When a prospective employee is applying for a job, such as air pilot or engine driver, in which his sudden incapacity can hazard the lives of others, there is of course no ethical objection to the doctor's recommending his rejection if he is found to have a condition making him liable to such incapacity. But many people applying for jobs where this risk to others does not arise are nevertheless compelled to have a medical examination. And although they have all the right qualifications and are accepted "subject to medical examination" they may later be informed that because they have "failed" the medical they cannot after all have the job. I have come across many such rejects during my medical career. In the *Guardian* of 23 August 1978 appeared a news item under the heading "Healthy man who failed medical loses job." The man concerned had obtained a job as a porter and bench hand but the company doctor found he had hypertension and commented, "I am sure he is fit for work, but we are not so much concerned about his present health as his future health." If this kind of medical rejection can be justified by one doctor working for one corporation, it can equally be justified by other doctors working for other corporations. In consequence, unfortunates with, say, hypertension, diabetes, heart murmurs, and albuminuria may be unable to get any employment.

I have suggested¹ that those doctors who advise rejection on medical grounds need the following modified version of the Hippocratic Oath: "The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong, unless I am examining them on behalf of an employer, when the welfare of the patient shall count for nothing, and the interests of the employer shall be my sole concern." Such doctors would do well to consider how they would feel if they were at the receiving end. Suppose that a senior registrar, after years of fruitless application for consultant appointments, is finally made a consultant "subject to medical examination." He is later informed that because his blood pressure is too high he cannot become a consultant after all. Would his rage and despair be lessened by the kindly assurance of the chairman of the appointments committee that he will be able to stay on as a supernumerary senior registrar?

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¹ Todd, J W, *Lancet*, 1965, 1, 797.

A patient's charter

SIR,—I wish to comment on the stimulating paper by the late Dr B B Zeitlyn (14 July, p 103).

Despite the merits of many staff, and allowing for the unattractive presentation of some of the people with whom they deal, it seems clear that some patients sadly are downgraded in their contact with the NHS. This hazard extends across all strata of staff, being related to temperamental and social factors rather than to status. An example of the former might be a personal need to seek relationships with the dependent and a liability to react angrily if superiority is challenged, while in the latter group is the erroneous "them and us" ethos to which Dr Zeitlyn referred.

My own experiences as a patient or patient's relative have generally been very favourable but I am uneasily aware that this may not be typical. Sensitivity training and opportunities effectively to ventilate various stresses should help toward better awareness of psychodynamics, and indeed most of us may benefit from recognising the more destructive as well as the more constructive aspects of our personalities.

Patients and relatives could perhaps often become more complete partners in the therapeutic efforts (rather than appearing as objects to be manipulated), and this does not deny them the security of professional decisiveness when this is justified. An increase in the already almost intolerable pressures on some NHS staff is not implied, and with an easing of relationships actual improvement in this respect could follow.

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Royal Commission report

SIR,—In attacking the independent contractor status of general practitioners, the Royal Commission has done a very great disservice to the NHS. 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.

While there is some hope (but no guarantee) that the present government will refuse to implement these disastrous proposals, in the long term there is considerable danger that some power-hungry future administration will seek to implement them. This prospect must weigh heavily in the minds of young doctors coming into general practice, and will influence their motivation in many subtle ways, none of which will be to the advantage of their patients.

It is important that the BMA declares its total opposition to the general introduction of a salaried service for GPs, and pursues this policy with skill, persistence, and determination.

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SIR,—The report of the Royal Commission¹ has, I believe, neglected to clarify the role of community physicians, and because of this discussion is complicated by whether the community physician is regarded as a specialist doctor or an administrator. This highlights the dichotomy between the roles of specialist adviser in epidemiology and that of medical administrator.

Medical administrators work as officers to health authorities and this role is neither that of an independent adviser nor that of a representative of medical staff.² However, the function of the specialist adviser in epidemiology is more that of an independent consultant and it is in this capacity that the community physician may, in the interests of the health of the population, need to put forward proposals which are not necessarily those of the health authority.

The recent report by the Unit for the Study of Health-Policy,³ addressing itself to the low morale and lack of recruitment within the specialty, recognises this problem when it

proposes the creation of local health promotion teams. The report realistically accepts that in order to function effectively the members of these teams should have independence and political support.

