this resolution, which I understand was not reached at the ARM, would effectively remove the opportunity for private practice from consultants in the laboratory specialties.

(4) The limit of 10% of gross NHS earnings seems invidious. Why not 10% of the maximum pay of a whole-time consultant? Furthermore, the proposal opens up opportunities for fiddling and for harassment.

(5) The position of medical academics and of specialists in community medicine is not considered in the documents I have received. Both, for different reasons, are unable to undertake private practice; are they therefore to be left out, or is a separate scale for them to be negotiated?

I am not convinced by the assurances that no part of the money required will come from that currently used to pay consultants. The Secretary of State makes this promise only for the current financial year, and, as we have seen in 1978 and 1979, the view of the Review Body is that if some consultants are to get more others are to get less. Mr Bolt in paragraph 1(e) tells us that the Review Body has not previously considered the income of whole-time consultants from private practice: of course not—previously they have not had any. There is no assurance for the future.

I urge that acceptance of these proposals should not be rushed, that the opinions of those who may be adversely affected should be canvassed, and that the royal colleges and specialist associations should be consulted, with particular reference to the possible effects on recruitment to the specialties concerned.

It is my view that a major part of the present lack of consultant morale is the situation whereby a senior registrar on promotion to consultant undertakes greater responsibility but suffers a reduction in salary. If the salary scale of consultants were altered so that a maximum part-time consultant were to receive a substantially greater salary than a senior registrar, a state of affairs which existed during the first half of the life of the Health Service, a great deal would have been done. I commend this attitude to our negotiators.

DAVID ASHLEY

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SIR,—It may seem churlish to criticise the Central Committee for Hospital Medical Services when it has just apparently negotiated a further pay rise for all consultants, though we may quietly wonder how many more hospitals will have to close to provide the extra money within cash limits. The alleged rise for whole-time consultants—the right to do private practice up to 10% of our income—may, however, be illusory. Clearly also the CCHMS cannot know what proportion of whole-time consultants have such a contract because of an unwillingness to practise privately and what proportion have previously not had sufficient private practice available to make maximum part-time status worth while. The “rise” will apply only to this latter group and it is not clear that the CCHMS has a mandate from whole-timers as a whole to make this change.

Many whole-timers confidently expect that the Review Body will take this option of an extra 10% into account and that whole-timers who do not do private practice will soon suffer a 10% relative cut in salary. Mr David Bolt states (15 September, p 684) that the Review

Body has not taken private practice earnings into account before. They may not do so in future, but the accuracy of Mr Bolt's prognostications on the Review Body's pricing of the “new” contract gives little cause for optimism about this implied expectation.

Time is short before the offer is formally accepted. Perhaps all whole-timers who feel as pessimistic as I do could add five minutes to their next dictating session to write to Mr Bolt expressing their concern at this possible change in their contract, the fact that their morale might not have been raised when they read about it, and their hope that this aspect of the new proposals will not be accepted on their behalf.

SAM BAXTER

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Functional budgeting

SIR,—The clearly expressed objects of my letter (2 June, p 1485) about “functional budgeting” were to stimulate wider discussion of the possible implications of this and allied systems for clinicians, and to elicit from those of our medical colleagues with personal experience informed first-hand comment on the practical advantages and disadvantages. The published response to date, from Dr J N Todd and Mr P M Worsley (21 July, p 212) and Mr D F Thomas (25 August, p 502), disappoints these hopes.

Your correspondents can be assured that clinicians are only too aware that they operate within ever-tighter budgetary constraints and that few can foster for long any delusions of “divine right to spend whatever they wish,” as Mr Thomas puts it. However, a society conditioned to the philosophy of health services free-at-the-time must expect both the dispensers and the consumers of those services to display similarly dissociated attitudes.

