who were subsequently registered as congenital rubella cases (11 August, p 396). The Office of Health Economics estimated that between 200 and 250 children are born annually (in non-epidemic years) with congenital rubella syndrome.² After the 1978 epidemic, 1500-2000 rubella-damaged babies are expected to be born this year.³

An estimate of the cost of the care of a person living from 16 to 65 years of age in a Spastics Society home is £173 000 at present day costs. If loss of earnings is added at, say, £5 000 per annum, the total cost becomes £373 000. Clearly the costs vary with the degree of handicap. It is therefore against the background of this order of expense that one should evaluate a screening programme. However, I think it is debatable whether any screening programme should have to justify itself on the basis of economics alone.

Is, then, Dr Wilson questioning the habit of serotesting before vaccination? We know that rubella vaccine can be teratogenic, but this varies with the immune state of the mother at the time of vaccination, the gestational age of the fetus, and the type of vaccine used. One study⁴ of 65 seronegative women vaccinated in early pregnancy who went to term showed that all were delivered of normal babies. The study estimated the risk of major malformations to be less than 5.5%. However, doubts about the safety of the vaccine become irrelevant in a properly designed survey, which would exclude pregnant women at the time of vaccination and provide effective contraceptive advice for three months afterwards. A compromise may be the policy of taking and storing blood at the time of immunisation, testing it only if it is subsequently discovered that, inadvertently, the woman was pregnant. On the basis of the results, a therapeutic abortion may be advised.

Certainly a screening programme involving adult women is difficult and costly. Certainly the uptake rate will be less than 100% but I would not like to predict the 25% suggested. However, these are no reasons for abandoning the attempt to prevent some rubella-damaged children.

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¹ Wells, N, *Birth Impairments*, p 27. London, Office of Health Economics, 1978.

² *British Medical Journal*, 1978, 2, 1441.

³ Preblud, S R, et al, *British Medical Journal*, 1978, 2, 960.

Labetalol in severe tetanus

SIR,—We read with interest the reports of treatment with labetalol in tetanus (28 April, p 1121; 28 July, p 274), and wish to report our experience of continuous intravenous infusion of labetalol in a patient whose arrhythmias and hypertension persisted intermittently for three weeks.

A 70-year-old woman pricked her finger while gardening and the wound became infected. Trismus developed six days later and after a further two days she developed respiratory spasms and paroxysms of supraventricular tachycardia and hypertension. She was paralysed with intravenous pancuronium, ventilated, and sedated with large doses of diazepam and phenoperidine. Repeated intravenous boluses of propranolol were given in an attempt to control the episodes of tachycardia and hypertension. The next day an intravenous infusion of labetalol (1 mg/min) was begun but paroxysms of tachycardia continued. Four hours later she became hypotensive and oliguric but these features resolved when the labetalol was

stopped. The following day she had a sustained supraventricular tachycardia and hypertension, which persisted for four hours after labetalol infusion was recommenced. The infusion was continued for 10 days, during which time there were no episodes of tachycardia lasting more than 30 seconds. In the 10 days after labetalol was stopped the paroxysms of supraventricular tachycardia recurred, on average two or three times each day; but this period coincided with the time when the patient was being weaned off the ventilator and was receiving less sedation. These episodes were treated with intravenous boluses, initially of propranolol and later of verapamil, which appeared to be more effective than the propranolol.

The rapid fluctuations in arrhythmias and blood pressure which occur in tetanus make it difficult to assess the effects of sympathetic blocking drugs in this disease, because an apparent therapeutic response to an intravenous bolus may reflect spontaneous resolution. In this case, however, the episodes of supraventricular tachycardia were less frequent and less severe during labetalol infusion and recurred when the drug was stopped, although sedation was also decreased at this time. We conclude that labetalol infusion (1 mg/min) is unlikely to correct an established arrhythmia but may be useful in prophylaxis in severe tetanus. It is not, however, a substitute for adequate sedation and may cause hypotension initially.

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Emphyseus

SIR,—By chance, I came across the word emphyteusis in the *Shorter Oxford English Dictionary*. It has been known since 1618 and its literal meaning is implanting, the word in a legal term denoting "a perpetual right in a piece of another's land." I see no reason why this melodious word should not be adopted by cardiologists with reference to pacemakers. Only recently, after all, neurologists have appropriated the banking term deficit. The Greek equivalents of implant and implantee must be left to Hellenists.

I must declare my interest: I carry a pacemaker between my right pectoral muscles and the superficial integument. I would much prefer to be known by a soft Greek expression than by the ugly neologism implantee.

