announcement by the GMC that it is no longer to pay the legal costs of bringing doctors before the professional conduct committee will dismay those who had welcomed the process as fair, quick, and effective,[1] particularly since, compared with countries such as the United States, Australia, and Denmark, other official bodies in Britain have tackled the problem of research fraud less than resolutely—with no fewer than 12 of the 16 known miscreants having been dealt with through the GMC. What sort of message, then, is the GMC now sending to both the profession and the public about the change in its attitudes to a serious problem?

In a closed society such as exists in this country we are used to official bodies not having to justify their actions (typified by the GMC's spokesperson's comment that "the council does not discuss these decisions"[1]), even when, as in this case, the council was set up and continues to be funded by the profession. Despite this secrecy, however, I pose two questions. Firstly, does this decision mean that the GMC will continue to fund actions against doctors accused of other offences, such as adultery or alcoholism? And, secondly, was this decision debated by the full council, or taken by a subcommittee or even an individual officer or official? I think we should be told.

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1 Kingman S. GMC may not pay legal costs for investigating fraud. *BMJ* 1992;307:403-4. (14 August.)

GMC's annual report gives a poor impression

EDITOR,—The annual report of the General Medical Council was sent to all doctors this week.[1] This glossy document, with photographs of smiling president and chairpeople of committees, is presumably designed to show how open and forward looking the council has become. Unfortunately, this is belied by the figure relating to complaints received for the period 1 September 1991 to 31 August 1992. Of 499 complaints relating to doctors' personal behaviour that were considered, 86 (17%) got as far as the preliminary proceedings committee. By comparison of 697 complaints relating to medical treatment that were considered, 38 (5%) reached the same committee. The general public will have difficulty in avoiding the conclusion that the council is more concerned with doctors' personal conduct than with harm to patients.

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1 General Medical Council. *Annual report 1992*. London: GMC, 1993.

Thousands starving in Liberia

EDITOR,—Rightly your journal mentioned the desperate situation in Liberia.[1] Liberia is another example, like Bosnia and Somalia, of how the lack of reaction of the international community causes thousands of innocent civilians to die. The one year old embargo on the areas controlled by NPFL (National Patriotic Front of Liberia, one of the warring factions), still takes an increasing toll of human life. The war has displaced about a quarter of a million people from their homesteads. In June 1993, a rapid assessment by a team of Médecins sans Frontières revealed a famine situation. In 30 villages around the front line a group of 2280 children under 5 was assessed; 35% were suffering from severe kwashiorkor, but for security reasons a proper (random) nutritional survey could not be implemented.

These results justified and prompted immediate action. Feeding centres were started, and within two weeks 3000 children got therapeutic feeding. Yet, because of the embargo, indispensable food supplies could not be brought into the area. The embargo, sanctioned by the United Nations respresentative, apparently included humanitarian aid.

Médecins sans Frontières offers strictly neutral and impartial aid to victims of natural and manmade disasters. Free access to the area is a prerequisite for our activities. We managed to maintain a minimal, cross border "lifeline" from the Ivory Coast. Since the beginning of August a fragile peace agreement has been signed, giving hope for free access to the area. However, the result has been the opposite: the border is still kept closed as the arrival of UN observers is awaited, and even the cross border lifeline has now been blocked. Thousands of children are starving, but a convoy with food is halted at the border. We acknowledge political and military constraints in the conflict, but the international community should take up responsibility and offer immediate help.

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1 Godlee F. Thousands starving in Liberia's civil war. *BMJ* 1993;307:85. (10 July.)

The Calman report

Should lead to consultant based service

EDITOR,—Bruce Charlton's editorial on the service implications of the Calman report[1] leaves several points requiring clarification. Firstly, the notion that "Calman opens the door to a consultant led service" is incorrect. Our present system is undoubtedly consultant led. Calman, when taken in conjunction with the new deal and *Achieving a Balance*, leads us towards a consultant based service in which trainees are trained, with some service commitment, in an organised, continually assessed manner in an efficient time period. It does not say that registrars or trainee consultants, if that is what the new grade is to be called, will be supernumerary; on the contrary, most trainees would emphasise the importance of a degree of (supervised) service commitment.

