It is evident that Dr. Ashworth is referring to a city (πόλις) or outpatients' clinic that is headed by consultants, a "policlinic" (in Swedish, as in German, "poliklinik"), and not to a clinic for the diagnosis and treatment of diseases of many (or all) kinds (πολύς, κλίνη). Nowadays, if not quite in Jonathan Hutchinson's time (vide the dictionary, which quotes his definition), the name "polyclinic" would suggest a general practitioner's surgery or dispensary; and, since no practitioner or group of practitioners is likely to have any use for it, should we not ban it? And should we not resist any move to call an outpatients' department a "policlinic"? If we wished to confound patients and staff alike and upset *The Times*, as Jonathan Hutchinson did (vide the dictionary's quotation from the issue of 16 December, 1898), we could of course call that part of it staffed by resident or junior doctors whose duty it is to send patients to the appropriate part of the "policlinic" a "polyclinic." It might then seem odd to *The Times* that titles, whatever they have "come to denote," should be chosen which suggest that the sick rise from their various beds in order to occupy a communal one provided by the city.—I am, etc.,

Peppermint Grove, Western Australia. GERALD C. MOSS

REFERENCE

[1] *A New English Dictionary*, 1909, ed. J. A. H. Murray, Oxford.

Local Government Reform and the Health Services

SIR,—Since Miss Elizabeth Burney's article (1 July, p. 41) I have been scanning the columns of your journal in order to see if any of my colleagues in the public health service, whom I felt sure would be able to draft a far better letter than I could do myself, had seen fit to reply. After an interval of three weeks a letter has at last appeared, from the pen of Dr. P. O. Nicholas, of Bolton (22 July, p. 239), and I can only endorse the general tenor of his remarks.

When one has spent a not inconsiderable proportion of one's own, albeit relatively short, medical lifetime in acquiring experience and knowledge in order to be the better able to administer the community health services, one does indeed wonder who are these "others" who are going to guide these selfsame services.

I would venture to say that many of my colleagues, who have been similarly engaged in the same pursuits as myself, would seriously question the soundness of further fragmenting these services and the suitability of anyone else to run them in a sufficiently realistic and understanding manner.—I am, etc.,

Shire Hall, Cambridge. PETER SYLVESTER.

Annual Representative Meeting

SIR,—May I endorse Dr. J. D. Shapland's letter concerning the Annual Representative Meeting? It is deplorable that a limited number of "microphone hogs" were allowed to take up the time of the A.R.M. over details which should have been thrashed out elsewhere. This sort of thing has been progressively more noticeable over a number of years, and I am disgusted at the way hospital matters are rushed through in the last hours of the meeting. What hope is there of getting a better deal for hospital doctors? As far as I am concerned the A.R.M. has fallen into disrepute and only drastic reforms will restore its reputation.—I am, etc.,

Epsom District Hospital, Epsom, Surrey. E. N. CALLUM.

***The Secretary of the B.M.A. states: The Chairman of the Central Committee for Hospital Medical Services has decided to call a special meeting of his Committee in order to debate the motions under "Hospital and Consultant Services" which were not debated at the A.R.M. at Bristol. The Divisions that proposed the motions will be invited to send representatives to the meeting.—ED., *B.M.J.*

Degrees of Seniority

SIR,—Senior hospital medical officers will welcome the news that the Central Consultants and Specialists Committee has agreed to support the resolution from the S.H.M.O. Group Executive Committee that in the event of any future pay award to medical assistants the existing differential between the salary scales of the S.H.M.O. grade and the medical assistant grade should be maintained (*Supplement*, 15 July, p. 67).

The reason for this resolution should be made clear—namely, that senior hospital medical officers are recognized as of senior status with duties and responsibilities above those of medical assistants, the latter being responsible to named consultants and of intermediate grade (H.M. (67) 26).—I am, etc.,

NORMAN V. WILLIAMS.

Cefn Mably Hospital, St. Mellons, Nr. Cardiff.

B.M.A. as a Negotiating Body

SIR,—The Representative Body at Bristol debated for two hours on Saturday morning, 8 July, a dispute with the Junior Hospital Doctors Association (22 July, *Supplement*, p. 69). It was revealed in the debate that the J.H.D.A. had previously published actionable matter about B.M.A. negotiations, but neither had action been taken against the J.H.D.A., nor, apparently, had the J.H.D.A. been warned about the effect repetition would have on future negotiations.

Now, if the B.M.A. is going to speak to outside bodies, and subsequently negotiate on their behalf, then surely it must establish a code of conduct as a prologue to any such negotiations. If outside bodies are going to use B.M.A. personnel and their resources to help achieve a common objective then the B.M.A. is entitled to, and indeed must, place some restriction on published criticism for the duration of the negotiations.

It was ironical that on Monday, 10 July, the Representative Body should have voted heavily against having non-B.M.A. members on regional councils. The R.B. thus refused to give these non-members the advantages of the resources of the B.M.A. Yet it would appear that what they had refused to do at regional level was already being done with the J.H.D.A. centrally, at the highest level, even to the extent of negotiating on their behalf with the Minister. The status of these negotiations with the J.H.D.A. needs defining.

I do not advocate that the B.M.A. should refuse to negotiate with and on behalf of outside bodies, but I do believe that outside bodies must first recognize their responsibilities towards the B.M.A. in terms of their own behaviour and publications.—I am, etc.,

Leeds. JOHN D. SINSON.

Radio Communication and the G.P.

SIR,—I was surprised that in the interesting article "Radio Communication and the Emergency Department" (15 July, p. 170) by Dr. M. H. Hall and Mr. R. S. Garden there was no mention of a link with the general-practitioner service. More and more family doctors like myself are availing themselves of the great help of a radio transceiver in their cars. This is particularly true in areas where the Emergency Treatment Service is active.

It would be of benefit to general practitioner and hospital alike if there was a means of communicating with the hospital directly from the general practitioner's car. In many hospitals there is a relay unit for direct communication with the ambulance service. It would be easy to adapt this system to communicate with the family doctor, except for the fact that the frequencies used are usually too dissimilar.

It is hoped that the committee considering the equipment of the ambulance service, and bodies controlling other medical radio links, will bear in mind the general practitioner and his needs in this connexion.—I am, etc.,

Glasgow. KENNETH HARDEN.

Points from Letters

Opportunities in British Medicine

Dr. D. C. G. BETT (Farnborough Hospital, Kent) writes: I see in your issue of 15 July (p. 128) that the Ministry of Health intends to send a team to North America to try to persuade British doctors there to return home.

I think many of us still in Britain would be interested to know what this team is going to say to these expatriates. We have listened to many fine words from the Ministry, but when these have been translated into actual practice the result is usually very far short of the original promise. If Dr. R. H. Barrett and his colleagues have anything real, which is likely to attract doctors back to Britain, I feel that the good news might be made public now.

Casualty Department—or G.P. Service?

Mr E. P. ABSON (Ryde, Isle of Wight) writes: It is circumstances and not the diagnosis which determines attendance, and the casualty department must be capable of dealing with the immediate needs in many different specialties (1 July, p. 46). Well over 50% of the work and the main responsibility are in making the diagnosis, and, more difficult and important, eliminating more serious diagnoses over a wider spectrum. A man who has fallen 50 ft. (15 m.), and (if the "missed injury" is not to be missed) any case of general trauma, requires full examination and perhaps observation, even though the final conclusion may be "bruise—no treatment."

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