volume to 9 volumes of whole blood¹ followed immediately by gentle mixing. The appropriate tests should be carried out as soon as possible.

E K BLACKBURN
Chairman

N K SHINTON
Secretary

Anticoagulant Control Panel
of British Committee for
Standardisation in Haematology

Coventry and Warwickshire
Hospital,
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¹ Ingram, G I C, and Hills, M, *Thrombosis and Haemostasis*, 1976, **36**, 237.

duction of a continuing choice as indicated in (10) above.

D HUNTER SMITH
T J DEEBLE
J ALAN AMOS
D BRYDEN
F M ELDERKIN
W D PATERSON
T G GIRDWOOD
R MCNEILL
A INGLIS
E CARR-SAUNDERS
JOHN WRIGHT
J CHATERJEE

R J C SOUTHERN
R L MC MILLAN
J T TAYLOR
S C BANERJEE
E J MACDOUGALL
T M SINGH
J N HAWORTH
F B BUCKLEY
C F ROLLAND
JOHN WOOD
CLIFFORD SALTER

Garlands Hospital, City General Hospital,
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work require the allocated two sessions for necessary administrative and on-call commitments then 12 scheduled sessions must require three such extra sessions, bringing the total to 15.

Our initial proposition was that the new contract will discriminate against those consultants who work the largest number of scheduled clinical and laboratory sessions. If the adjustment we propose is not made our case must stand.

R B PAYNE
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The new consultant contract

SIR,—We full-timers view the possible implementation of the new contract with increasing distaste. Among our objections to it are the following:

(1) There is uncertainty regarding the availability and distribution of extra NHDs. (2) The financial constraints within which employing authorities inevitably work mean that all consultants will be effectively competing for extra NHDs—with divisive results. (3) Varying interpretations of the contract will create anomalies between regions. (4) Future consultants will be deprived of the choice of full-time status, since this will depend entirely on the availability of four extra NHDs. (5) Those who, in future, are not interested in private practice or have no chance of it and who are therefore able to devote the whole of their professional energies to the NHS will not be offered the present modest premium to do so. This cannot be in the interests of potential full-timers, or of the NHS. (6) The new contract represents a radical alteration in terms of service, rather than just a change in the method of remuneration. There is no justification for substituting it without any choice for the present contract on the basis of last year's unsatisfactory ballot. (7) The hoped-for increase in earnings, which was the main incentive to accept the new contract, might be disappointingly small, and would almost certainly be considered by some to have been inequitably distributed. The level of remuneration should be regarded as a separate issue from the structure of the contract. (8) Many full-timers, present and potential, would prefer an open contract of the existing type, by which they would assume a defined responsibility in return for an inclusive salary. The latter would have to be reasonably attractive in comparison with the proceeds of an average new-style contract—otherwise the option which existing full-timers will have to retain their present contracts will be seriously devalued. (9) The new contract is too complicated and will require a great deal of extra administrative work both to set up and to oversee; if the choice of a salaried open contract remains for future as well as present consultants administrative complications would be reduced in proportion to the number choosing the old-style contract, which is inherently much simpler. (10) While we have no desire to deprive those who may prefer it of a new-style contract, we cannot agree that its introduction should prevent our successors from choosing an open salaried contract, suitably priced, if that is what they prefer.

The purposes of this letter are to mobilise opposition among full-timers to the new contract as it stands at present and to serve notice on our negotiators and on the DHSS that such opposition exists on a substantial scale. We insist that our views merit serious consideration. In the event of a further ballot—and it is hard to believe that this can decently be avoided—we intend to vote against the new contract, irrespective of pricing, unless it is amended by the intro-

SIR,—Dr C C Booth and his colleagues (17 March, p 755) have described the pathological features of the new contract in detail and most workers in this field would agree with them that malnutrition is the main aetiological factor. But from such a wealth of scientific talent one expects a more precise prescription for therapy than "the BMA must convince the Government."

Other consultants are familiar with the degenerative aspects of the new proposals and would welcome ways of restoring the health of the profession without resorting to radical reconstructive surgery.

What exactly do Northwick Park advise?

E N GLICK

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SIR,—I write in total support of the letter of Dr C C Booth, undersigned by 47 of his colleagues (17 March, p 755). The proposed new consultant contract is unacceptable, no matter what the pricing.

M G REVILL

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Proposed consultant contract—equal pay for equal work?

SIR,—We are most grateful to you for publishing our comments on the new contract (17 March, p 755). The Secretary replies that our calculations are fallacious because the two sessions allocated in the new standard 10-session contract for on-call responsibility and for administrative commitments are genuine sessions requiring work and effort.