The advantages of emergency care being undertaken by fully trained doctors and consistency of doctor seen in outpatient clinics are added to by even more important aspects: fewer inappropriate investigations (omitting those "just in case the boss wants it"); fewer admissions from casualty and general practitioners because the consultant has the knowledge and confidence to manage the case otherwise; and fewer returns to clinic "after six months" instead of a more appropriate discharge to the general practitioner. All these will reduce iatrogenic morbidity and costs to an ovestretched service.

The essential aspect, that the consultant retains clinical responsibility, is never negotiable. But it is vital that urgent negotiations on the administrative "blight" suffered by many consultants are begun, to deflect the excessive work load now being transferred to them. One area of possible assistance was highlighted by the Junior Doctors Committee in its submission to the Calman committee, suggesting a five stranded consultant contract; basic clinical responsibility with one or more of the following strands; research, management, teaching, and continuing medical education. The areas of team working and continuous periods of duty also need rapid reappraisal, looking at appropriate remuneration for the vast amount of unpaid work undertaken by consultants, aiming to make the job worthwhile once more.

The call for a fundamental review of consultant practices has for too long been left unheard. The profession must grasp this opportunity to improve its own prospects. It is vital of course that this transition is carefully and openly managed to allow the most appropriate use of resources and skills. Those in government also looking to reassess the consultant's role certainly have other, probably less palatable, goals in mind.

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1 Charlton BG. Service implications of the Calman report. *BMJ* 1993;307:338-9. (7 August.)

Service implications uncertain

EDITOR,—Bruce Charlton's crystal ball gazing at the service implications of the Calman report is inevitably based on conjecture but is none the less thought provoking.[1] There is almost universal agreement that the NHS requires significantly more consultants, but many remain cynical that the resources required to fund the necessary increase in consultant numbers will be provided. I would like to make four points in relation to Charlton's editorial.

Firstly, many higher specialist trainees are likely, for the benefit of their training, to continue to opt for contracts of 83 hours a week rather than 72 hours. Secondly, there is a difference between training becoming more formalised and the suggestion that "in effect registrars will become supernumerary." Just as flight simulators play a part in training, pilots still have to clock up several hundred hours of flying before their receive their pilot's licence. It is difficult to envisage how newly appointed consultants will be able to deal effectively with emergencies if they have been supernumerary for the previous five years.

Thirdly, I do not believe that there will be draconian reductions in the numbers of trainees. The suggestion quoted elsewhere that the number of higher specialist trainees will be reduced by 5/12 is naive. It assumes that training to be a consultant currently takes 12 years but in future will only take seven. Already, appointment to a consultant post in some specialties is closer to seven years of specialist training than to 12. Also, it is likely that only a handful of trainees will be appointed to a consultant post immediately after achieving their certificate of completion of specialist training. I suggest that the actual reduction in higher specialist trainees in the United Kingdom will be less than a fifth. Against that, there are currently several hundred overseas doctors waiting to benefit from the training posts that will become free.

Finally, the "intermediate tier" will not be lost. It is one of the fundamentals of *Achieving a Balance*. What many fail to recognise is that the safety net is for the benefit of patients, not the medical profession. In the acute specialties it is necessary to have a doctor of sufficient experience in that specialty in the hospital to be able to deal with emergency situations and, most important, to be able to recognise when a consultant opinion is required and when it is not.

At present the NHS is paying lip service to quality. Instead of publishing lists of how many outpatients are seen within half an hour of their appointment time, hospitals should be required to publish lists of the medical staffing of the acute specialties in each hospital and the grade of staff who are on call for emergencies in those specialties.

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1 Charlton BG. Service implications of the Calman report. *BMJ* 1993;307:338-9. (7 August.)