obtained at favourable charges. Limited residential accommodation is available for fellows' use. There are several lecture rooms within the college and these are regularly used for anaesthetic lectures in addition to the large meetings in the Edward Lumley Hall. The library facilities are excellent and the Hunterian Museum is unique. Fellows in the Faculty of Anaesthetists are able to use all these facilities as of right. It is theirs, shared on conditions of equality with the surgical and dental fellows.

What has the independent college of anaesthetists to offer in comparison with all this? At present the Association of Anaesthetists has rented offices, with cramped accommodation and no private office for the president, editor, or other officers. The Edward Lumley Hall at the College of Surgeons has its critics as a venue for large meetings, but it is noticeable that the Association of Anaesthetists has not been able to rent better accommodation for its scientific meetings in London.

It has been suggested that anaesthetists are paying too much in their annual subscription to the College of Surgeons. But is £20 per annum a large sum in these inflationary times? It is no more than the present subscription to the association. We suggest that, contrary to the belief of many advocates of the independent college, the ordinary anaesthetist will be paying much more in subscriptions and have less benefit than he does now if the plan comes to fruition. It will still be necessary to maintain and pay for a separate association structure, as the charitable status of a college would prevent it from negotiating with the Department of Health on terms and conditions of service.

Others have emphasised the political advantages of unity within the Royal College of Surgeons. We subscribe to the view that a combined voice is more powerful than separate individual voices and see no reason to believe that an independent college would lead to a greater representation of anaesthetists on national bodies. In any future political controversy it is surely obvious that the power or influence exerted by anaesthetists, fully backed by the College of Surgeons and its council, would be far greater than such power wielded independently by a new college, which, in its early years at least, would be lacking in prestige and tradition, relatively unknown, and therefore held in only moderate esteem.

We submit that both faculty and association are doing an excellent job in their respective fields at the present time. The ink is hardly dry on the revised charter of the Royal College of Surgeons. The specialty has already been honoured in the election of one of its members to the important position of vice-president of the college. It will take time for other changes to become apparent. It is clear, for example, that anaesthetists will have more influence on matters relating to the college funds in the years to come. In 1969 few would have foreseen the changes which have occurred within the college in the past decade. Who knows what can happen by 1989? In our view the new charter must be allowed time for its results to become apparent. The real enemies lie not within the profession, but without.

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Pay and parity

SIR,—No one, surely, will dispute the evidence on pay scales provided by Dr B D Scott (27

January, p 271), but we trust that these figures will not be used for pay parity arguments by our negotiators. These figures relate only to similar Government-repressed salaries. Mr David Ennals was recently heard on television news to state that Health Service workers should have pay parity with private industry. One of us has argued¹ that salaries should be comparable to those of other professional groups such as barristers. We would like to update those figures and would remind readers that many legal fees are paid by the Government for legal aid cases. We are informed that a barrister in the first five years after qualifying may expect to receive £5000-£8000 while senior partners earn around £20 000, against which many expenses may be claimed, and at this stage are comparable in professional status to a hospital consultant. Likewise, solicitors of the same seniority have a similar earning capacity. It is important to realise that the fees that make up these salaries have not been increased for seven years and are soon to be reviewed, no doubt leading to a considerable increase in potential earnings. Thus, while accepting Dr Scott's figures, we must press our Review Body to compare our levels of remuneration with those of professional groups whose incomes lie in the free sector, unfettered by government policies.

A E MACKINNON

I J REECE

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Children's Hospital,
Sheffield

¹ Reece, I J, *British Medical Journal*, 1975, 4, 523.

Industrial anarchy in the NHS

SIR,—The current industrial unrest requires firm leadership, not only by Government and unions, but, as you suggest, by the medical profession. I was therefore extremely disappointed by your leading article (10 February, p 364). Having correctly pointed out the low pay of ancillary workers in the Health Service, you then proceeded to offer as a solution to higher pay a reduction in staffing because "the NHS is overmanned (at virtually every level)." Such a comment would suggest that you have not seen the inside of a hospital for a great many years. The pressures on staff are numerous, and, while I have no doubt there are a few jobs which could be made more efficient and productive, for the vast majority of personnel, in this hospital at least, there is a constant pressure which requires a performance of duties far in excess of the optimum. The cry to "cut out administrators" is often heard, but this would lead to minute savings compared with the total cost of the Service. Your writer offers nothing in the way of constructive proposals to solve the industrial unrest.

I submit that we should support the justifiable grievances of the Health Service workers—while not supporting their industrial action—and we should be considering, as a profession, ways of incorporating ancillary staff into the care of the patient as part of a working team in order to increase job satisfaction, and from this to improve productivity.