We do not dispute the latter contention in the least. However, the extent of the on-call and administrative components in the new contract are clearly related to the extent of the clinical and laboratory work performed, because they are to be reduced pro rata if fewer than eight scheduled sessions are worked. We fail to understand why a consultant's on-call commitment and responsibilities will not therefore increase pro rata if he works more than eight scheduled sessions. The gravamen of our assertion is that any clinical or laboratory sessions above the standard contract will generate further on-call and administrative commitments. Therefore, such extra scheduled sessions should be remunerated at 125% of the normal sessional rate to accommodate the demands of this unscheduled work. To state the position in another way: if eight sessions of scheduled

Saving pay-beds

SIR,—The Health Services Board has now opened a new phase of its campaign to remove authorisation for private beds from NHS hospitals, and I would be grateful for the opportunity to draw the attention of consultants to this matter and to give some guidance on the steps necessary to counter it.

On 1 March the board sent a letter to all consultants employed in the NHS in England, indicating its intention to apply section 70(c) and (d) of the National Health Service Act 1977 to remaining authorisations for private beds. These two subsections instruct the board to inquire into the measures which have been taken to create alternative facilities to replace hospital private beds and, where it is not satisfied that everything possible has been done, to issue "due warning" that the existing authorisations in the hospitals concerned will be withdrawn by a specified date. For this purpose the board has divided hospitals with private bed authorisations into four groups according to the number of beds still retained, and has set a timetable for the various stages of the exercise, starting with the smallest units with fewer than 10 beds and ending with units having over 20 beds. In its programme the date for implementation of withdrawal in the largest units will be 1 July 1982.

Superficially, this might appear to mean that there will be no authorised private beds remaining in NHS hospitals after 1 July 1982, but this is, of course, not the case. The board is bound by the Act of 1977, which indicates fairly precisely the criteria by which the board must judge the efforts made to create alternative facilities. Consequently, where suitable evidence can be presented to the board regarding the efforts made it will be obliged to give it very serious consideration and to retain the authorisations if all reasonable steps have been taken. It would be quite inappropriate to issue advice to consultants on how best to tackle the problem of creating and presenting such evidence in this letter, but within the next three to four weeks chairmen of medical executive committees (or medical staff committees) in all affected hospitals will receive a letter setting out in detail the steps which should be taken to allow an acceptable case to be made to the board to defend the remaining beds. If, by any chance, a hospital has not received such a letter by Easter, at the latest, a copy will be sent immediately in response to a request to BMA House.

Sadly, a number of hospitals covered by the Health Services Board's proposals sent out in October and December 1978 do not appear to have taken any steps to present evidence to the board opposing its recommendations. I fear

that this must lead to the closure proposals being implemented in full. I would urge all consultants to take the new proposals very seriously, even though the time for implementation may seem a long way off, and to act promptly on the lines suggested in our letter. To take no action must be interpreted by the board as acceptance of the proposals, and will inevitably lead to the unnecessary loss of authorisations for private patient accommodation from hospitals which can ill afford it.

D E BOLT

Chairman,
Joint JCC/CCHMS Subcommittee
on Independent Medical Practice

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New GP charter

SIR,—The report of the New Charter Working Group is commendable. However, as you say in your leading article (24 February, p 509), "Since the NHS started, the question of how much a doctor was worth has never been answered to everyone's satisfaction." We are all living in hard times and under pressure, but there is no doubt that the living standards of general practitioners have been greatly reduced over the last few years. To set oneself up in general practice today is an extremely traumatic experience, and I am surprised that people are still dedicated enough to do this and not emigrate. Certainly in this area the cost of housing has become almost prohibitive, and I am sure that the next person to enter general practice in this area will be living in a council house unless he or she has substantial means.

Secondly, to try to buy oneself into the practice—that is, the building, unless working at a health centre—is almost impossible owing to the substantial sum needed and the rates of interest. What has happened to the cost rent scheme, phase II?

Thirdly, the cost of cars is becoming absolutely crippling. If one lives in the country, then one requires two cars. To replace two cars would cost at least £10 000. Where does one raise the money? There is the argument for leasing a car, but this is not advantageous to those paying the lower rate of tax.

The only way to survive with a reasonable standard of living is to go on borrowing money from one source or another or rely on one's parents or parents-in-law to subsidise oneself. Gone are the days when the general practitioner was a respected member of the community, basically because he is unable to afford a certain standard of living which the public used to expect.

There may be some left-wing doctors who would say that this was a good thing, but I am sure that the majority of general practitioners feel the same way as I do, that it is a disgrace that our standard of living continues to decrease. It is high time some really strong action was taken.

CHARLES BALE

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SIR,—I must register my protest at the new GP charter. I do not criticise it because it is so clearly aimed at benefiting doctors and not patients but because some aspects of it are detrimental to the unity of general practice. The items for fee payment per service are arbitrary and divisive. The extension of this

concept beyond one or two well-defined items will not do.