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Makerere University Medical School

SIR,—Many doctors throughout the world are concerned with the fate of this famous African medical school. My wife and I have just returned from a four-day visit to Makerere, where we were able to assess the present situation. Contrary to some rumours, the medical school has never ceased to function and has sustained its large student intake and heavy teaching programme. At the time of our visit some final examinations were being conducted with scrupulous attention to their organisation.

The enormous problems which have faced the medical school are by no means over, but this would seem to be an opportune time to

pay tribute to the university and hospital staff who have remained in Uganda, often at personal sacrifice, and have maintained high standards in such difficult conditions.

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Minor operations in general practice

SIR,—May I add to the correspondence that has followed Dr J S Brown's article (16 June, p 1609)? The problem I should like to highlight is the provision of the services of the central sterile supply department (CSSD).

I am denied free use of the CSSD for my minor surgery service because, according to my district administrator, it is DHSS policy that GPs will not be provided with sterile supplies. I can, however, be supplied with the CSSD facilities I require if I pay a recurring sterilisation charge for each pack. Therefore my partners and I are expected to pay for the privilege of reducing the surgical waiting list at our local hospital.

As Dr Brown's article has shown the cost-effectiveness of minor surgery within general practice, surely we should now be given some active help and encouragement to provide a service which benefits both the patient and the over-stretched hospital service.

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Functional budgeting

SIR,—I have only recently had brought to my attention the letter from Mr P J E Wilson (2 June, p 1485) on functional budgeting. Although you have published a reply to this from Messrs Todd and Worsley (21 July, p 213), I feel that as so many of Mr Wilson's arguments are inaccurate I should write to you as an officer at the "sharp end" who has a very satisfactory budgeting system in operation.

It grieves me to see that some consultants are still very suspicious of the concept of budgeting. I feel that this suspicion stems from an ignorance of why we must have this kind of system; the benefits that can accrue from it, both from the viewpoint of the budget holder and also from that of the management team; and the part that all staff can, and should, play in the control of expenditure—even medical staff. Mr Todd and Mr Worsley pointed out the salient argument that medical staff have it in their power to commit considerable resources—they put it at least 60%, but I would venture to suggest that the figure is much higher when we look at the total effects of patients being admitted to hospital, including catering, laundry, etc. Medical staff have through the ages felt that they should not be controlled over their expenditure and that they should have the divine right to spend whatever they wish.

We have had such a budgeting system in this district for over three years now. All managers are involved, including the medical staff. This involvement has been largely at their own request and I am sure that they would bear testimony to the fairness of the system and the benefits that they reap. As well as the service-providing specialties such

as pathology and radiology having budgets, we have also allocated budgets to some clinical specialties such as rheumatology and rehabilitation and radiotherapy and we are currently in discussion with each of the cog-wheel divisions on various aspects for which a budget could be issued.

Mr Wilson has raised a number of specific points and the following comments might answer some of them for him. (1) It is implicit that a budget holder should have full responsibility for his department, including hiring and firing. (2) We do not deter efficient understanding—in fact we positively encourage it by allowing the reuse of such savings by the saver. (3) In certain circumstances we allow underspendings to be carried forward from one year to the next. (4) I am not sure what Mr Wilson means by “supplementing the budget by non-statutory means”—I am intrigued. (5) When I wished to implement functional budgeting back in 1976 I did not do this unobtrusively. I convened a considerable number of meetings to discuss my proposals and always received a very favourable reaction. The psychology of budgeting is that unless you take all staff along with you it is doomed to failure. (6) We have nominated budget holders from the medical as well as the non-medical echelons and where a clinician is head of a department we have always nominated him, the “professional” head being the budget manager to deal with the budget on a day-to-day basis.

I could say so much more to Mr Wilson on budgeting and I think that I could convince him of the need for functional budgeting. I very much regret the negative attitude that he has taken, particularly in his final paragraph. As I said earlier, there is an absolute need to control NHS expenditure and that particularly includes the clinical expenditure. It is in areas such as drugs and medical supplies that we have traditionally had little control and this perhaps accounts for some of our current financial problems.

I urge Mr Wilson and his colleagues to support us in the control of our expenditure—we may not then need to consider cutting back on patient services.

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Royal Commission report

SIR,—Dr C J R Hart (11 August, p 392) asserts that “in health as in any other form of personal service, the true interests of the individual can never be protected and fostered by professional workers employed directly by the State.”

In the community the statement is insulting to such professional workers as health visitors, midwives, community nurses, physiotherapists, and—unless Dr Hart differentiates State and local authority employees—social workers and teachers. In the hospital service the statement insults every salaried professional from senior registrar to junior staff nurse and also insults such consultants (about two-fifths of the total) as have opted for full-time salaried posts.

