priced. The new contract, based on the notional half day, allows some definition but preserves "professionalism" by its time-honoured flexibility. Only through this mechanism will it at last be possible to recognise the long hours at present worked by the majority of full-time consultants.

The notional half days above the standard 10 must remain "uncertain." Otherwise they will become an integral part of the basic contract and the value of the notional half day would be reduced accordingly. It is important to realise that no consultant need work more than 10 notional half days. We did not design the contract so that consultants would have to work their present large number of hours in order to earn a professional salary. If the standard contract is adequately priced the financial imperative to take on extra notional half days will be removed, and because of the present high rate of taxation it is unlikely many consultants will think it worth working more than 13 notional half days.

The new standard contract will indeed mean the end of the present concepts of full time and maximum part time. In practice, if the present level of service is maintained, as the Secretary of State has promised, full-time consultants working a five-day week will get an extra two notional half days added to the standard 10. Thus there will be a "differential" over the standard week based on the work they do. More consultants will be able to engage in private practice even on a very modest scale because there will be no "fine" for doing so.

Last year's ballot was on the principle of the contract. It received the support of 70% of consultants. It was properly conducted by the Electoral Reform Society. The pricing of the contract has always been recognised by the BMA as a separate issue. A second ballot has already been budgeted for and hospital consultants have been asked to notify the BMA of their addresses to ensure that a voting paper may be sent to them.

The new contract will initially require extra administrative work, but once operational it should not need more supervision than any other contract if the consultants' pattern of work does not change. Preserving an option of the open-ended undefined contract as well as this new defined contract would be even more difficult to administer. The principle of the 10 notional half-day contract has gained favour over the last 10 years. A very large majority of senior registrars voted for the new contract and the contract was endorsed by the Hospital Junior Staff Committee. Our immediate successors are therefore in favour of it. The new contract does provide the mechanism for paying the consultant the professional salary for his professional work and it is now up to the Review Body to recognise the full worth of consultants in the Health Service.

JAMES APPLEYARD

Kent and Canterbury Hospital,
Canterbury CT1 3NG

SIR,—There are numerous valid objections to the new consultant contract but I have not so far noted in your correspondence columns any discussion of one that seems to me to be of great importance.

A consultant's remuneration would depend on the number of NHDs he works in excess of the basic 10 and also on his on-call commit-

ment. This is to be subject to review (normally every two years and at least every five years). If the service were to be improved by an additional consultant appointment in one's specialty, the employing authority could justifiably argue that it should no longer be necessary for one to work as many NHDs as previously and, in many cases, that one's banding for on-call commitment should be downgraded.

While it is disturbing enough that a consultant's salary might be greatly reduced by an additional appointment, it is even more worrying that the interests of an individual consultant and those of the Health Service should be in conflict. How can we be expected to advise dispassionately on the development of the service when that advice which may best serve the community in which we work is likely to result in a reduction of our own salaries?

It is inevitable that if we abandon a "professional" contract with its open-ended commitment and adopt a contract of the type proposed we shall have to face serious dilemmas and abuses. Mr David Bolt and his fellow negotiators do not hesitate to remind us that the overwhelming majority of consultants appear to want a contract such as they have negotiated. Those of us who feel that acceptance of this contract would be a disaster, both for the profession and for the Health Service, must continue to expose the shortcomings of the new contract, of which the negotiators must be aware but of which they say nothing.

A M ZALIN

Wordsley Hospital,
Stourbridge, West Midlands
DY8 5QX

"Time-expired" senior registrars

SIR,—As one concerned with the training of registrars and senior registrars in obstetrics and gynaecology, I would like to support the comments made by Mr C Wastell in his letter (17 March, p 493). Like general medicine and surgery, obstetrics and gynaecology is one of the popular specialties and there is therefore a log-jam produced by too many applicants for too few consultant posts.

In a free market it would be reasonable to allow market forces to apply but there would then be more than one employer. With a single employer, the NHS, and emigration now virtually impossible, this is manifestly unfair, particularly as consultant posts are not filled exclusively from the senior registrar ranks but are also filled from university posts of lecturer and senior lecturer and, as in some recent appointments, from abroad.

The defence of the monopolistic employer, the DHSS, and the senior registrar training committees—that senior registrars were aware when they signed it that their contract was for four years only—really must not go unchallenged. In the past four years this has been honoured in the breach rather than in the observance, and there are many eminent consultants who have had senior registrar posts for as long as twice that time. Indeed, at one time the DHSS positively directed that senior registrars must not have their appointments terminated after four years. In any case, with only one employer what else can a registrar do but sign a contract for a post which is a mandatory step to eventual promotion to consultant, whatever its terms?