The report of the Royal Commission explicitly states that the specialty must be supported in the next few years if it is to survive. However, its recommendations for the provision of adequate supporting staff, guidance on consensus management, and the formation of a central Institute of Health Services Research will probably help only to a limited extent. If, as the report states, the specialty has a future and "the present decline should not be allowed to continue," then something more radical is needed.

The Duncan report⁴ confirmed the need for two types of career appointment within community medicine. However, it is probably only by a much firmer commitment to the independent specialist consultant role that the potential of community medicine may be realised.

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

² Cang, S, et al, *Doctors and the NHS*. Brunel Institute of Organisation and Social Studies, 1978.

³ Unit for the Study of Health Policy, *Rethinking Community Medicine: Towards a Renaissance in Public Health?* London, Unit for the Study of Health Policy, 1979.

⁴ Joint Working Party, *The State of Community Medicine*. London, British Medical Association and Faculty of Community Medicine, 1979.

SIR,—I am dismayed at the Royal Commission report that care by some doctors is mediocre in general practice. The commission blames inadequate training and a set of national standards, yet no one mentions work load.

We often see patients at five-minute intervals. Why? Because we need so many on our lists to make practice financially viable. I calculate that if I gave every patient the 20 minutes or so they require I would be working 24 hours continuously per day.

No, neither this report nor the audit suggested is valid considering the condition of general practice today. You cannot criticise or audit a system whose structure is basically unsound. Until GPs' lists are cut by giving them fair remuneration per patient this report is not valid. Audit work, by all means, but at least give us time to think.

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A medical union in the United States

SIR,—I read with interest Dr J D J Havard's article "A medical union in the United States" (2 June, p 1500).

The problems of malpractice insurance, which have stayed at crisis levels for several years, are the result of the legal system prevailing in the United States. Lawyers take most civil liability cases on a contingency basis, getting nothing if they lose but up to 50% plus expenses if they win. This has resulted in intense antagonism between the medical and legal professions, although only a relatively few lawyers engage in malpractice work. (However, it is ethical for a trial lawyer to pay part of his fee to the referring attorney, although fee splitting by the medical profession is both unethical and illegal.)

Unfortunately the membership of most state

legislatures is predominantly lawyers. This has led, in the case of New York State, to the legislature's passing an amendment to the no-fault automobile accident insurance law whereby any doctor treating an automobile accident case must accept the same fee schedule as allowed by workmen's compensation (about half the regular private fee).

A number of New York State orthopaedic surgeons founded a society called the Surgical Specialties Association of New York State to fight this unacceptably low fee schedule. They applied for a legal injunction against the application of the new fee schedule, but this was denied by the courts. In order to bring pressure on the New York State legislature, they then organised a strike against caring for patients under the workmen's compensation laws, except in emergency situations. As the Surgical Specialties Association is not a trades union, the attorney general of New York State has instituted a prosecution against eight orthopaedic members, charging them with conspiracy to have physicians withhold services from patients. This has been felt by many doctors to be a purely political move by the politicians in power gradually to wear down the medical profession.

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Money and medicine

SIR,—In his very amusing excursion through the morals of the just price (21 July, p 220), Professor Rudolf Klein omits an element which would certainly not have escaped any of the earlier commissions whose work on medical remuneration he quotes. For simplicity, this may be referred to as the family investment factor.

While student grants and, more particularly, the appropriate means tests remain at their present level, it would cost two consultants some £7000, paid out of taxed income, to start an offspring on the same course. This is very much more than if sonny had decided to be a coal miner, or daughter a university teacher. The consultants themselves, if they qualified before the effect of the 1944 Education Act made itself felt, represent an even greater investment by the same family; it is likely that *her* dowry, rather than the down-payment for a house, was some five-sixths of a medical education, a second-hand fur coat, and some medical textbooks which were already becoming obsolete.

Professor Klein is right to say that the schoolmen would have felt at home in the argument. They were notoriously reluctant to admit that a profit on an investment was justified, but I fancy that they would have been acutely sensitive to those factors which resulted in the reduction of the wealth or circumstances of a family.

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Remuneration of armed Forces medical services

SIR,—Figures that I quoted on recruiting to the armed Forces medical services in my report to the Annual Representative Meeting in Liverpool have been challenged by the Ministry of Defence. It maintains that these

differ from those quoted by the Armed Forces Pay Review Body in its supplement to the *Eighth Report on Medical and Dental Services of the Armed Forces*. May I therefore explain the circumstances?

