It is disingenuous to suggest that the new proposals unify, and the designation whole-time and part-time is being dispensed with. This will only occur when all are on a 10/11ths contract, which may be the ultimate goal or destination—the only way then to improve remuneration being in the open market?

A N G CLARK

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SIR,—At first glance the proposed alterations to the consultant contract appear to be fair to all. The maximum part-time consultant gets paid for an extra session without actually doing any more work, while the whole-timer is allowed to earn up to a roughly equivalent sum in private practice, although naturally he has to work extra to get it. We are assured that the extra money will not come from the general pool available for consultant remuneration. Presumably it comes from other people's salaries, medical and surgical equipment, repair and maintenance of buildings, or some non-essential item like administration. That will probably mean fewer medical secretaries, but so what?

Having got over the salary hurdle next year, does the extra cash continue to come out of everyone's pocket except ours or will the position finally stabilise, with the whole-timers losing what part-timers gain? Where do the private patients come from who are going to consult the whole-timers? Surely from those who would normally consult part-timers. In the final analysis thus even the part-timers are no better off. The whole thing is about as sensible as the 1974 reorganisation.

The number of pay-beds in NHS hospitals has been drastically reduced, and many hospitals have no facilities for private out-patient consultations. Thus some whole-time consultants are going to have to set up facilities outside hospital if they are to do any private work, which is hardly feasible on a gross turnover of one-tenth of one's salary.

For goodness' sake ballot the hospital medical staff before you introduce this latest blunder.

P J ADAMS D E FLETCHER
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SIR,—I was very interested by the attitudes of your correspondents (6 October, p 868) concerning consultant contract proposals.

Drs G M Sterling and David Ashley were concerned that part-time consultants would receive an automatic pay rise for no increase in actual work. I am sure that I must be in a similar position to other part-time consultants in that on taking up my appointment I was offered the choice of either a full-time contract or a 9/11ths contract. However, I was offered no choice in work load, my NHS work load being identical whether I was full time or part time. This meant little more than a 2/11ths penalty for my desire to retain at least part of my clinical independence. I am afraid therefore that an increase of 1/11th in my salary would be only a lessening of this financial penalty for having the audacity to be other than totally State-owned.

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Medical academics and research workers

SIR,—Your briefing (13 October, p 946) on medical academics and research workers provides a useful background to the present position, but some factual errors need correction.

Firstly, it is claimed that the Medical Academic Staff Committee (MASC) had established formal negotiating machinery for clinical academic staff just as the consultants decided to bury their work-sensitive contract. This is not so. What did happen was that at their annual meeting on 4 June 1979 the Conference of Medical Academic Representatives ratified the negotiating committee's constitution, and I suspect that this decision has been confused with the formal establishment of the negotiating machinery. The Clinical Academic Staff Salaries Committee (CASSC) has yet to receive final Government approval, and although this may be achieved within the next few days it has not been ratified at the time of writing.

Secondly, it is stated that academics voted by a small majority to proceed with the new contract. Again this is not true. What is true is that the academic staff voted to support their NHS consultant colleagues in their negotiations; academic staff were not themselves directly affected by the new contract.

Finally, the remit of the negotiating committee is wider than is indicated in your briefing. Discussions will be held on salary and salary-related matters, which clearly include domiciliary fees and other benefits. Unfortunately, the committee has not been empowered to discuss terms and conditions of service, which will remain the subject of negotiation with individual universities. Nevertheless, the establishment of the Clinical Academic Staff Salaries Committee will be a major step forward in the representation of clinical academic staff, and I have no doubt that its value will be seen by all concerned in the coming months.

J P PAYNE

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*.*We apologise for these errors.—Ed, BMJ.

Private practice for pathologists

SIR,—A booklet entitled *Private Practice for Pathologists* has been issued by the BMA in concert with Private Patients Plan. The authors advocate small private laboratories each run by a single "all-purpose" pathologist with two technicians and limited equipment, charging first-class fees for what can be only third-class service. Such glorified clinical side rooms might make a lot of money for pathologists but they would be very unsatisfactory for patients and clinicians.

Surely only the very best is good enough for private medicine. That is what patients pay for. Subscribers to PPP should insist that their laboratory investigations are done in a first-class laboratory staffed by a consultant specialising in the relevant discipline of pathology.

The role of the BMA, I suggest, should be to insist that doctors treating private patients have free access to NHS laboratories, for which the patients have paid through taxation. A necessary corollary should be, of course, proper remuneration for full-time consultant

pathologists, some of whom are among the worst-rewarded members of the medical profession.