There is, of course, no dispute about the desirability of informational feedback on the expenditure generated by doctors in treating their patients; and I suggest it is this, the soft-sell aspect of functional budgeting, that medical staff may involve themselves in “largely at their own request.” Great difficulty, however, lies in arriving at cost breakdown with reliable precision or meaning. More importantly, it is very hard to measure the larger fiscal implications of treating in a particular way, or of not treating at all. The problem is well illustrated by the specious assertion made by Dr Todd and Mr Worsley that 60% of hospital expenditure is generated in “patient treatment departments, in which the work load is effectively controlled (or not controlled?) by clinicians.” Mr Thomas seizes on this “salient argument” and embellishes it with Illichian zeal by laying to the charge of medical staff “the total effects of patients being admitted to hospital, including catering, laundry, etc” (I can only guess at what profligacies are implied by his portentous “etcetera”).

Bald figures are notoriously adaptable to any argument but it is surely not disingenuous to point out that in 1973-4 58.9% of hospital expenditure went almost even-handedly to nursing and ancillary salaries and wages. A further 10% went to medical and dental salaries. Only 8.2% was spent on drugs, dressings, appliances, and equipment, the very areas in which Mr Thomas complains that “we [administration?] have traditionally had little control.” If Mr Thomas insists on throwing in provisions, we may add to the doctors' bill another 4.4%, and laundry would account for some fraction of 3.8%.¹ I cannot make these items approach 30%, let alone exceed 60%.

Your correspondents betray a crucial disunity of principle. Thus Dr Todd and Mr Worsley, in helping me over one of my misunderstandings,

state that “clinical units manifestly do not fall within [the] definition” of “identifiable departments with responsible departmental heads,” “because they use services supplied by many departments.” Mr Thomas on the other hand proudly cites clinical departments of rheumatology, rehabilitation, and radiotherapy as being already embraced by his own district's schema and is exploring the inclusion of others via his local cogwheel divisions.

On points of detail, is not Mr Thomas oddly naive in supposing that clinical budget holders can ever have the power to hire and fire in any real sense? What are his “certain circumstances” in which underspendings can be carried forward from one year to the next? What are the circumstances in which they cannot? Are those circumstances immutable? If not, who will change the rule?

In accepting that “it is unlikely that specialty budgeting will be the answer” and that “other approaches are probably essential,” Dr Todd and Mr Worsley sound more in touch with the realities of modern medical care in hospitals than does Mr Thomas. The latter, with respect, should not claim to speak from “the sharp end.” That unenviable position is occupied by the clinician, who rightly balks at his threatened conversion (to use the horrible transatlantic jargon) into a decision unit making a decision package which is then ranked by top management with the assistance of the central budget office.²

I feel that the letter from Mr Thomas rather gives the game away over the motivations behind functional budgeting—nowhere more so than in his minatory final paragraph. Unless there is political as distinct from budgetary rethinking, patient services will inevitably be cut back. It is essential that the nominated responsibility for such cuts remains firmly where it belongs and is not devolved to the point of service.

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¹ *Compendium of Health Statistics*, 2nd edn, London, Office of Health Economics, 1977.

² Clynych, E J, *International Journal of Public Administration*, 1979, 1, 43.

Cost of treatment in the NHS

SIR,—Dr R A Keable-Elliott (22 September, p 749) suggests replacing the present system of prescription charges with a more elaborate one. He outlines a number of anomalies the present system creates, but surely the easiest way to avoid these anomalies is to follow the advice of the Royal Commission and abolish prescription charges altogether. I fear that charging hospital patients for drugs would only increase the present bureaucracy and it is illogical to charge for drugs and not “board and lodging” in hospital. Drugs are part of the patients' treatment; food usually is not. Making NHS prescriptions available to private patients surely would increase demands on the NHS budget, and would not benefit the service if the growth of private practice decreased the time doctors gave to the NHS.

