Consultants can be appointed only from candidates who have risen through the system to the senior registrar cadre. The chance of doctors from ethnic minorities achieving this is hampered by their inability to get a good registrar post. It is generally known that many otherwise well qualified senior house officers are unlikely to be short listed for registrar jobs simply because their names are easily recognised as foreign.

The restrictive system of appointment to registrar posts that have future prospects—previously based on unwritten understanding—is now becoming official policy with the categorisation of jobs into career and visiting posts, as proposed in *Achieving a Balance*. The real intention of this is to exclude all foreign competition. A few doctors from ethnic minorities are now being caught in the no man's land of being unable to apply for either visiting registrar jobs (because they have full residency status) or career registrar jobs (because their names do not sound right).

The average doctor from an ethnic minority asks to be allowed to compete where meritocracy is the norm. If the Commission for Racial Equality cannot do something for him or her at registrar level neither can it do anything at consultant level.

C MBUBAEBU

London SE9 1RH

1 Beecham L. Are doctors from ethnic minorities discriminated against? *BMJ* 1992;304:1513. (6 June.)

Neonatal intensive care and the NHS reforms

EDITOR,—Information on the effects of the NHS reforms on neonatal intensive care was sought by a questionnaire sent out last March, at the end of the first full year of the changes. The questionnaire was sent to named neonatologists working in 50 British neonatal units, including all the recognised regional and subregional units in every health region in England and Wales as well as Scotland and Northern Ireland.

Forms were returned from 33 neonatal intensive care units, which tended to represent the larger units. The median (range) number of infants mechanically ventilated in these units was 116 (18-200) a year. Thirteen units were part of hospitals that had become trusts in either the first or the second wave. Ten respondents reported that their unit had received an increase in its recurrent budget in the financial year 1991-2, and six of these were in trust hospitals. Only three units reported a reduction in their recurrent budget, and all were in non-trust hospitals. Nine units reported that they had admitted "significantly more" babies to their unit for intensive care in the current year compared

with the previous year; only two reported having admitted "significantly fewer." Five of the units that had admitted more babies were in hospitals that had no plans to become trusts, and one of those that had admitted fewer babies was in a hospital intending to become a trust.

Replies were obtained from at least one unit in each of the 14 English health regions as well as Wales, Scotland, and Northern Ireland. Responses indicated that there was a regional plan or strategy for perinatal services in each of the 17 regions, but six indicated that there seemed to be a fading or absent financial commitment to the plan. Only three regions seemed to be considering proposals for regional contracting of neonatal intensive care.

All respondents expressed a view on the effects of the NHS reforms on their units. Nineteen thought that there had been no change in their service, and seven stated that there had been an improvement and seven a deterioration. The commonest reason given for a worsening of the service was the perception that the regional structure of neonatal services was falling apart.

Despite the evidence for more babies being offered intensive care in the units sampled, there are few data to suggest that this is due to the NHS reforms; indeed, most of the units that admitted significantly more babies were in institutions that had not expressed an interest in becoming trust hospitals. The main concern of the consultants was the possibility of individual units "going it alone" and reducing the drive towards strategic planning of services on a regional basis. This is a particular fear in London.

MALCOLM LEVENE

Academic Unit of Child Health,
University of Leeds,
Leeds General Infirmary,
Leeds LS2 9NS

Checking quality of health care records

EDITOR,—C P J Charlton and C J Cuninghame express concern¹ about the accuracy and completeness of computer based immunisation records in Grampian.² We have addressed this issue before and are continually reviewing the quality of our immunisation records.^{3,4}

Immunisation data are held on the same computer as general practitioner registration data from which target payments are made, based on exactly the same denominator. This circumvents the problem reported by Jammi Nagaray Rao whereby general practitioners have to notify both the family health services authority and child health computers.⁵ At the time the data are entered the patient's details are checked by the computer against registration data, age at immunisation is validated for the accepted range of giving times, and vaccine data—manufacturer, batch number, and expiry dates—are compared. When discrepancies occur these are investigated and corrected by primary care staff. Grampian has a relatively stable population, and the proportion of children not registered with general practitioners is extremely small. We also, however, monitor all health visitors' immunisation records of children newly transferred into the area, cross checking with general practice sources.

The main method of data quality assurance is by quarterly feedback of immunisation figures to general practitioners, who receive target payments on the basis of the accuracy of these data. General practitioners and staff cooperate, using the information as a prompt for immunisations not yet performed and for correcting inaccuracies. Because of the continuous nature of this feedback discrepancies are minimised, and we have no reason to believe that the level of any residual error has changed throughout our study.²