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?

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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 outpatient 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.

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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.

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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.

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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.