In the popular specialties there are few, if any, unfilled consultant posts. A recent *Health Trends* showed only one unfilled post in obstetrics and gynaecology. Are all the posts filled really desirable, or are they filled by "time-expired" senior registrars desperate to avoid dismissal? It is difficult not to conclude that the employing authority in finding itself with too many fully trained obstetricians (that is, senior registrars) is using the four-year rule to fill unattractive posts.

To conclude, I would repeat what Mr Wastell has already said, that to dismiss a fully trained surgeon, physician, or obstetrician who has nowhere else to go and no other reasonable way of earning a living is an appalling waste, and would certainly not be tolerated if it were applied to a member of the ancillary staff at the hospital where the same senior registrar was working.

ROGER DE VERE

Westminster Hospital,
London SW1P 2AP

¹ *Health Trends*, 1978, 10, 63.

Emergency recall fees and extra-duty allowances

SIR,—Medical assistant and assistant dental surgeons should be receiving emergency recall fees from 1 April 1979 in common with other senior hospital medical staff. However, the Medical Assistants Subcommittee of the CCHMS, which is negotiating our new contract, decided that they would prefer to retain extra-duty allowances and voted against the present implementation of the emergency recall fee system. This decision was apparently made without reference to the members whom they represent, and as only approximately one-third of assistants receive extra-duty allowances it is biased in favour of a minority. It would be interesting to hear how they justify their action. I personally am not eligible for extra-duty allowance but am expected to be available for emergency recall. It would appear therefore that some medical assistants are now the only group of hospital medical staff who can be called in for emergency duties without remuneration.

I feel strongly that the subcommittee should urgently rethink its policy, return to the negotiating table, and correct this anomaly.

PATRICIA MORLEY

Department of Diagnostic Radiology,
Western Infirmary,
Glasgow G11 6NT

Recall and on-call fees for radiologists

SIR,—Dr N Simmons¹ (*World Medicine*, 10 March 1979) has drawn attention to a statement in the 1978 Review Body Report—that "the joint view of the professions and the health departments is that certain groups of specialties . . . do not normally involve an on-call commitment for emergency admissions." The decision to include radiology in this category was based, we understand, on the results of a survey of the pattern of consultant work carried out by the DHSS. None of us in this department can remember being asked about this matter, nor has the subject been discussed at any meetings of our local CHMS.

In this teaching hospital an on-call radiologist rota limited to consultants and

senior registrars has been in operation for over 15 years—the consultant commitment varying from one night per week to every night in the week, dictated largely by the type of radiological expertise required. In some situations—for example, neuroradiology—the consultant could have completed an emergency investigation before the patient is seen by a consultant in any other discipline, yet he is to be excluded from “banding.”

Our negotiators repeatedly advise, indeed exhort, acceptance of the new consultant contract on the grounds that it is designed to be of great benefit to the shortage specialties—this by way of additional paid sessions in the evenings and at weekends—chief administrative medical officers permitting. The refusal to recognise an on-call commitment for radiologists, despite their entitlement to recall fees, seems quite illogical; this feature of the new contract could be a definite deterrent to the young doctor seeking a career in active clinical radiology.

We conclude that the DHSS, supported by our negotiators, is happy to settle for the continuance of an outmoded form of radiological practice.

LEWIS A GILLANDERS
PETER WARD
A F MACDONALD
R G MAHAFFY
A P BAYLISS
J WEIR
JOHN S CANTLAY

Department of Diagnostic Radiology,
Aberdeen Royal Infirmary,
Aberdeen AB9 2ZB

¹ Simmons, N, *World Medicine*, 1979, 14 (11), 7.

* * *The Secretary writes: “There is nothing in the new contract agreement that limits the availability of on-call banding to any specialty. If a consultant in any specialty can show his employing authority that he needs to provide the kind of availability in the contract document, he will be entitled to the appropriate on-call banding, and the writers of this letter would seem to have an excellent case for this.—Ed, *BMJ*.”

Financing health care

SIR,—The 1977 LMC Conference asked for a charter to bring GPs’ salaries in line with those in other EEC countries. The disparity is not limited to GPs, however; it is even greater when specialists’ income is compared. Another cause of dissatisfaction, perhaps even more important, has been excessive work load, arising primarily from the increased demand inseparable from a service which is free at the time of use. The fact that standards of medical care in the UK are as good as they are is a tribute to the medical profession. Most doctors in general and hospital practice work long hours in an attempt to provide good quality medicine and most patients realise this. But more medical time must be made available and the country must spend more on medical care.