Given rough parity of income there are at least some GPs who would prefer a fixed salary to a remuneration liable to fall if several large families leave the district or if a smaller

number of patients seek services outside the scope of the NHS. If we accept that salaried people, from High Court judges to hospital cleaners, are in general no less honest and conscientious than are people who obtain their income directly from those they serve (groups ranging from, for example, stock-brokers to domestic servants) what exactly is the objection to giving intending GPs the same choice as is afforded to prospective consultants—that is, making a choice between full-time salaried employment and work in which some or all of the remuneration is not directly from the State? Those who prefer capitation fees and other sources of income would still be free to make their selection.

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Alternatives for community physicians

SIR,—Many readers of Dr Jay Noren's paper (4 August, p 345) will feel that at least the first two of his alternatives for community medicine, abolition and substitution of clinicians, are synonymous with extinction of the specialty. But is this a representative view? Most of his sample of community physicians and others in related academic work appear to be far removed from day-to-day service with clinical colleagues, and only eight (including an unspecified number of clinicians on DMTs) were at district level.

The work of the former medical officer of health spanned more than a century. Among his achievements were the recognition and gradual abolition of adverse environmental factors, promotion of health of children and young people, and development of health education. Many have become distinguished community physicians, yet Dr Noren does not see prevention or health promotion within the community physician's function. In contrast, community physicians will welcome the emphasis on prevention in the report of the Royal Commission on the National Health Service.¹

Dr Noren has, however, correctly identified some of the current problems of community medicine—preoccupation with administration (also shown by Donaldson and Hall²), the inability to develop epidemiologically based studies because of lack of supporting staff, and the wastage of skilled manpower because of overspecialisation within the craft. All these difficulties have already been highlighted by community physicians themselves in the Duncan working party report³; and the Royal Commission also has stressed the importance of proper support.

The five years which have elapsed since NHS reorganisation have shown the deficiencies of the structure, but five years is a short time for a new specialty to evolve. In the period of reappraisal and readjustment which is approaching, opportunities to reshape community medicine to meet the needs of the NHS must not be lost. Departments of community medicine formed within health authorities must have their own budgets to ensure the adequate provision of supporting staff, and they should deploy the available community medicine manpower in the way best suited for local requirements. Management roles must be further clarified and strengthened if community medicine is to assist clinicians to develop their services and

achieve maximum benefit from resources. Finally, training objectives must be set to produce community physicians who are not only capable epidemiologists but who are also thoroughly familiar with the service needs of the NHS and with environmental problems.

Dr Noren's suggestion of “full power and authority for resource allocation” is likely to be overoptimistic; but, given adequate training, a workable structure, and sufficient support, community medicine could have a much more realistic influence on future decision making.

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¹ Royal Commission on the National Health Service, Report, Cmnd 7615. London, HMSO, 1979.

² Donaldson, R J, and Hall D J, *Community Medicine*, 1979, 1, 52.

³ *The State of Community Medicine*. Joint Working Party, London, British Medical Association and Faculty of Community Medicine, 1979.

CCHMS proposals

SIR,—It is with mixed feelings that I write concerning the CCHMS proposals (23 June, p 1730) on the existing consultant contract, outlined in the Linkman letter No 8. When I qualified I never contemplated having to argue about salary—certainly when I became a consultant I naively felt that my financial troubles were over.

During the past decade we have all seen the effects of that well-known Roman principle “Divide et impera”—so ably practised by Mrs Barbara Castle and now I believe by the CCHMS. We have seen general practitioner set against hospital doctor, junior against senior hospital doctor, and now full-time consultant against part-timer.

I do not believe that anyone will argue with the HCSA statement that equal work should command equal pay. However, when a consultant opts for a maximum part-time contract he is able to practise his skills in the marketplace to make up the two-elevenths of his salary denied to him by taking this option. I have always been, and always will be, a strong protagonist of private practice for those who wish to take this option, and the fact that a part-time colleague enjoys a much higher standard of living than myself has never before caused me or many of my full-time associates any concern whatever.

However, we now see that the CCHMS is trying to negotiate, without a mandate I may say, for major alterations to our existing contract, having failed utterly to procure a realistically priced work-sensitive contract. We see among other proposals that part-time consultants should be paid ten-elevenths of a full-time salary or, put another way, that they should be paid for one of the sessions during which they are unavailable for the NHS. I would like to question the right of the CCHMS to negotiate for one section of consultants vis-à-vis another.

Let us assume that a week consists of 11 working sessions, including Saturday morning, for most mortals who wish for any sort of family life. Most private practitioners would use two of these sessions for their practice in one way or another. It is reasonable to assume that during these two sessions he or she will not be available to the NHS for anything other than nominal cover. It is argued that the maximum part-time consultant devotes “substantially the whole of his time” to the NHS