Dr Keable-Elliott failed to put the cost of drugs to the NHS in its full context, and perhaps relate it to the costs of, for example, bed occupancy and the use of laboratory and radiology resources, for none of which adequate auditing systems exist. While the average total cost to the NHS per prescription was £2.16 in 1978, the cost per hospital inpatient week in England was approximately £310. Pharmaceutical services still represent about 10% of total NHS expenditure, and this proportion has remained constant for over 10 years. I therefore feel that Dr Keable-Elliott's

suggestions will produce little real benefit to the taxpayer.

LAURENCE GERLIS

Pinner, Middx

SIR,—In commenting on Dr R A Keable-Elliott's "Talking Point" (22 September, p 749) may I widen the subject somewhat? Dr Keable-Elliott's analysis of the "nonsense" of the present prescription charge situation and his proposals for rationalisation are, as one would expect, a fair analysis and a sound solution.

In his telling series of anecdotal examples, however, he misses one which I believe is very germane: "Dr X prescribes profusely, so that patients on his list (if not exempt) who consult him obtain quite a lot of drugs—and pay charges accordingly. Dr Y, on the other hand uses a prescription pad less readily, but has a higher incidence of referral of patients to the neighbouring outpatient department than does Dr X."

Neither of them knows this, and even if they did neither has much idea—because he has never been instructed—whether, taking year with year, Dr X's system is more costly than Dr Y's or vice versa. This state of affairs is not, of course, limited to general practitioners or to prescribing. Mr A insists that his hernia patients must remain in hospital for eight days, whereas Mr B discharges his in 24-48 hours—but inevitably with heavier involvement of family doctor and district nurse.

It is an awesome prospect, but if we are really to be serious in talking health service economics and economies it is not true that all NHS doctors (and possibly students) should have some education in this subject? After all, a large proportion of the total NHS cost arises from the decisions of clinicians—in both career and training grades. Is it heretical to suggest that when weighing up what are the therapeutic possibilities for a patient or a group of patients, the clinician should have in his mind some idea of the relative costs of these possibilities?

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Points

Medical confidentiality and the law

Dr BRIAN KIRMAN (London SW16 2HS) writes: Dr Michael Ryan (15 September, p 648) ... says that in the Soviet Union a medical worker cannot refuse to give evidence as a witness in the judicial process. He must know that this is exactly the situation in this country. The medical practitioner, like any other witness, swears to tell "the whole truth." Moreover, medical notes are in no sense the doctor's private property. These must be made available if the Court so requires. Consequently some psychiatrists here have considered keeping a separate file of genuinely private notes; but this is clearly impracticable as a routine. Furthermore, the recent rash of public inquiries with semi-judicial status has involved much public ventilation of "private" medical records and evidence. ...

Herpes zoster

Dr VERONIQUE MOENS (Royal Berkshire Hospital, Reading) writes: Professor A P Waterson (8 September, p 566) comments on

the rarity of zoster virus infections during pregnancy. I agree that there are very few, but they are certainly not restricted to 13 cases. Recently I had shingles at 17 weeks' pregnancy, and I do not think that this was a recorded case. ... I was delivered of a normal and very healthy daughter, now 5 months old. Clinically there have been no problems, and although the baby was said to be small on ultrasound her birth weight was 3320 g and delivery was at the expected date. I personally think that there are a lot more such cases than are recorded, but as they are benign no great attention is paid to them.

Dr K M HUNTINGTON (London SW3 6PX) writes: ... Professor A P Waterson (8 September, p 564) says that herpes zoster in early pregnancy is rare, with only 13 recorded cases. I would like to report a patient aged 38 who developed herpes zoster on 18 December 1978. The first day of her last period was 7 November. This was her first pregnancy and she delivered normally on 12 August. Her baby daughter weighed 3740 g and seems normal in every respect. ...

Postprandial cardiac arrests?

Dr I N FINDLAY (Renfrew PA4 8UF) writes: Minerva comments (15 September, p 678) on an analysis of cardiac arrests.¹ The two peak periods, 1-3 pm and 6-9 pm, are postprandial. Could the ingestion of hospital food be a cause?