It is not necessary to have been in general practice for 20 years, as I have been, to know that good practice consists in good history-taking and adequate simple clinical examination, often under pressure. Asking an elderly arthritic lady to remove her garments, including her corset, and have her abdomen examined to see whether she really does have a procidentia can add five or ten minutes to an already busy surgery, but this is what good general practice is about—not how many electrocardiograms or desensitisations you do, although I frequently do both of these latter items already.

Quality control of thoroughness is not possible in general practice and cannot be priced. Aiming to increase our pay in arbitrary fashion by methods which will predictably be most contentious is not the answer.

M D COULTER

Sandy, Beds

Distribution of general medical practitioners

SIR,—In their letter Dr B Jarman and Miss Margaret Lally (17 March, p 757) succinctly defined certain features of general practice in Inner London with special reference to Kensington, Chelsea, and Westminster. Another aspect of the work load is provided by the presence of a substantial number of migrants, many of whom come from western and central Europe and North Africa. Some are full-time students, but most come to improve their English and find work in the hotel and catering industry. Their sojourn varies from a few months to two or three years at most, with frequent changes of address. They are mostly young adults of varying social and educational backgrounds, and some are used to a sophisticated standard of medicine at home. They have widely different attitudes to and expectations of our NHS, although I have found very few overt attempts of abuse. A temporary registration of three months, on average, involves from two to six items of service. Whatever the problem, they invariably present themselves with a physical symptom, and, although a consultation can be full of interest, language difficulties often make the procedure a lengthy one.

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MWF action on future of women doctors

SIR,—The Medical Women's Federation's careers symposium on 9 March was held to draw to the attention of the public, the profession, and Government the fact that action was necessary to avoid wasting the money (amounting to £40 000 each) spent on training the increasing numbers of women doctors and underusing their skills.

By 1983 1400 women doctors will graduate from UK medical schools each year, compared with the previous 400 a year. At present 60% of women doctors in non-training posts in England and Wales are in positions without autonomy of practice—posts such as clinical assistant and clinical medical officer. At the symposium varying views were expressed by speakers on how women doctors should organise their lives. The federation considers that this should be a matter for the individual

to choose. Now they cannot choose. To make choice possible, changes will be necessary.

Firstly, the "take-home" pay for doctors working full time must be adequate, reflecting the value of their training. Unless it is, women doctors cannot pay for the assistance they require with child care in order to work. Crèche provision and pre-school child care facilities must also improve.

Secondly, urgent action is required to make opportunities for part-time training and career posts available in all medical disciplines. Half-time work in many training jobs amounts to 40 hours a week—it is far from being a derisory commitment.

Thirdly, single women doctors should not, as at present, be hampered in their attempts to pursue their careers because of the expectation that they will get married. Husbands (themselves often medical) of women doctors will surely come to realise that it is in their interest for their medical wives to work. This is the husband's escape route from the burden of being the sole breadwinner and working longer hours than he wishes, and/or taking a job he may not enjoy because it is well paid. It will be necessary for husbands of women doctors to encourage them to use their training and for men to share in the responsibility for the care of their own children.

The need for career counselling of both women medical students and women doctors was emphasised at the conference. This is now available for women doctors from the MWF liaison officer, and will soon be set up by the federation for women medical students.

So much for the aims: how to achieve them?

(1) For a woman doctor with children to take up full-time work as, for example, a consultant a take-home pay of more than £8000 a year is necessary to cover the cost of the facilities which enable her to work, such as nanny, car, medical subscriptions, and telephone. Money over and above this is required if she pays for her own food and housing. At present the take-home pay is about £6000 a year. Consultants' pay is used as an example, but the principle applies to all forms of medical practice. Government and Opposition spokesmen, and the Doctors and Dentists' Review Body, will be informed of these and other relevant figures. (Justification for sums quoted is available from the MWF office.)

(2) The MWF will put to all local authorities and hospitals detailed suggestions for action concerning pre-school child care and crèche facilities.

(3) Strong representation will be made to the health departments for central funding of part-time senior registrar posts, as happened before 1974. Central funding would remove the disparity between provision of posts in different regions, clearly demonstrated at the conference. The profession's negotiators and the royal colleges will receive detailed suggestions on the steps to be taken to set up sufficient part-time training and career posts. The federation will insist that the Central Manpower Committee should be reconstituted with at least one woman doctor elected to represent her colleagues.

(4) The Equal Opportunities Commission will be requested to take up cases in law where the present system can be shown to discriminate unreasonably against women doctors.

(5) Members of Parliament will be widely canvassed for their support.

The careers' conference demonstrated that the problems were even worse than we had thought and that anger among women doctors at the present state of affairs was mounting. Unless the present system of low pay for doctors and few opportunities for part-time training and work is changed, the enormous investment in doubling medical student numbers will still result in an undermanned Health Service.

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Medical Women's Federation

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