district units and community services develop.

Finally, as to training and recruitment, the experience in our region should reassure Drs. Bleden and Price. Several general hospital units train most successfully their psychiatric nurses in conjunction with neighbouring mental hospitals. Many psychiatric nurses proceed with their training in the general hospital to ultimately reach the top of the Salmon ladder. It is somewhat disconcerting that most severe criticism of our regional policy comes from people who have never worked here.—We are, etc.,

JAN T. LEYBERG
MARION E. MACKAY

Department of Psychiatry,
John Mackay Clinic,
Bolton District General Hospital,
Bolton, Lancs

¹ Leyberg, J. T., *Lancet*, 1959, 2, 282.

² National Health Service, *The Report of the Committee of Inquiry into Whittingham Hospital*, London, H.M.S.O., 1972.

³ Leyberg, J. T., *British Hospital Journal and Social Services Review*, 1969, 79, 2189.

⁴ Department of Health and Social Security, *Hospital Services for the Mentally Ill*, London, H.M.S.O., 1971.

Revised Regulations for G.P.s

SIR,—With reference the report of the General Medical Services Committee of 13 April (*Supplement*, 29 April, p. 40) other comments on the revised regulations and terms of service for N.H.S. general practitioners were made but not reported.

For the G.M.S. Committee to ask the Conference of Representatives of L.M.C.S. to accept revised or recast regulations this year is, to my mind, an error of judgement. Such amendments can hardly be described as minor—for instance, the removal of patient responsibility from the independent contractor general practitioner if he is in hospital suffering from a cardiovascular accident. In fact the proposed recasting so alters the original contract (E.C.16) signed by general practitioners as to warrant a fresh signature from each principal.

We have waited six years for these revisions, so why not wait till 1973 when we will know the new deal before we accept and sign again? Some will say that the signed contracts will be transferred by statute to the new area health authority, but why agree to the rules before we see what the new game is going to be? As one who has worked for years to further the concept of a new unified and rationalized National Health Service, and one who has always questioned the so-called "independence" of the independent contractor, I now marvel at the advice of my colleagues on the G.M.S. Committee to local medical committees.

Many younger principles while accepting the status quo until 1974 may have in mind a choice of contracts thereafter, such as a part-time (say, 9/11ths) contract of service on a sessional basis, like our consultant colleagues. Furthermore, it may well be that many general practitioners interested in medicopolitics, realizing the need for their active participation on some of the many committees that will be needed in the management of the new Service, will not be prepared to enter into a contractual obligation for service for 365 days in every year.—I am, etc.,

G. MURRAY JONES

Caerphilly, Glam

G.M.C. Annual Retention Fee

SIR,—I have just received a charming letter from Lord Cohen of Birkenhead in which he blithely tells me that the annual retention fee has been increased from £2 to £5 from 1 May 1972, and that the British Medical Association offered no objection to the proposed increase. This is an increase of 150%, an enormous increase even in these inflationary days. Who can foretell the time when it will be increased to £7.50, to £10, to £12.50, with no foreseeable limit? The escalation is inevitable.

I am totally opposed to the principle that members of the profession should be forced—yes, forced—to pay the ever-increasing expenses of the General Medical Council. Nevertheless, last year you very kindly published a letter from me (8 May 1971, p. 342) in which I suggested a compromise. I suggested that those functions of the G.M.C. which are specifically designed to protect the public should be paid for by the public through public funds. This would at least lighten the financial burden on registered members of the profession. My suggestion did not appear to arouse a flicker of interest anywhere. Certainly there were no follow-up letters published in your columns, nor did the Durham Division of the B.M.A. seem to be interested. I put the suggestion forward again, in the hope that it will be accepted before it is too late.—I am, etc.,

PETER WADDINGTON

Durham

Hospital Staffing

SIR,—Correspondence on this subject, which was opened by Dr. Mary M. Anderson and others (19 February, p. 511) has highlighted some of the adverse effects of the recent staffing recommendations on the obstetrical and other services. In view of the current precarious position of many of our accident and emergency departments all over the country with regard to junior staffing I would like to draw attention to the effect that can be expected if the recommendations are implemented as they stand.

Ten years ago the subcommittee on accident and emergency services in its report¹ laid down certain minimum staffing norms for each major accident unit, and it also recommended concentrating the service to a smaller number of major centres which were to be strategically placed. Many subsequent papers and reports have only helped to reiterate these recommendations. For convenience I shall outline these staffing recommendations: consultants 3, intermediate grade (medical assistant, senior registrar, and registrar) 3; junior (S.H.O.) a requisite number (four or more).

Although these recommendations were endorsed by the Department of Health and Social Security of the day the implementation has been rather patchy, and 10 years later we find that a considerable number of our departments are still understaffed, though admittedly the service has now been more concentrated by reducing the number of functioning and viable departments from 800 to about 350. If we are to accept J. L. Kilgour's premise² that in 10 years' time we can expect a staffing ratio of three consultants to one specialist and two general professional trainees this would mean that in 10 years our already understaffed accident

and emergency departments will have precisely 50% of the present junior staff recommended by the Platt report. To any consultant who has been in active charge of such a department, such a staffing ratio must surely appear not only ludicrous but disastrous. It is difficult to understand the apparent complacency that exists regarding the prospects of our rendering an essential service to some 30% of the population of this land with these recommendations. The increased output of our medical schools even to the recommended proportions could almost entirely be absorbed by the existing 350 accident and emergency (casualty) departments all over the country. We will therefore continue to rely, as at present in our regional hospitals, on overseas graduates, who constitute 80-100% of the junior staff of many a provincial department.

It will probably be suggested that general practitioners will flock to the assistance on any such occasion, but some simple calculations will make it obvious what exactly this will mean. A normal general practitioner session is 3½ hours, and therefore at least six such sessions would be required to provide a 24-hour cover in each department at a cost of £42 per day. Translated in terms of a week and applied to all the 350 departments, we would require 4,700 sessions per week at a cost of £102,900. Admittedly, this figure could be halved if the burden were to be equally shared by the junior doctors and general practitioners, but the problem would still be difficult.

The ultimate burden of the problem will no doubt, as usual, be placed fairly and squarely on the shoulders of the consultants, regardless of whether they are orthopaedic surgeons, traumatologists, or casualty surgeons and we will be expected to produce an indefinite number of rabbits out of a limited number of hats.—I am, etc.,

G. I. B. DA COSTA

Shotley Bridge General Hospital,
Co. Durham

¹ Ministry of Health and Department of Health for Scotland, *Medical Staffing Structure in the Hospital Service*, London, H.M.S.O., 1961.

² Kilgour, J. L., *British Journal of Hospital Medicine*, July 1971, 18.

G.P.s in District Hospitals

SIR,—Within the constraints of brevity I would offer the following proposals for comment. General practitioners are fast approaching a state of training so far in advance of the 1948 pattern that they may well be expected to form a hierarchy. Community physicians may well expect to expand their role into health education and will necessarily overlap with postgraduate general practice training.

If, in addition, overseas groups withdraw their support the time would be ripe for senior practitioners to take charge of general multidisciplinary district general hospital firms, provided that the beds were allocated according to the local authority electoral rolls. Put another way, the hospital is necessarily part of the community and a senior practitioner might well expect to retain general clinical care of the patients in his practice area in their homes or in hospital.—I am, etc.,

PATRICK A. LAWRENCE

Oxford