During my active professional life I never differentiated between the private and NHS patients investigated by the laboratory team which I led, and I neither expected nor received fees from my colleagues' private patients, who got the best which we could give. I know that a great many pathologists take a similar attitude. I hope that this booklet and the proposals it conveys will be withdrawn.

MARK HUGHES

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*.*The Secretary writes: "Many private laboratories of the type described in *Private Practice for Pathologists* already exist and are giving first-class service. Using modern equipment, they attain very high standards. Many consultants now believe that the private sector should become more self-supporting, and it seems that all shades of political opinion are inclining to this view."—Ed, BMJ.

The Three Wise Men

SIR,—The *BMA News Review*¹ informs us that the fee payable under the Three Wise Men procedure to doctors investigating the professional competence or misconduct of another doctor on a specific charge has been increased (from £12 to £18.40 a day). Your readers would be well advised to consider their position before they don the cloak of wisdom in such circumstances.

In 1960 the Ministry of Health suggested to hospital authorities the setting up by medical staff committees of machinery to assist in preventing harm to patients resulting from physical or mental disability, including drug addiction, of hospital medical or dental staff (HM (60) 45). This machinery became known as the Three Wise Men procedure. A practitioner undertaking such a task at the request of his health authority could shelter under the protection of qualified privilege in any subsequent legal action in defamation provided that it could not be shown that he had acted with malice. Of course, he would lose such protection if he exceeded the privilege bestowed on him by the law. In other words, if an aggrieved colleague were to institute legal proceedings against a Wise Man then the latter would succeed in his defence only if it could be shown that he had acted in good faith with the object of assisting in preventing harm to patients in the circumstances already described, and that he had reported his opinion only to the person authorised to receive it.

The procedure does not apply to disciplinary proceedings involving personal or professional conduct or professional competence (HM (61) 112). A practitioner who purports to be acting as a Wise Man in disciplinary inquiries could be defenceless in the event of subsequent legal proceedings in defamation.

A practitioner should also consider carefully the importance of being able to establish that he had acted in good faith. For example, a gynaecologist might find himself in some difficulty if he reported adversely on the organisation of an eye department which was under the direction of an ophthalmologist about whom no possible hint of physical or mental disability had been raised.

The task of the trio is often difficult and can be critical in the determination of a colleague's career. As for the acceptance of a fee, how unfortunate if this came to be measured in pieces of silver.

F C SHELLEY

Bovingdon, Herts

¹ *BMA News Review*, 1979, 5(9), 72.

The forgotten men

SIR,—Qualifying in 1942, I took a surgical house post, and showing some surgical skill was invited to take a vacant surgical registrar post at the end of the year. I thus entered a reserved occupation, undertaking surgery possibly far beyond my capability for four years, first at the General Hospital in Birmingham and then at the Queen Elizabeth Hospital in the same city. In March 1946 I was directed to the Royal Air Force, which I served first as a flight-lieutenant and later as a squadron-leader/surgeon in India until demobilised in September 1947. There are many in my position who worked in a reserved occupation for the period of the war and later did their service time, brief though it may have been. Present regulations provide for half the period of war service to be recognised as pensionable—for example, service in the Forces from 1939 to 1945 represents an additional 3/80ths to their final pension.

So far no consideration appears to have been given to the "reserved" class. I and many others were directed into occupations to serve the community at much the same risk as those in the Forces. We could not leave these reserved occupations. Why should this group of "forgotten men" and possibly women not have their period in a reserved occupation recognised as war service, and added to any period of service they undertook?

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Clinical practice and community medicine

SIR,—Professor E D Acheson (6 October, p 880) suggests that community medicine specialists should have the opportunity of practising without their own specialty. This practice is rather uncommon in other branches of medicine and seems of doubtful merit. Certainly if I were a patient I would feel better served by a doctor who was engaged full time in the specialty appropriate to my illness.

The article shows that many doctors involved in community medicine have had several years' clinical experience prior to entering the field. This may indicate that their advancement in the clinical specialties was poor enough to make the second choice of community medicine (which is generally rather unpopular) appealing to many. If this is the case it is unreasonable that a "back door" entry to clinical work should be allowed, especially in certain hospital disciplines (the most popular choice among the community medicine specialists questioned) which are already fully manned with doctors expressing a *principal* interest in such work.