D COLIN-JONES

Royal Portsmouth Hospital,
Portsmouth

Resignation from the NHS

SIR,—During the lull in our medicopolitical affairs we ought to be thinking about what happens after the Review Body reports. Whether this body recommends an acceptable level of remuneration for the new contract seems to me to be irrelevant. It is the second and third reports which will be vital. From past experience our "independent" Review Body has slowly let our standard of living fall while the various Governments have given us sharp downward prods. The question is whether or not we are going to take any action in protest. The 1975 imposition of a 40-hour week was a fiasco. Only a minority of hospital doctors followed the advice of their leaders. Opinion polls indicate that the public are fed up with industrial action and I think that highly paid doctors would be sitting ducks for the media to pick off.

Thus we are left with accepting passively that which we are offered or considering resignation from the National Health Service. The latter is, I believe, the only honourable course and would be understood by all men who have left uncongenial employment. Resignation would have to be carefully planned with agency arrangements, as most consultants would be terrified of taking such an action unless they were assured that the BMA held the requisite number of signed but undated resignations.

As a member of the Northern Regional Committee for Hospital Medical Services I gain the impression that militancy increases centripetally, and, as in our previous forays, our leaders at centre will find that the troops at the periphery will fail to follow.

J P TURNEY

West Cumberland Hospital,
Cumbria

GPs and casualties

SIR,—This practice is 26 miles from a district general hospital and its accident and emergency department. We care for the casualties which arise in our practice area at our surgery, because it is not practical to send them to the district general hospital and because it is not practical to leave our practice premises to treat them at our community hospital, disrupting the work in our own premises by our absence. This way of providing casualty services for remote areas is recognised by the Walpole Lewin report (para 6.4 page 23) but is not recognised financially and the General Medical Services Committee is not at present negotiating for the remuneration of general practitioners who provide casualty care for their own patients.

Doctors who feel compelled to provide casualty care for their patients because of isolation from casualty departments should be financially rewarded for doing so and I believe that the GMSC should negotiate for our proper remuneration.

M J LEVERTON

Millom, Cumbria

* * *The Secretary writes: "The GMSC has recently completed negotiations with the Department of Health for new arrangements for remunerating general practitioners providing casualty services in cottage hospitals. These new arrangements are presently being priced—by the Review Body. The Secretary of State has a responsibility to provide adequate

casualty services. It will be a matter for local negotiation with health authorities to ensure that casualty services are available in all areas, and where these have to be provided by general practitioners they must be adequately paid for the work undertaken."—ED, *BMJ*.

Next year's pay

SIR,—It appears from several articles in the paramedical press that Dr R A Keable-Elliott is attempting to persuade the Government to give us the whole of the outstanding 20% increase in remuneration, including the third phase 10%, due in 1980. I hope he realises that this will cause a shortfall of somewhere around 13% on 1 April next year. The excuse given is that our negotiators are worried lest the Government impose a wage freeze. Surely this cannot apply to agreements already made by the Government. I fail to see why our negotiators have been panicked into such a manoeuvre. I personally would be quite happy to take my 10%, plus whatever additions the Review Body sees fit to give us this April and await next year's 10%, plus an element for inflation. If I was negotiating on behalf of the Government I would seize Dr Keable-Elliott's suggestion with both hands.

I would guess we will pick up somewhere around 22 or 23% on 1 April this year if everyone has done their homework properly. If inflation continues at its present level then a similar amount would be expected next year. Faith in the BMA among its members must have been badly shaken by the debacle of the clinical assistants' arbitration. Now I find Dr Keable-Elliott giving away a substantial part of my future income without so much as having discussed whether or not I would agree. Just whose side is he on?

MICHAEL WYNN

Buckie, Aberdeen

Short-term medical certification

SIR,—Those who listened to a recent edition of *Any Questions?* (Radio 4, 2 February) will have heard Mr Arthur Scargill say that in his opinion miners should be paid more than doctors. I do not share his view, but as a GP in a mining community I can understand how some might do so.

It is a lamentable but incontrovertible fact that a considerable part of my work could be done equally well by my receptionist, and my patients know it. I refer to the issuing of short-term medical certificates, a chore which in many cases requires no medical knowledge or skill whatsoever. It is obvious that in some practices this is far less of a burden than in others, but in a mining practice such as mine (I am in a partnership of three with just under 9000 patients) up to 20 "consultations" a day per partner are for the purpose of certification for "illnesses" which can be neither confirmed nor excluded by clinical examination. The arguments put forward in the DHSS letter published in this week's *BMJ* (17 February, p 501) are purely those of expediency and should not, I submit, be accepted by the profession. I cannot see that increased use of the form Med 5 would help appreciably.

