casualty department of the average district general hospital is surgical. By far the most important part of this is related to orthopaedic surgery, and it is for this reason that the orthopaedic faculty has consistently opposed the idea of an independent casualty department. Had the orthopaedic consultants been able or willing during the past 20 years to take an active part in the running of casualty departments and in supervising the work of casualty officers the idea of an independent casualty consultant would never have arisen.

At the present time it is fashionable to emphasise the medical side of casualty work and to underrate the importance of the much larger surgical side. This is due, I think, to the determination of orthopaedists not to allow the independent casualty department to take any part in the orthopaedic care of accidents and to the wish of the casualty surgeons to appease the perennial opposition of the orthopaedic faculty to the casualty department's independence. This train of thought, on the part of both orthopaedists and casualty surgeons, has resulted in a number of unsatisfactory casualty consultant appointments in recent years and is at the present time resulting in the spectacle of appointments committees going around the country and failing to make appointments at all.

The independence of the accident and emergency department under its own consultant staff has clearly come to stay. But I cannot see these consultant posts being rewarding or attracting the right type of applicant unless the appointee has an orthopaedic background, is accepted as competent by the local orthopaedic department, and is welcomed by them to take a part in the care of fractures and allied injuries. I do not think there is any prospect of improvement in the accident and emergency service unless these two complementary hospital departments work together and the casualty consultant is regarded as one of the orthopaedic team.

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General practice records

SIR,—A close reading of the article about our record system (25 November, p 1510) will answer some of the points raised by Dr N M Maclean in his letter (9 December, p 1646). For example, the continuation cards are punched and held together by treasury tags and the four special cards are tagged on the front in strict order. Consequently, it is impossible for them to be misfiled. The problem lists (fig 3) and analyses of problems are written in capital letters and are therefore legible.

One of us (JSW) has used both systems but does not share Dr Maclean's overwhelming conviction that A4 records are superior to our modification of the existing medical record envelope (MRE). He found that the style of recording on A4 tended to revert to that of hospital note-taking, being more detailed but not necessarily more helpful. Note-taking in the surgery demands an approach that takes into account the limited time available for writing during the average consultation. Use of the MRE has encouraged the habit of thinking before writing instead of thinking while writing. The limited space of MREs is, we think, not a disadvantage in the context of the usually brief consultation in general practice, particularly when the front of the record is structured.

We agree with Dr Maclean on the importance of this structuring, whichever record system is used. It was the lack of progress in introducing A4 folders that led us to evolve our simple and *inexpensive* system. We have found it to be viable and a considerable advance in our management of patients. It, or something similar, could be introduced by GPs now, without much expense or waiting for more years of discussion, delay, and disappointment.

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J S WRIGHT

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**This correspondence is now closed.—ED, *BMJ*.

Redistribution of registrars

SIR,—The stand taken by the Trent Regional Manpower Committee on the distribution of senior registrar and registrar posts (16 December, p 1729) is one of fundamental importance within the Health Service. The present impasse between regions makes the position of deprived areas within a "donor" region even more parlous. In supporting Trent's claim for equity it is reasonable to expect that the same principles be applied at sub-regional level. It is not acceptable that, for instance, Kent Area on 31 December 1977 had only 12 senior registrar posts in all the clinical specialties (that is, 1:120 675 population) within the South-east Thames Region, which has an overall ratio of 1:21 567. Just to reach the 1977 national average provision of 4·62 whole-time equivalents per 100 000 population Kent could expect an additional 55 senior registrar posts.

At registrar grade the problem is equally grave. The Kent level of provision (1:15 913 population) is disproportionately low against the regional standard of 1:9787—and again this implies in Kent a shortfall of 62 registrars below the 1977 national average level of 10·55 whole-time equivalents per 100 000 population. Adequate hospital staffing is a key factor in the quality of health care which an authority can provide. It is naïve not to accept that senior training posts also have a service function—and indeed it is essential as part of training that they do so.

In the conflict between career structures and service provision which underlies these shortages it is incumbent upon the profession to recognise the practical consequences of the present situation. "Centres of population" with too few doctors may well take a different view from "centres of excellence" with too few patients.

GILLIAN MATTHEWS

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Honorary registrar posts in the NHS

SIR,—Professor L P Le Quesne's reply (2 December, p 1575) depicts my letter (4 November, p 1374) as outrageous. Yet its main point was simple enough and so self-evidently just as to be barely contentious.

Entrée to consultant posts (and academic equivalents) comes, in the main, through two training systems, the NHS and the academic. The former is subject to numerical control (and indirectly to quality control) by the Central Manpower Committee; the latter experiences no better numerical control than that imposed by the vagaries of university budgets, and in many cases there is no control of content (and until all such posts have control of content Professor Le Quesne's second paragraph may be dismissed as mere obfuscation).

I can think of no more damning indictment of his views than his comment that "to fetter the development of the work of academic departments by constraints concerned entirely with the manpower requirements of the Health Service would be a damaging restriction of their freedom and of their obligations." As "manpower requirements" could read "career prospects for trainee specialists" he displays a reprehensibly dismissive attitude to the relevance of the underling. If the work of academic departments is of such enormous importance, then it should be accommodated by an expansion of career, not training grades.

The universities are naturally reluctant to countenance restrictions on their empires, but control of manpower is essential, being a sine qua non for proper staff structure and career planning. They, like the NHS, must move to a situation in which the numbers in training are reduced to a level which gives reasonable career prospects, the resulting extra service work being done by expanded service grades. The Central Manpower Committee is the appropriate instrument, though it will obviously require minor modification to allow the universities to be represented when their posts fall within its remit.

TOM MCFARLANE

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Private beds in Westminster area

SIR,—The St Marylebone Division is concerned about the availability of private beds in the Westminster area for routine and emergency patients. With the closure of private beds within NHS hospitals and the influx of foreign patients to Harley Street there would appear to be a problem. We would be pleased to hear from any consultant or private family doctor who has experienced such difficulty.

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Correction

Immunisation of adults against diphtheria

In the letter from Dr R Mitchell and Mr A Barr (11 November, p 1371) the sentence beginning on the 22nd line should have read: "In this second series we found that only 4·9% of donors had antitoxin levels over 0·1 IU/ml and only 0·58% over 2·0 IU/ml."

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