Dr. Herford has in mind,[2] upon which I cannot comment because I see little of them in my own work. Supplementing these examinations there should be facilities for remedial exercises, where indicated, and for proper midday feeding for all in this age group. In order to test out such ideas, would it not be possible to run some pilot schemes in which the results in all-round well-being after two years could be compared with those of areas where matters are allowed to proceed as at present ?—I am, etc.,

R. Y. TAYLOR.

Yeovil, Somerset.

REFERENCES

[1] Taylor, R. Y., *Publ. Hlth (Lond.)*, 1966, **80**, 146.
[2] Herford, M. E. M., ibid., 1962, **76**, 283.

Consultant Distinction Awards

SIR,—Dr. T. Manners (4 November, p. p. 298) highlights one of the greatest problems facing the hospital service today. The tendency of the present Review Body to extend the scope of the distinction award system inevitably means that it is regarded as part of the consultant's essential salary structure. This also means that the very substantial number of consultants who will never receive an award, many of whom have little or no private practice today, will, unless some considerable changes are made, remain with few exceptions the lowest paid of all senior doctors both in the hospital service and in general practice.

This state of affairs creates two fundamental problems. It ensures that the consultant who works hard to provide the best possible National Health service to his patients goes unrewarded, whereas his colleague who works less hard inevitably develops waiting-lists, and so patients, in desperation, begin to come to him privately. This in turn leads to less time being available for hospital work and more work falling on the shoulders of junior staff. Thus does the reward increase as the contribution to the National Health Service decreases. The second great problem concerns the integration of general practitioners into the hospital service. As one who for years has supported this policy in the form of clinical assistantships and the smaller cottage-type hospital I was delighted to see that the Scottish Working Party[1] advocates its extension. They foresee that the disparity between the rewards of general practice and the basic salaries of the hospital service will prevent many general practitioners from taking on hospital commitments. On the other hand, if the medical assistant salary is increased to the point where it competes with general practice, not only the registrar but also the consultant will find that his session earns him less than his assistant.

The distinction awards can never overcome these fundamental problems, and unless the Government and Review Body realize their importance and put forward definite proposals for surmounting them the next 15 years may be remembered as a period of rising waiting-lists and a constant move towards private practice, to the lasting detriment of a hospital service the great achievement of which has been to provide for the less fortunate members of our society a standard of medical care unequalled throughout the world. No Government, and least of all a Socialist Government, should allow anything to imperil it.—I am, etc.,

Princess Margaret Hospital, Swindon, Wilts. K. D. CROW.

REFERENCE

[1] *Organization of the Medical Work in the Hospital Service in Scotland*, 1967, H.M.S.O.

Countersigning of Forms

SIR,—After a long and distressing illness a patient of mine died last month of carcinoma of the bronchus. The appropriate form for a night visit (E.C. 81a) was sent to me by the Southern Relief Service, having been signed by their doctor but not by the patient's widow. I cannot bring myself to debase my profession by taking this form round to the house of my deceased patient at the time of his widow's grief. For this reason I am sending the form to the executive council in its present state.

I feel the larger issue of having similar forms countersigned at all is a source of deep concern and dissatisfaction to all members of the medical profession.—I am, etc.,

Wallington, Surrey. C. R. NUNAN.

Approval of Emergency Treatment Service

SIR,—Your correspondent Dr. A. Dowling (25 November, p. 490) attempts to defend the Emergency Treatment Service and suggests medico-political influences as the reason for its "non-starter" status in London.

I would like to question whether there is any real need of the service at all in a well-organized general-practitioner service. Surely in most towns (at least of the size where E.T.S. operates) it should be possible for doctors to organize themselves in efficient practices with four to five partners and thus ensure about one night on in four. Is that asking too much ? And also are doctors really happy about State Registered Nurses answering the phone ?

There is a lot of emotional talk about whole patient care and responsibility for one's patients, but if one of a group of general practitioners cannot be on call to deal with one of their patient's acute appendicitis, cardiac asthma, or simply answer a pertinent question are those doctors really providing a service in keeping with the tradition of good family doctoring ? The answer is "no," and as soon as doctors do something about making their services efficient the sooner will schemes such as E.T.S. wither and patients will be much more satisfied.—I am, etc.,

London S.W.17. PETER FITT.

Educating the Public

SIR,—The Government, we are informed,[1] has agreed to continue with the "education of the public in the use of doctors' services," for which we must be grateful. However, I am sure that this has been used as an argument between our negotiators and the Ministry.

Surely, if they really wished to improve the lot of individual doctors, it would be much more efficient if they set aside a proportion of the sum they are now making available for leaflets, posters, and newsflashes for a grant to individual practitioners, who could then compose their own "notes for the guidance of patients," which, if approved, could be included with the medical card sent out by the executive councils. This is a practice which has been carried out for many years by our own very helpful council and caters for the vast variety between different practices.—I am, etc.,

Cambridge. GORDON SIMPSON.

REFERENCE

[1] *Ministry of Health Letter*, E.C.L. 90/67.

Simplifying Filing

SIR,—The world is getting rather full of paper and other records, such as radiographs. Especially in medical establishments there would seem to be a lack of system with regard to what to keep and what to throw away. As far as my experience reaches there is in practice a rather arbitrary custom of deciding that after x years documents must be discarded to make room for more recent ones. At this stage it is impracticable to sort them out as to their relative values, so they all go out together.

The following is a suggestion to allow documents to be marked when they are being dealt with in the first place in such a way that a clerk can go through them periodically and throw out those which have been marked with the relative lack of priority. As far as medical documents are concerned they seem to me to have four more or less separate values: Clinical "C"; Research "R"; Administrative "A"; and Litigious "L." The periods I suggest as being useful and not too numerous are 1, 3, 10, 30, and 100 years, combining these in a diagram or table:

	Yrs	1	3	10	30	100
	C					
	R					
Date	A					
	L					

If this diagram is stamped on relevant documents it is easy when reporting on or filing the document to tick the relevant "boxes" to indicate conspicuously that a valuable report or radiograph should not be thrown away before a less valuable one. Presumably the "C" and "R" lines would be the responsibility of the consultant and the "A" and "L" lines would be the responsibility of the hospital secretary. And the whole would give a clear indication for discarding, retaining, or reassessing.

At this stage I will not enter into a lengthy discussion ; that will be more fitting when the C.R.A.L. has been tried out in practice. This is merely a preliminary notice.—I am, etc.,

Halstead, Essex. W. A. L. COLLIER.