I make no pretence to high academic ability, but I bitterly resent the fact that in much of my work my medical training is quite superfluous, and that a section of my patients judge me

not by my clinical ability, such as it is, but by the ease with which I can be "conned." It is surely quite illogical to advocate, as do the proponents of the new "charter," the training of more GPs, and the reduction in list sizes, without first ensuring that those already in practice do not have to waste so much of their time on such menial tasks.

The continuation of the present farcical system of certification, while no doubt very convenient for the DHSS, is resulting in the devaluation of general practice as a profession in the eyes of a significant section of the community, and Mr Scargill's statement is but a sign of this devaluation. This consideration must surely transcend all others in any further negotiations with the Department.

E W STURTON

Worksop, Notts

Normansfield and the NHS

SIR,—Dr T L Pilkington (3 February, p 348) appears to think that because psychiatrists have moved around and surgeons have not the former are more enlightened, although he does not give any reason why this should be so, whereas one could think of a number of explanations for this activity.

Unfortunately, only part of my letter (13 January, p 131) was published in the *BMJ*. Surgeons and those in other specialties usually have a rather longer course of training before they achieve consultant status than do psychiatrists, and most of them have moved many times by the time they achieve their final appointment and are older because of the increased length of training required before they are appointed. Perhaps, therefore, psychiatrists accept the change more willingly. To add to their troubles, those who practise surgery, medicine, and often even general practice find themselves moved about because of the rather bureaucratically imposed regulations from the royal colleges and other examining bodies and the need to have a much wider experience before they achieve the ultimate senior appointment. One would point out, however, that one of the reasons that the armed Forces find it difficult to recruit staff is the domestic insecurity which is involved and that the population at large thinks that it is entitled to have work brought to the workers rather than have the worker move his home. Higher appointments are expected to be very generously rewarded under the terms of disturbance which precede appointment. In my own case I was greatly discouraged from my family's choice of career in the Foreign Service by this very fact. If consultants are to be moved around in this fashion then I am sure the specialties will rapidly lose their popularity and an increasingly apparent shortage in some fields will reach a crisis level.

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Careers for part-time doctors

SIR,—I have read with great interest the Talking Points (13 January, p 144 and 3 February, p 359) on "Revised career structure: first priority" and "The new consultant contract and women senior registrars". I have been considering the problems of doctors in non-

training grades who wish to work on a sessional basis in NHS hospitals and would like to proffer the following ideas for discussion.

At present the main categories of doctors in non-training hospital posts are consultants, hospital practitioners, medical assistants, and clinical assistants. As many medical assistants are full time my suggestions are confined to the other three categories. Consultants have a defined service commitment with ultimate responsibility for their patients, and need to have satisfactorily completed an approved course of training with a recognised higher qualification. Hospital practitioners are principals in general practice with a defined period of experience in the hospital work they undertake. Clinical assistants comprise the rest—those who either have not completed a full vocational training course or are unable to offer enough notional half days to be appointed as a consultant. No allowance is made for higher qualifications or experience, prospects for promotion are limited, and the salary scale has no increments.

Part-time doctors are unhappy at the lack of a defined mechanism for employment; they do not fit into the present system and special arrangements have to be made to employ them as individuals as they are frequently tied to a geographical area.

What is needed is a combination of the hospital practitioner and clinical assistant grades and the elimination of the principal in general practice qualification. There should be a pool of sessions that can be applied for and the applicant should be graded according to experience and higher qualifications and put at the appropriate point on an incremental scale. It is a matter for discussion whether the sessions should be funded nationally or by area health authorities, as there will always be the problem of a well-qualified doctor forced to move from one area to another because of personal and not professional reasons—and also the local service requirements have to be considered.

The name of the post needs careful consideration so that it neither implies a permanent subordinate status nor carries emotional overtones such as those evoked by the terms junior and senior hospital medical officer. Hospital practitioner is an inoffensive title if the restriction to principals in general practice is removed.

The number of doctors wishing to provide a service to the NHS on a less than full-time basis is likely to increase with the well-documented rise in female medical students. Although many of them should be able to complete their vocational training and become successful consultants provision should be made for those who are unable to fit into the present system.

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Correction

Miniature peak-flow meters

The second sentence of the second paragraph of this letter by Dr B M Wright (17 February, p 489) should have read "In addition a correlation coefficient of 0.902 with the standard meter compared with 0.990 for the mini-meter, means that it is only about one-third as precise as the latter".