It may well be that an option to practise in a clinical field would encourage recruitment

into community medicine, and although those engaged in that specialty would seem to be in favour of such an option I wonder if their full-time clinical colleagues would be as enthusiastic.

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First things first

SIR,—Was Professor Norman Browse (15 September, p 682) writing as a surgical scientist or as a doctor simply expressing an idea when he described his plan for the future staffing of our hospitals? How did he determine that a consultant plus his house officer and the sessional support of someone in the hospital practitioner grade (albeit with some registrar experience) would provide adequate standards of care for the average hospital patient?

Frankly, I doubt that we should pay much attention to such pronouncements from the ivory towers because, rest assured, such changes will not affect the major teaching emporia. We have already seen the refusal by some to be RAWPed of their junior staff, and there is little chance that they will participate in any future policy for a reduction in junior staff or an increased consultant presence at the bedside. Nevertheless, the stage is set for a prospective pilot study, and if those who are agitating for changes in medical manpower can wait a little longer perhaps Professor Browse might show us how his idea works in practice, and how it truly affects patient care.

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Lack of flexibility in vocational training?

SIR,—For some time I have been aware that the control of vocational training for general practice has been taken over by a minority of very active doctors who have an almost fanatical zeal and rigidity. I have had an impression of empire building, but have hoped that I am wrong. I have, however, met a number of other general practitioners from various parts of the country, all concerned with vocational training, with views similar to mine. For five years, as a course organiser, I have voiced my opinions in my own region and as a result have come into sharp conflict with those who control vocational training here, and who seem to feel that there is no place for any view other than the "party line."

I applaud the high ideals and hard work of those who have improved the standard of vocational training over the years, but I am afraid that at present they are in real danger of losing sight of their objectives in the mass of educational jargon and apparatus they are using. There seems to be a total lack of flexibility in the use of modern educational methods in vocational training. Our trainees are required to learn in small groups, with audio and videotapes and with endless questionnaires. No account is taken of the fact that not everyone will learn most readily with all these gadgets. We are dealing with adult, qualified doctors, each of whom is an individual, and we must not try to force them into any educational mould. The educational programmes and methods which we use must be tailored to encourage each individual doctor to fulfil

his own potential in his own way, not to stifle him and make him conform to the pattern of a standard good general practitioner. In Stafford we have tried to apply this approach, using a high level of co-operation between hospital consultants and local general practitioners; and at times methods may have been unorthodox. I am sure that there is both room and need for vocational training schemes of this type, as there is for more rigid and formalised ones.

There must be standards by which trainers and training practices are selected, but these must not be too rigid. Before he has a trainee in his practice a trainer can reasonably be expected to have made some attempt to understand the basic principles of postgraduate education. Indeed, our postgraduate medical centre organised the original courses at Keele University for this purpose, but I feel that it is quite unnecessary to have to attend repeated small group meetings to keep up to scratch. Occasional refresher courses certainly, but our main job is to treat our patients, and this is what we should be doing. For most general practitioners the teaching commitment is secondary, although carried out with the same conscientiousness and individuality as the first.

I am concerned that the approval of a training practice can be withdrawn at any time and without any reason being given, even on appeal. While this procedure continues, I cannot see how an aspiring trainer who has not met with the approval of the powers-that-be can hope to improve himself. Most of us are prepared, when criticised, to look at the grounds for criticism and decide what we can change, but this cannot be done if we have no idea of what is being asked. The approach used by visiting teams to assess practices and training schemes has left a feeling of uncompromising arrogance with general practitioners and consultants alike. This does nothing to commend the college in the eyes of hospital consultants, who know a good deal about the clinical competence of general practitioners, and whose views on this might be of more use in assessing a potential training practice than, say, a detailed knowledge of its premises.

I realise that my views could become as rigid as are those I criticise, and I keep this point in mind. I am not trying to throw out the vocational training baby with the bath water, but hope that it will not be allowed to drown. I am deeply disturbed to find that we have, at the heart of postgraduate training for a large number of doctors in this country, an organisation which deals with its critics by elimination. Suddenly, Siberia seems to be much nearer.

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If I was forced to cut

SIR,—“If I were forced to cut,” please.

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*.*It seems that neither form is incorrect. If the first be distasteful, then we are sorry. Nevertheless, we have no desire to linger at the decline and fall of the English subjunctive mood, but prefer to accept the advice given in Sir Ernest Gowers's *Complete Plain Words* and get along without it whenever we can.—
ED, *BMJ*.