and eclampsia have an immunogenetic basis which, as Dr Ikedife suggests, is the reverse of rhesus disease—exposure to the relevant antigen being protective rather than the reverse. If this becomes established then the way is open to devise prophylactic immunotherapy.[3]

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[1] Feeney JG. In: Bonner J, MacGillivary I, Symonds EM, eds. *Pregnancy hypertension.* Lancaster: MTP Press, 1980: 41-4.
[2] Feeney JG, Scott JS. *Eur J Obstet Gynaecol Reproductive Biol* (in press).
[3] Scott JS, Jenkins DM, Needs JA. In: Bonnar J, MacGillivary I, Symonds EM. *Pregnancy hypertension.* Lancaster: MTP Press, 1980: 15-7.

Regional specialties and "Patients First"

SIR,—The 1974 reorganisation of the National Health Service failed to provide adequate financial administration of regional specialties such as neurosurgery, cardiac surgery, radiotherapy, etc. Essentially the districts or areas are not interested in these expensive specialties, and referral to the region is met with the response that the region supplies the area with all necessary finance. But further inquiry reveals that the region does not know exactly or even approximately how much money is allocated within the district or area budget to such specialties.

Neither your leading article (2 August, p 342) nor the paper *Patients First* refers to this important deficiency, although the evidence of the Society of British Neurological Surgeons to the Royal Commission on the National Health Service and the report of the London Health Planning Consortium on neurology and neurosurgery stressed the current difficulties.

May I ask through you that the Department of Health and Social Security considers ways of fairly financing regional specialties in the future? At the moment the situation is most unsatisfactory from everybody's point of view, but *Patients First* does not consider this.

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Appointment of consultants

SIR,—While Dr James Andrews (9 August, p 457) is commenting on the question of regional appointment of consultants I feel it would be of value to reconsider the actual wording of the Appointment of Consultants Regulation 1974. Statute 1974 (No 361)7.2 states: "The committee shall consider all applications so referred to them and they shall select from the applications the person or persons the committee shall consider suitable for the appointment." This is to say that the members of the advisory appointments committee decides which applicants for a consultant post they wish to interview. It follows that there can be no guarantee that any individual doctor, no matter how good his qualifications or experience, will be selected for interview for a post for which he has applied as this is solely a matter for the committee to decide. This specious Act in fact gives great scope for local manipulation.

In my opinion some form of amendment is required—for example: "They shall select for interview up to six persons with the greatest experience in that specialty and thereby recommend one person for appointment. Experience shall be judged independently by the external consultant for the relevant specialty (schedule 1.2b ii) and he shall answer to the lay member at the time of interview and to his college for any queries concerning any person who has been discounted." In this way a committee should be accountable for its action and appointments would be made on the basis of experience and not simply to suit the flavour of local politics.

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Consultants and responsibility

SIR,—Having been increasingly concerned for many years about the surplus registrar problem,[1] described in a *BMJ* leading article last year as a "scandal,"[2] I have read in detail the great amount currently being written and reported about it.

One point never seems to be mentioned, yet it is probably one of the most fundamental of all aspects of the organisation of medical work: that is, the individual consultant's responsibility for the individual patient. If my name is on a patient's case record as a consultant, albeit honorary, then I feel I owe that patient a very great deal of responsibility. It is a source of anxiety to me if that patient receives unsatisfactory treatment from myself, but much more so if an assistant is involved.

Accordingly, it seems to me that a consultant must minimise his delegation of responsibility rather than maximise it. The latter seems to be the aim of much current practice and many plans for the future, including the reintroduction or expansion of the permanent subconsultant grade. The best that can be said of them is that they are economically inefficient.

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[1] Phillips CI. *Lancet* 1973;ii:33-5.
[2] Anonymous. *Br Med J* 1979;i:1299-1300.

Reimbursement for related ancillary staff

SIR,—It appears that related ancillary staff after all are going to be included in the reimbursement scheme. The excuses emanating from the DHSS when it failed to put right this gross injustice have been countered.

The "new" excuse is lack of money. This is no excuse at all—and if it can be called an excuse it is the lamest of the lot because we all know that if I chose to employ someone in my surgery other than my wife, reimbursement would be immediately forthcoming; or if I was reprehensible enough to divorce my wife and employ a girl friend cash would be available.

The latest advice to the profession is that we must adopt a responsible attitude; I entirely agree. Responsibility works both ways, in other words we should show a sense of responsibility to those people who should be paid for working and who have worked hard in the profession for 14-odd years for nothing.

The final delaying tactic of the DHSS is that something has "got to be worked out." This again is a poor excuse. All the DHSS have got to do is to agree to pay those wives who are acting as ancillary staff in exactly the same way as non-related ancillary staff. There is a scale known as the Whitley scale for nurses, and there are scales of pay laid down for medical secretaries and all Health Service workers. It would be ludicrous for any government department to suggest that it is going to take two years to work out pay.

One wonders if the Department running the Health Service has any sense of fair play at all? How many of its employees are working for nothing?

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Review of social service organisation needed?

SIR,—Dr H A F Mackay's strictures (26 July, p 313) are unfair. He bases his indictment of the role and operation of social workers on three sketchy anecdotes for which, he says, there are explanations "within the system." Why does he not reveal these explanations? Could they include a shortage of part III accommodation in his district? If so, it is every bit as unreasonable to blame the social service departments as it would be to blame clinicians for under-provision in the Health Service.

Social workers are here to stay and, whether we like it or not, they are not an ancillary profession. It is in our interest and, even more, in the interest of the public that we should have a good working relationship with them. To this end, Sir, what is needed, especially in the medical press, is less expression of King-Canute-type sentiments and more fairmindedness towards another caring profession.

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Vocational training for general practice

SIR,—The reports from the National General Practitioner Trainee Conference in Exeter and the letter from Dr A R Rogers (9 August, p 457) reveal the naivety of many trainees, who believe that because trainers are paid £2550 per annum all trainees should receive, personally, £2550-worth of teaching each year. The idea has mistakenly arisen that because this payment is equivalent to two clinical assistant sessions a trainer is obliged to give seven hours of teaching a week to his trainee.

It is important to remember that the payment made to trainers is a grant and not salary. This grant is paid to compensate the trainer for the time that will be spent away from his usual practice duties. In addition to the teaching of the trainee, the grant is designed to compensate the trainer for the time that he spends attending trainers' courses and meetings. There is also time spent travelling to organisational meetings with the course organiser and other trainers within a training scheme. There will be time spent attending the various half-day or day-release courses. There will be additional practice expenses to cover extra secretarial time, telephone costs, stationery costs, advertising and interviewing costs, and the purchase of books for a practice library.