Many of us, and especially our younger colleagues, are heartily sick of this continued internecine war. We have been working hard for several years for a new contract, based on equal pay for equal work, and designed to prevent the iniquitous misuse of the terms of the present contract.

Although in theory the maximum part-time consultant is contracted and paid in respect of nine three-and-a-half-hour sessions per week, in practice this is far from the truth. The great majority of consultants in the acute specialties are maximum part time. I can assure Mr Ross that most of my colleagues (including anaesthetists particularly) work very much longer hours than their contractual time. It is uncommon for clinics to last for less than three-and-a-half hours before one starts the letters, etc; and many major surgical lists every week last for four to five hours or more, owing to sheer pressure of work.

Earlier this year I tested my contract (specifically for nine sessions) during the fairly lengthy absence of my colleague. After a long battle I was forced to accept that I was obliged to provide "reasonable" cover. The relevant part of my contract was based on the authority's interpretation of the word "reasonable," and I found myself on continuous call (no locum was available) for over three weeks—unpaid.

Although many of us regard the negotiation arena as a contest between the gentleman and players, and are no longer shocked when the CCHMS is outmanoeuvred by the DHSS (all the tricks of the trade), we nevertheless have a measure of sympathy for Messrs Grabham, Bolt, *et al.* I am sure that we support equal pay for equal work; but let us not forget that, as with criminals, most of us are volunteers in our choice of maximum part-time or full-time contracts. It is illogical to plead for equality, and immediately call for an extension of discriminatory penalties. It is a fact of life that some work harder than others—just look around. Surely it is fairer to have a single form of contract, based on present needs, and flexible enough to satisfy all, while defining a reasonable working week.

Am I right in thinking that at the inception of the NHS, consultants were persuaded "in" by Nye Bevan's assurance that living standards would be safeguarded, and salaries related to a group of other professionals? If so this promise should be exhumed and repeated in large print in the *BMJ* every week.

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SIR,—I note that the Secretary of the BMA believes me to be wrongly informed about the CCHMS proposals for renegotiation of the existing consultant contract (25 August, p 50). The following comments were omitted from my first letter in the interests of brevity. However, I still believe that some full-time consultants would be adversely affected by a narrowing of the remunerative differential between himself and his part-time colleague, despite the carrot of "limited private practice." This "benefit" is not available to a proportion of full-time consultants despite your statement to the contrary.

The reasons for this non-availability are: (1) Some consultants enjoy academic appointments. (2) Private practice is not available to

certain consultants—(a) by nature of their specialty (eg, geriatrics, certain aspects of psychiatry, certain branches of pathology, etc; (b) because of the need for highly specialised equipment such as that for radiotherapy, neurosurgery, etc; or (c) owing to the geographical siting of that particular consultant's hospital. (3) There are diverse personal reasons, which may be political or just not wanting to be involved with private practice.

For those full-time consultants who would wish to take up this limited benefit, what constitutes the ceiling on their earnings in private practice? It has been suggested that full-time consultants might earn up to 10% of their National Health salary by private work and that this fraction will be increased proportionally by a merit award. "To those that have shall be given..." A good biblical theory, but tell that to the man in the dole queue and I could guess his reaction.

No, Sir, I am not mistaken. It is the CCHMS that is misguided. These are not sound proposals: not all consultants would benefit as you suggest and therefore the proposals are divisive and should be abandoned.

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Private referrals

SIR,—In the current debate there seems to be an assumption that private medical treatment is a middle-class affair, general practitioner referral to a consultant in private practice being viewed as a way for the "well-off" to "jump the NHS queue." I decided to test this assumption.

I work in a mining town famous for its left-wing politics. It has known great poverty, and this, together with the heavy nature of local employment, is reflected in the high level of morbidity in the elderly. Use of general practitioner services is high, though about average for practices in such areas.¹ My practice of 2600 patients (with an age-sex distribution almost exactly that of the general population²) generates a median work load of 50 surgery consultations, two new home visits, and two revisits each day.

Over the last six months I referred 185 patients for specialist opinion, a fairly average referral rate.³ Of these, 21 were for private consultation—that is, 11.4%. Six were referred to an ear, nose, and throat surgeon, five to a general surgeon, five to an orthopaedic surgeon, two to a physician, and one each to a dermatologist, an ophthalmologist, and a gynaecologist. In all cases I made the decision that referral was both appropriate and timely.

Eight patients (including one requesting abortion) were offered an urgent NHS consultation but this was rejected in all cases. One patient even requested private referral in preference to immediate admission. Another preferred to take his traumatic phimosis to a surgeon just one day earlier than the first available NHS appointment. Only one of the eight would have had to wait longer than one week through the NHS and four would have been seen within the week. Yet, despite being told this, five requested private consultation because of the time factor.

The 21 referrals included two children and two pensioners, suggesting that it is adult workers who seek private referral most frequently. Of the adults, six were male and 13 were female, suggesting that men like their womenfolk to be dealt with quickly as well as effectively. The distribution of patients by Registrar General's social class of the head of the household was: I and II—4 (19%); III—10 (48%); IV and V—5 (23%); not known—2 (10%). The equivalent

proportions nationally are 17.5%, 49%, 8%, and 3%, respectively.²

The occupations of the patients (or their husbands or fathers) were: one company director, two representatives, four miners, four light-engineering workers, an ambulanceman, a fireman, a glassworker, a steelworker, a brewery worker, and a student. Two others were "factory workers." The final pair were a widow and a young woman who works as an NHS kitchen assistant.

Though I would be the first to admit that these data are insufficient to confirm or refute any hypothesis, they suggest that some commonly held assumptions about private referral are wrong. I would hope that they would be sufficient stimulus to bring the entire debate out of the murky waters of political ideology through a factual assessment of what the people actually want.

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¹ Office of Population Censuses and Surveys, *Morbidity Statistics from General Practice*. Studies on Medical and Population Subjects No 26. London, HMSO, 1974.

² Central Statistical Office, *Social Trends*. London, HMSO, 1978.

³ Royal College of General Practitioners, *Trends in General Practice*. London, RCGP, 1977.

Survival of the fittest?

SIR,—Dr T J Daymond's letter (1 September, p 554) touches, for me, a sore spot and rubs salt into an old wound, because he recalls an effort into which I put all I had to give, to no avail. Twenty-three years ago I proposed anticipatory appointment, a device soon to be known as prolepsis when somebody found that the Greeks had a word for it. I pulled out all the stops I knew but failed to get the idea accepted.

Registrars and senior registrars were greatly in excess of requirement, with obvious unhappy consequences. Briefly, my suggestion was that foreseeable consultant vacancies should be advertised, say, 18 months in advance and filled by appointment not less than 12 months in advance of the due date. The successful candidate could then have been offered one of at least three options. He could remain in post as a senior registrar (though not encouraged to do so); he could take a year's work in some needy, developing country; he could take a training or research post the better to fit himself for his substantive appointment; or he could take a long holiday. He would in any case have had ample time to find accommodation for living and to accustom himself and his wife and family (if any) to their future environment. In addition (provided the successful candidate was sufficiently enterprising) the whole trainee log jam would have moved forward a year earlier than could otherwise have been the case.

"And those behind cried 'Forward' but those in front cried 'Back.'" The Establishment would have none of it. In the more permissive climate of today prolepsis might now be acceptable, though less popular with some. It is said of farmers in hilly country that those who go up come down, and those who come down go up. I am told that some senior registrars are, for financial reasons, often in no great hurry to "go up" to consultant grade.

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