theless, it is encouraging to see that there are at least a few consultants who recognise that the senior registrar grade should be abolished and that the present system of choosing colleagues to be appointed consultants is blatantly unfair.

HAYDN DIDIER

Bedford

[1] Browse N, *World Med* 1981;**16**(1):21-2.

SIR,—Mr J J Shipman's letter (14 March, p 907) is a welcome piece of flotsam on the tide of irrationality that threatens to drown good medicine. I would particularly agree with his views on research at registrar/senior registrar level. These grades are training posts, enabling potential consultants to become competent at dealing with the clinical problems with which they will be presented. Such training should obviously include reading current literature and acquiring modern knowledge.

Research, however, does not further such knowledge. On the contrary, the very considerable time required for research detracts from the time which could be spent gaining more practical experience. Moreover, the majority of doctors do not make good researchers, their basic training being very different from that of the pure scientist. No one, of course, would deny that important developments have resulted from clinical research. But it is equally undeniable that many papers in current journals are never going to be of relevance to any patient. Good research is of incontrovertible value, but it should be controlled and kept in its place, which is, in general, in the hands of the universities. Consultants can, of course, do research if they wish, as a treat.

Few doctors would be so naive as to believe that the publication of papers is in any way related to the clinical ability of a potential consultant. Despite this, the present vogue is to publish at all costs. The resultant annual volume of irrelevances is enormous. Registrars scurry hither and thither, amassing data. I do not suppose that they themselves believe in the usefulness of such labours. So why do they do it? Simply because at interview they will be armed with a list of publications—the longer the better. The basic fault lies not with them but with the interviewers, scrutinising the application forms, recognising the futility of the majority of publications, yet frequently appointing the pseudoresearcher in preference to the trained clinician. Yet, at the end of the day, the duty of the doctor is to treat his patients.

I hope Mr Shipman and those of his colleagues who agree with him (and I suspect that they may be many) will stick to their guns at interview time. If ever I face him across the green table, I hope he will allow me on his raft: I promise that it will not capsize with the weight of my papers.

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Consultants' milage and car allowances

SIR,—Fife Division was delighted to see its resolution in favour of more realistic car allowances adopted at the 1980 Annual Representatives Meeting. Our negotiators are to be congratulated on their achievements in this field so far, but there are a few more furrows to plough.

As ever, the DHSS insists on placing the emphasis on a minimum milage, ignoring the frequency (or regularity) of callout and ignoring the degree of urgency with which the consultant may be summoned. Consider the example of an anaesthetist who lives a mile from his base hospital and who has no junior staff. When on call, he may be required within the life-saving four minutes of a cardiac arrest. Yet 50 such calls a month would not rate him an essential user, still less a regular user.

The scheme for car purchase loans at Treasury rates of interest, while welcome for those newly appointed, rules out the established consultant. Here again, the gift looks better in its box than when unwrapped, for many garages offer hire purchase terms ranging from 10% to 0% per year.

One short-term answer is to buy a diesel-engine car. My own car qualifies for the maximum rate milage allowance but will do 33 miles (nearly 56 km) per gallon on very short journeys around town. It has other advantages: diesel fuel contains no lead and combustion is so efficient as to emit only 0·5% carbon monoxide, as compared with 3-5% for a petrol engine. Furthermore, diesel fuel is cheaper than petrol on the motorways and on the Continent. Meantime, while we await further results from our negotiators a look of insufferable piety is worn by yours sincerely.

JOHN DUNCAN
Honorary Secretary, Fife Division BMA

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Backdated rent increases for hospital doctors

SIR,—I wish to record in your columns my complete dissatisfaction at the way in which my "interests" have been served by the BMA.

I have a non-resident post with no on-call liabilities (and only occasional out-of-hours duties on Saturdays) in a hospital 60 miles from my home and until recently I occupied a room at the hospital during the week because it was marginally cheaper than commuting every day. On 9 January I first saw the DHSS circular No MDE/3/1 (10 December 1980), which reported a rent increase of nearly 50%, which was to be backdated to April 1980. My first reaction was one of incredulity—surely no landlord can backdate a rent increase?

My defence society agreed with me at first, but has now decided that there is nothing it can do as the BMA approved the increase. I am faced with a bill for nine months' rent arrears amounting to almost £200. It is now less expensive to commute and I have given up the room, but unfortunately I cannot backdate my decision.

S MILLERSHIP

Chelmsford, Essex

**The Secretary writes: "The recently announced increases in rents for hospital residential accommodation were the first increases since 1 April 1979. The reason for the delay in implementing new rates, and the consequent large backdated increase faced by some resident doctors, is that protracted negotiations took place between DHSS and the Hospital Junior Staff Committee negotiators to restructure the resident charges scheme. The aim of the negotiators was to benefit, for the future, those hospital doctors who have little choice but to occupy hospital resident accommodation. Resident doctors on rotas of up to one in three receive free accommodation, and those on one-in-four rotas pay far less under the new scheme. Doctors on one-in-five rotas are marginally worse off. It is the doctors on larger rotas who choose to occupy hospital accommodation who have been faced with the larger increases."—ED, *BMJ*.

Health services research

SIR,—Your otherwise excellent leading article on health services research (14 March, p 845) neglects one trifling matter—namely, health services research undertaken by clinicians, community physicians, and other staff of health authorities within the NHS. Not all biomedical or clinical research is done in research units and university departments by a long chalk; NHS clinicians make a major contribution. So also with service research. Health authority staff may indeed be best placed to undertake it, often by the reorganisation of their services in a way which makes scientific evaluation possible and often without recourse to soft monies. They are in the applied business.

I should like to suggest that health authorities could provide the key which unlocks the problem of developing health services research. The Government's policy of decentralisation and diversity should encourage this to happen. Professional research-committee men might not.

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SIR,—Your leading article 14 March (p 845) continues to perpetuate misunderstandings about the role of the Medical Research Council in health services research which the letter from Professor A J Buller and myself (7 March, p 820) was designed to dispel. To recite "the dangers of shifting the initiative in the commissioning of policy-related research substantially from the health departments to the research councils" is an exercise in fiction: the MRC does not propose now or in the future to place commissions for health services research with anyone. Along with other possible contractors we will *accept* commissions from the health departments if we have the capability to carry them out. The MRC hopes that its modest expansion of activity in health services research, which will be funded from its own share of the Science Vote, will enable it to become a more useful contractor for the health departments in the future.

May I emphasise again that the new agreement with the health departments has not resulted in the transfer to the MRC of any funds at present employed by the departments to undertake health services research or in a request that we take over from the departments any of their responsibilities for policy in this field? The only change is that the Medical Research Council will allot, within five years, up to £2m extra annually for the "research community" you speak of in your editorial to spend in this field—something I thought that it would have welcomed. This extra money will be made available as commitments in other fields fall in.

J L GOWANS
Secretary

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