delineation and variegated content to relate to identified and comprehensible units therein. This, to me, must ease essential co-operation and exchange of intelligence within the umbrella of services to which a patient is surely entitled—services which continue to bear an artificial distinction between "health" and "welfare"—and must also potentiate the emergence of community-orientated and general-hospital-contained psychiatric facilities.

Of course the theme can be carried to absurd conclusions and I would join Dr Spencer in deploring disturbance of long-stay patients in any move towards achieving sectorisation. This should not blind us, however, to the many benefits inherent in the concept, benefits which are evident in the many psychiatric hospitals wherein such a change in organisation has been pursued.

M SACKWOOD

Northern Regional Health Authority,
Newcastle upon Tyne

SIR,—May I present the other side of the coin to Dr D A Spencer's recommendation (4 October, p 39) to leave well alone in large "subnormal" hospitals and not to designate particular wards to serve specific areas as recommended in Command Paper 4683 (1971) "Better Services for the Mentally Handicapped"?

Since sectorisation one multidisciplinary team is responsible for the in- and out-patient services for the mentally handicapped of a population of about 200 000. Our previously rather cosy, inward-looking attitude was considerably changed when the team was made responsible for coping with the pressure of a geographically defined waiting list. We have had to face up to the fact that we have to admit multiply handicapped high-dependency patients and discharge low-dependency old friends into hostels, etc.

Wards had to be refurbished and historic hangovers like the one that all mentally handicapped need medical and nursing care "from the cradle to the grave" had to be overcome—not a very popular notion in some quarters. However, sectorisation reaped rewards. We now have "five-day" patients, who go home on a Friday night, and "day-only" patients in our wards. Each ward has two short-term-care places all year round and transport problems have been eased. All this had the beneficial effect of greatly reducing the separation between in- and out-patients.

Sector meetings, attended by representatives of family doctors and by area social workers, have considerably helped to make a better use of our still rather inadequate facilities.

RUDOLPH PAYNE

Little Plumstead Hospital,
Norwich

Mobility for the disabled

SIR,—Many of your readers will have read in the press about the new mobility allowance to be introduced by the Department of Health and Social Security at the beginning of 1976. However, they may not have realised that for some classes of disabled person urgent action is necessary if their rights are to be preserved.

At present disabled persons eligible for assistance with personal transport (that is, an invalid three-wheeler or a private car allowance) are split into three groups. The first two groups cover severely disabled persons who are unable or virtually unable to walk and the third group covers the less severely disabled who need a vehicle to go to and from work. While the majority, if not all, of the people in the first two groups will continue to be entitled to help, no new applications in the third group will be considered after the end of this year. Thus any patients who qualify in the third group but have not yet applied for help must apply without delay.

At present four-wheel cars are issued to disabled haemophiliacs, related disabled people living in the same household, and disabled parents of young children. Again, from the end of this year no new applications will be considered for the issue of four-wheel cars except from war pensioners. Thus any patients in these categories who have not already applied for help must do so without delay.

The Disabled Drivers' Association is doing its utmost to advise anybody who may be affected by these new regulations, but only with the co-operation of the medical profession can we hope to contact the vast numbers we believe are involved. In addition, we are organising a mass lobby of members of Parliament later this year to press for changes in the totally inadequate provisions of the new mobility allowance and would hope that these ridiculous anomalies can be avoided. Is the disabled mother to be forced back to carrying her children in her three-wheeler? Is the disabled haemophiliac to return to suffering haemorrhages while driving the three-wheeler?

Should any of your readers require any further information or assistance this association will always be pleased to assist.

DOUGLAS A CAMPBELL

Chairman,
Disabled Drivers' Association

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Junior hospital staff contract

SIR,—We are compelled to write to you over the results of the recently negotiated junior hospital doctor contract as we feel that once again Government has taken advantage of the usual political naivety of doctors as a body to secure advantages for Government as an employer while making little or nothing in the way of concessions. When the proposed 40-hour week was first proclaimed earlier this year as having been accepted by the Secretary of State to the Department of Health and Social Security in principle many of us felt that perhaps at last junior hospital doctors were to get a more realistic recognition of the work load covered by us and the overall responsibility of our work. The BMA considered this to be an improvement, and even when the Review Body reported in September the Association was reported to have welcomed its findings notwithstanding the fact that one-third of all junior hospital doctors will lose income at a stroke.

Things are even more serious when one realises that the 30% who will lose income are largely taken from the more senior ranks of junior hospital doctors—those already

committed to hospital medicine—the registrars and the senior registrars who provide considerable skill and expertise and have higher qualifications. This is the group most significantly hit, as a lot of these provide on-call cover and frequently give advice over the telephone, yet not always being required on the spot in hospital to manage a problem. While the purists may argue that being on call merely involves being on the end of a telephone, it none the less severely restricts one's activities.

To come to the more detailed criticism of the new contract proposed by the DHSS, we must at once concede its similarity to the curate's egg and briefly deal with the good parts. It provides a written statement of where and how long the junior hospital doctor is expected to work and more specific details of the hospital he is to be employed at than hitherto. It seeks to define his working week in terms of hours rather than define his minimum off-duty periods, a point of some importance when considering, for example, application for extra payment for working "unsocial hours."

However, far from obtaining a 40-hour week we are worse off than before and the doctor now on call or working alternate nights immediately finds that from being entitled to two nights off in three he now is *contractually obliged* to work alternate nights, surely a far worse situation than obtained previously. Also, far from being paid extra for hours worked over 40 per week, he donates four hours for nothing before receiving any salary supplement. Should a colleague on the same firm be absent there is no longer the financial disincentive to his employing authority not to find locum cover—he will now no doubt be expected to provide his services free in covering the absent colleague.

We have already alluded to the loss of salary to be expected by one junior hospital doctor in three. If one analyses the pay levels offered for the commitment over 40 hours one finds that the doctor is to be paid at 30% of his normal rate for extra hours worked and 10% for an on-call commitment. For example, for a senior registrar on mid scale the hourly rate to be paid for working rather than being on call is approximately 85p—less than a hospital technician gets paid for ordinary hours from nine to five and less than the hospital cleaners get paid for their overtime. This for a highly qualified professional person with responsibility for patients' lives and welfare. At 28p per hour for being on call we consider that our spare time can be more profitably spent and would gladly forgo this insulting payment and be able to travel away from the restrictive call of the telephone.

We were originally led to believe that should the new contract be unacceptable, then we should have the option of retaining the present one and continuing with the present system. This option has apparently been removed in typical DHSS high-handed fashion.

Sir, recent developments call into question yet again the competence of the BMA as a negotiating team and the value to the profession of the Review Body as an independent assessor for professional status. The fact that some 28 years after the inception of the National Health Service the hospital doctors—junior and senior—are among the worst off in terms of conditions of service and salary levels vis-à-vis equivalent non-medical professional groups is sure testimony to the gross inefficiency of our negotiators over the years. Recent Review Body awards, falling immediately into line with the thinking of the government of the day, provide convincing proof that the Review Body is not independent and surely there is sufficient evidence to dispense finally with this charade. Indeed, a previous Review Body chairman felt sufficiently strongly on the issue of independence to resign rather than accept the Orwellian double-talk and hypocrisy of it all.