were to be filled by a Nottingham graduate, then some students would have both their jobs within the area, others only one. At a recent meeting of the students in the year it was evident that, since many wish to have both their posts within this area and as a simple "one in, one out" policy would not fill all the vacancies, some sort of allocation system would need to operate.

We understand that several other medical schools which annually face this problem have allocation systems. We would be most grateful if anyone responsible for operating any allocation system would write to us directly, giving details of the method of use, timing, and staff/student acceptability of any system, so that we might decide upon an appropriate system for the Nottingham area.

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Staffing of accident and emergency departments

SIR,—I believe that I am the only doctor in Britain to have worked up through the grades from senior house officer to consultant level in "straight" accident and emergency service. If there are any other fellow sufferers I would like to hear from who are of any background. Advancement from clinical medical officer to senior clinical medical officer appears to be arbitrary and inconsistent from region to region. Properly organised training programmes are urgently needed. These must be interlinked with, and seen to be equivalent to, the hospital training grades so that a planned programme of training and advancement to clear career goals is apparent. For example, clinical medical officers might participate in the hospital service while hospital registrars rotate through the community services. Depending on interest, training, experience, and qualifications, they might then progress to senior clinical medical officer or senior registrar within a certain defined period.

(3) Prospects. Any change in the career structure should be based on the important principle that there should be no loss of the consultant grade to all who enter the training programme and pass the necessary higher qualifications, including the MRCP. A training scheme for paediatricians might then work both in the hospital and in the community or wholly in one of these spheres. It will obviously take time for such proposals to be implemented. Meantime, we strongly suggest that doctors already working in the community health services should become fully integrated into clinical departments at a grade consistent with their training, experience, and present duties. Generous grants and training allowances for doctors wishing to take advantage of further training opportunities would be necessary.

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Clinical medical officers

SIR,—Paediatricians are concerned about the delay in clarifying the administrative base and career structure of community health doctors (senior clinical medical officers and clinical medical officers). We can ill afford the loss of these skilled clinicians, the majority of whom work in the child health services. For many of these doctors the sense of insecurity engendered by reorganisation of the NHS in 1974 was partially alleviated by "waiting for Court", but conventions of this important document and the negative reaction to it have merely added a sense of disillusionment and further loss of morale.

At a recent meeting of the Central Committee on Child Health and Family Medicine, Dr J R Preston, chairman of the Working Party on Community Health Doctors, is reported to have said (7 October, p 1039): "We have now to decide whether health doctors are to move steadily in a direction compatible with the profession of community medicine or to head off elsewhere." We recognise the difficult task faced by this working party, but we believe that any solution must take account of the following points:

1. Clinical base. These doctors are clinicians and should become or remain members of the appropriate clinical department or division staffed by the hospital although their work may be wholly or partly in the community.

(2) Training. At present there are no specific training requirements and doctors enter this service from a wide variety of backgrounds. For many, advancement from clinical medical officer to senior clinical medical officer appears to be arbitrary and inconsistent from region to region. Properly organised training programmes are urgently needed. These must be interlinked with, and seen to be equivalent to, the hospital training grades so that a planned programme of training and advancement to clear career goals is apparent. For example, clinical medical officers might participate in the hospital service while hospital registrars rotate through the community services. Depending on interest, training, experience, and qualifications, they might then progress to senior clinical medical officer or senior registrar within a certain defined period.