The UK is unusual in financing its NHS almost entirely from the State by taxation and national insurance and in making virtually no charge for medical care. In practice it is not possible to raise unlimited revenue for health care from taxation—there are always other services claiming such revenue and further increase of taxation would be self-defeating—higher direct taxation reduces incentive to work, while higher indirect taxation leads to

demands for higher wages and so to inflation or unemployment or both. If more money could be raised for the NHS in this way, Labour governments would have raised it. Most other European countries finance health care by two other methods—sickness insurance and direct part payment by patients in proportion to their use of the service. Contributions to sick funds are levied usually on employers and on employees. The main advantage is that the funds cannot, without legislation, be diverted to other uses. In nearly all health services in Western Europe, apart from West Germany and the Netherlands, insurance organisations pay about 75% to 80% of each GP fee up to a maximum indicated by a scale of fees, leaving the patient to pay the remaining 20-25% of the scale fee and also the whole of any sum the doctor may charge above the scale fee.

Part payment in the NHS would restore a direct link between supply and demand for medical time; increase supply of medical time; restrain unjustified demand for medical attention; and raise some extra finance for health care. One of the advantages would be that a significant proportion of doctors’ earnings would come from private rather than from official sources. All patients agreeing to participate would become private patients with 75% to 100% reimbursement of their fees. Thus there would be no clear distinction between private and public care and the old bogey of two standards of medical care would disappear. To facilitate transfer of medical records and to restrain any tendency for patients to consult more than one doctor for the same problem it might be desirable to retain registration of a patient with doctors.

Reforming the NHS in this way, with new sources of finance on European lines, not only is the only way in which UK GPs will ever earn incomes comparable to those of GPs in the EEC but, perhaps more important, it will also produce a higher standard of service to patients.

F G TOMLINS

London E4

Points

Who looks after the infant?

Dr CHRISTOPHER MAYCOCK (Crediton, Devon EX17 3JY) writes: Professor R S Illingworth, in his paper on his experience in a child health clinic (31 March, p 866), seems to be describing the general practitioner in his central role of doctor to the whole family. Many GPs run their own paediatric clinics, setting aside time for these sessions, often in co-operation with the health visitor. These doctors have the advantage of living close to their patients, knowing their families, and having records of their treatment and of their medical and social problems. They usually have facilities for urine microscopy and culture, for haemoglobinometry, and for writing prescriptions, etc. Sometimes criticism of general practice is directed at general practice itself rather than at the political and physical circumstances in which it often operates, and these in turn may arise from failures of political will and imagination at a higher level. Perhaps the main solution to this problem lies in practical encouragement of those general practitioners who have yet to provide the necessary services. . . .

Child-resistant containers

Dr R T D FITZGERALD (Sheerness, Kent ME12 1TR) writes: A large number of my elderly patients are quite unable to open child-resistant containers (7 April, p 951) on account of arthritis or senility. The result is that they have someone else open the bottles for them and then keep them with the tops lightly screwed on or even without any tops at all. As a result any child in the house has easy access to such a bottle placed within easy reach of an elderly person. . . . If the tops are screwed on properly elderly people are often unable to get at their medication, a situation reaching its extreme in the case of an old man found dead with a bottle of glyceryl trinitrate in his hands which he was unable to open. Now someone has invented a bottle top with a flange so that it is easily opened by arthritics—and therefore by children. You cannot have it both ways. There is only one safe way to keep drugs and that is in a place where young children cannot get at them. If you wish to add a deterrent then pills could be given a bitter coating instead of being sugared.

Oral temperature and hypothermia

Dr J M FORRESTER (Edinburgh EH10 5NS) writes: Dr K J Collins and Professor A N Exton-Smith (31 March, p 887) are reassuring about low oral temperatures in the elderly. Urine temperature may still be quite normal, they find, and so presumably may the temperature deep in the trunk. But why are they complacent about brain temperature? It is affected by face skin temperature.¹ It presumably fell in their young and older subjects in cold environments, since there was evidently some drop in the temperature deep in the external auditory meatus of their subjects. . . .

¹ *Lancet*, 1978, 2, 414.

Health and safety at work

Dr B J BOUCHER (The London Hospital (Mile End), London E1 4DG) writes: The valuable list of guidance material on safety that has been obtained by Miss Gwen M Prentice (7 April, p 956) not only will be of use to others . . . but its appearance in your columns, rather than throughout line management, highlights the shortfall in the provision of guidance to NHS staff. It also highlights the energy and time local staff have to expend, in order to begin their efforts to comply with the spirit and the requirements of the Health and Safety at Work Act. . . .

Corrections

Malaria in Wolverhampton

In the letter by Dr R G Thompson and others (7 April, p 952), owing to an oversight the authors’ acknowledgment of the help of their laboratory staff was omitted.

Driving after anaesthetics

In the letter by Dr W D A Smith (14 April, p 1016), “hypoxaemia” in the fifth line of the second paragraph should be “hypomania.”