¹ Eltringham, R J, and Dobson, M B, *British Journal of Anaesthesia*, 1979, 51, 72.

Olympics for the handicapped

Dr J R MIRREY (Redhill, Surrey RH1 6JN) writes: In your leading article (22 September, p 688) you gave coverage to the "Transplant Olympics," which took place the previous month, with 200 competitors. ... By a coincidence international games were also held the previous month for the amputees, the visually handicapped, and sufferers from cerebral palsy, with 430 entrants; but this was given no coverage despite of the fact that these people, though handicapped, gave some remarkably fine performances. The javelin, with defective muscle control, the high jump, when it cannot be seen, and running 100 metres with one leg are real achievements by any standards; and as 1981 is to be the International Year for Disabled Persons can we please have more coverage of this whole subject?

Mechanical aids to ventilators for use in the field

Dr O P DINNICK (Association of Anaesthetists Liaison Officer with British Standards Institution, Middlesex Hospital, London W1N 8AA) writes: Dr M G Harries's (18 August, p 426) reference to "international standards" for mechanical oxygen-powered ventilators may be misunderstood and merits clarification. The major paper to which he refers does indeed use the word "standards" in its title but it ... covers many aspects of cardiopulmonary resuscitation ... devoting barely a column to oxygen-powered mechanical breathing devices and not being a standard (as the term is commonly understood) for such

equipment. While many of the recommendations in this important document are indeed widely accepted, some of the requirements for oxygen-powered devices, especially in relation to external cardiac massage (ECM), are debatable. For example, one of the requirements approvingly quoted by Dr Harries is—in his words—"that a ventilator triggered by hand is the *only* device that is acceptable." While I agree that pressure-cycled mechanical ventilators are far from ideal when ECM is also required, a good case can be made for using time-cycled devices. ...

An International Standard for these devices has not so far been published by the International Standard Organisation (ISO), but one is being prepared by an ISO Technical Committee and the corresponding British Standards Institution committee.

Hazards of glazed pottery

A J CILLIERS (ICI South Africa (Pharmaceuticals) Limited, Johannesburg) writes: Your expert's answer to the query about the safety of glazed pottery for eating and drinking vessels sounds very reassuring (1 September, p 539). I am sure that he is correct if he is referring to commercially made pottery in the United Kingdom. However, in various other countries pottery is fired with low-temperature lead glazes which are known to have caused lead poisoning. This has been reported in the United States of America following the purchase of pottery by the wayside in Mexico on holiday, and I have been personally involved in a case of a similar nature following the purchase of pottery in Mozambique.

Oesophagus with an E?

Dr THOMAS B HUGH (Department of Surgery, St Vincent's Hospital, Sydney, Australia) writes: I wonder whether British gastroenterologists could be persuaded when referring to the gullet to adopt the spelling esophagus. Transatlantic variations in the spelling of this word are a nuisance to British authors wishing to publish in North America, as manuscripts, illustrations, and legends must be pruned carefully of redundant Os, a particularly tricky task when some are buried in compound words such as gastro-oesophageal (incidentally, is not "gastroesophageal" neater?) As a more or less impartial observer from the Antipodes, I despair of ever persuading the Americans to add an "o," whereas British commonsense must surely see the value of submitting national pride to the interests of uniformity. There are, of course, other practical precedents for dropping the "o"—for example, economy, ecology, and ecumenical. ... The *Oxford English Dictionary* gives approval to the alternative use of E for OE (including for esophagus) only when Greek-derived words have come into English through Romanic languages; oesophagus comes to us via the old French ysophague, and was ysophagus in fourteenth-century England.

Correction

Neonatal care

In the letter by Dr T H Hughes-Davies (8 September, p 609) we regret that "470 g" in the last sentence of the first paragraph is a misprint for "740 g."