remain our final (and indeed honourable) course of action.

I do believe that I can treat my patients better without the control of party dogma or an insensitive bureaucracy. The vital human need described by Professor Davis is not currently being met. We need extra resources, either from the Government or by allowing private medicine to contribute. If Government "in the national interest" decides that resources are not available, then we must be allowed to resign from the NHS and provide them ourselves.

The effect of Professor Davis's suggestion would be to remove this safeguard and make us totally dependent on the State or whichever cabal held the reigns of office.

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Manpower and GMC elections

SIR,—During this month we shall be electing medical colleagues to a newly constituted General Medical Council, the statutory responsibilities of which include the regulation of the training of doctors and the maintenance of high standards of medical practice throughout the entire country. As secretary of the Yorkshire Regional Manpower Committee I am particularly aware of the anomalies which currently exist regarding early postgraduate medical training and the disparity in the distribution of doctors throughout the country.

In respect of early postgraduate training and experience doctors are faced with the option of applying for entry to a general practitioner vocational training programme within eight or nine months of graduation from medical school, and, rightly or wrongly, they feel that their subsequent career is very much directed towards general practice. Is it right that we operate a system which forces this choice at such an early stage of post-graduate training? Would it not be more sensible to extend the period of uncommitted early professional training to enable doctors to gain training and practical experience in a wide range of disciplines before a choice of specific career is made? If this period of early professional training included the shortage specialties (radiology, anaesthesia, dermatology, and pathology) we would at least give doctors some experience in these specialties so that they can then exercise an informed choice regarding a specific career.

We must also give considerable thought to the distribution of medical manpower throughout the country. In particular, the distribution of senior registrars and registrars in the front line specialties (general surgery, anaesthesia, obstetrics and gynaecology, orthopaedics and trauma, and general medicine) leaves a great deal to be desired in terms of patient care on a national basis, as well as wasting the expertise and facilities which have become increasingly available in regional hospitals.

Undoubtedly the DHSS and the GMC will receive advice regarding manpower and its distribution from a number of sources, including the BMA and the royal colleges, but there can be no doubt that the GMC has a statutory responsibility for the training of doctors and the maintenance of high standards of medical practice on a national basis. The make-up of the new GMC is therefore of great importance, and in casting their votes during this month all doctors have a con-

siderable responsibility to ensure that those elected are experienced and interested enough to bear the national interest in mind.

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Pay-beds

SIR,—If our new Government really does wish the NHS to compete in the private sector through its pay-beds for additional revenue, it will have to ensure that both NHS staff and the general public fully appreciate the terms under which private practice operates in Britain and its financial implications to the NHS.

The position of the NHS consultant who sees private patients should be made clear, particularly in that he does no less work than any other consultant but does, however, relinquish 18% of his NHS salary in order to do additional private practice. This represents a saving to the NHS of some £2500 per year per such consultant and means that, as he must for financial considerations continue to see private patients, he must, in the absence of private facilities in the NHS, treat them entirely in independent hospitals outside the NHS.

It should be stressed that private patients in NHS hospitals are treated in addition to and not instead of NHS patients; that every pay-bed in a district general hospital has a revenue potential of £18 000 per year; and that those pay-beds which have already been withdrawn not only represent a financial loss to the NHS but are not used for extra NHS patients, being usually left empty or used as store rooms or as extra administrative offices.

In promoting the use of NHS pay-beds the Government should itself realise that NHS staff would be more enthusiastic about these if they could see direct benefit to their own hospitals resulting from the use of its pay-beds. If pay-bed revenue was spent in the same hospital where it was earned, and if much-needed equipment for the operating theatres, intensive care unit, x-ray department, and laboratories was so obtained in addition to long overdue decorating and even additional nursing staff, not only would the whole hospital and its NHS patients benefit enormously but one would find little support for the odd militant voice raised against pay-beds and those who would legitimately use them.

The Government might also consider backing up its professed policy in this direction by reducing pay-bed charges from their present penal level to a more realistic and competitive one. It might also reintroduce tax relief for provident health scheme subscribers and, at the same time, encourage these provident societies to provide cover for fees for essential services given to their subscribers by general practitioners—remembering that all societies insist on their subscribers being referred initially for consultant opinion by such general practitioners, who may also be required to validate the relevant claim form after completion of private treatment.

It is one thing for our new Government to announce somewhat vaguely that private practice is once again to be encouraged, but it remains to be seen what real action it intends to take in this direction. Meanwhile, the

independent hospital sector gains impetus, which can only be welcome news for the increasing numbers of the public who are interested in private treatment for themselves and their families.

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Sir Thomas Browne: appeal for St Peter Mancroft, Norwich

SIR,—To the many medical men throughout the world who are inspired by the life and writings of Sir Thomas Browne, his association with the Church of St Peter Mancroft, Norwich, will be well known. For 46 years he lived and practised from a house nearby the church where he and his family worshipped regularly. Sir Thomas Browne is buried in the church together with his wife, and their memorials are visited regularly by the many Sir Thomas Browne pilgrims to Norwich. It has been said of the altar of the church that it "linked Sir Thomas Browne's practice to his library and both of these to God."¹

Sir William Osler, whose devotion to Browne was unbounded, made a pilgrimage to St Peter Mancroft on his first visit to England. He was perturbed to find that the skull of his favourite author then lay on a dusty shelf in the museum of the Norfolk and Norwich Hospital and later provided a glass casket for the skull that in 1922 was reverently reinterred in St Peter Mancroft. Osler cared greatly for the church of St Peter Mancroft and was among the congregation when a memorial service was held there in 1905 as part of the celebrations to mark the tercentenary of Browne's birth.

Now this splendid mediaeval church is in urgent need of funds, both to restore and maintain its fabric and to expand its facilities by an imaginative plan of new building. The plans for this have been prepared by Robert Potter, FRIBA, who is responsible for the recent successful improvements to All Souls', Langham Place, and Surveyor to the Fabric of Saint Paul's Cathedral. It will be of interest to medical men that they include the conversion of the church's fifteenth century sacristy for a permanent display of the church's many historic items, including its memorabilia of Sir Thomas Browne.

£300 000 is required to meet the cost of the restoration and development scheme, of which over a half has already been subscribed. We very much hope that through the courtesy of your columns some members of the medical profession, here and overseas, will welcome the opportunity to contribute to this appeal. Further details are available from the Mancroft Appeal Office, the Chantry, Chantry Road, Norwich NR2 1QZ, to which donations may be sent and from where covenant forms are obtainable.

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¹ Huntley, F L, *Sir Thomas Browne. A Biographical and Critical Study*. Ann Arbor Paperbacks, The University of Michigan Press, 1968.