The Review Body Report was published on the last day of the Annual Representative Meeting and I therefore had no opportunity of knowing what figures were to be published; the figures that I used came from earlier estimates, which had been supplied to us officially and which applied to slightly different periods. I must also point out that the Review Body figures included preregistration medical officers, whereas mine referred only to fully qualified practitioners. I regret if this has caused any confusion. However, the differences to which I have referred do not alter the main burden of the argument to be derived from a study of either of these sets of figures. Up to the present time the recruiting figures to the armed Forces medical services and the number of voluntary resignations have given cause not merely for disquiet but also for alarm. *

The fully up-to-date remuneration for doctors and dentists in the armed Forces vigorously pressed for by the British Medical Association and my committee, and now awarded, will we hope do something to alleviate this crisis. This, however, is only a start, for we still feel that there has been misunderstanding in the way that the present analogue with general practitioners is applied. We shall be studying the whole question of the basis of the pay of doctors and dentists in the armed Forces in our discussions with the Review Body during the course of this year.

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VAT on emergency equipment

SIR,—It seems to me quite irrational that value-added tax should be charged on items of medical equipment which are needed to deal with acute emergencies. I am thinking in particular of defibrillators and monitors. It is essential that departments such as mine should have efficient equipment, and an additional 15% on top of an already expensive machine makes it increasingly unlikely that this will be obtained.

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Hospital practitioner grade

SIR,—At the ARM in Liverpool I asked for the following motion, which my division had introduced, to be withdrawn: "That until recalcitrant hospital consultants expedite the appointment of those suitably 'qualified' persons to the hospital practitioner grade, general practitioners should limit referral to the consultants of private patients." Nevertheless, many general practitioners believe that such action would be warranted.

As well as serving on the Surrey LMC and the Surrey AHA I am a member of the hospital practitioner grade vetting and appointing panel. No general practitioner is ever accepted for the grade until he has been vetted fully by the examining panel and there is full agreement about his suitability. A representa-

tive of one of the royal colleges is always present. Why is it that there are such inordinate delays before appointments are made or even substantiated after a candidate has been approved by the panel? My inquiries have shown that it is usually because some consultants—many of them HCMA members—are blocking the way, and I believe this happens because they are jealous of general practitioners' pay yet do not understand how it operates.

Surrey and Berkshire have several such "recalcitrants." When I tackle them the answer has always been, "General practitioners are paid too much as hospital practitioners." General practitioners do not go around asking for consultants' salaries to be reduced; in fact, if they are also competent private practitioners we augment their incomes by sending them private patients. Yet these same consultants are saying that hospital practitioners cannot be appointed because the general practitioners will get as much as a consultant. Why not?

In using such a dog in the manger argument they forget two facts: firstly, a 40% or more expense factor has to be built into all general practitioners' remuneration from all sources to cover expenses which whole-time consultants never have to bear; secondly, the Review Body judges what consultants should be paid, and for many this can include substantial merit awards. Indeed, the NHS gives a living to many consultants—and perhaps quite a few general practitioners—who in my view could never earn one in private practice.

The hospital practitioner grade should be implemented forthwith. Mr David Bolt has asked general practitioners for their help. We give our support willingly. Now it is time for all consultants to support general practitioners.

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Training posts and disillusioned registrars

SIR,—I read with some concern the letter of Dr Colin Taylor (30 June, p 1798), in which he lays the blame for his predicament and that of other disillusioned registrars on the regional postgraduate advice network. From my experience as a regional postgraduate dean I would like to suggest that in many instances junior doctors must accept some responsibility for their own career frustrations—for example, in selecting oversubscribed specialties unless they are of outstanding calibre. At the same time I would like to say that in discussing career prospects with junior doctors I am continually surprised that it very often appears that career advice from their consultants has been neither sought nor given and also that many doctors do not appreciate the scope and extent of the postgraduate network available to them.

In order to ensure that junior doctors take advantage of the postgraduate facilities available, the regional postgraduate committee of the South-west Thames Region has recommended that it should be written into job descriptions that junior doctors should discuss with their consultant their career aims and aspirations and their proposed training, study leave, etc, when they take up a new post, and should acquaint themselves with the clinical tutor and the postgraduate facilities available. The regional adviser in psychiatry has also recommended writing into the