Bradwell and Delamere's account is available for comparison.

A PINES

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¹ Pines, A, Slater, J D H, and Jowett, T P, *British Journal of Diseases of the Chest*, 1977, **71**, 203.
² Rennie, I D B, and Joseph, B, *Lancet*, 1970, **1**, 1247.

Commonwealth Medical Association

SIR,—I learn with amazement and considerable distress that Council has placed on the agenda of the next Annual Representatives' Meeting an item advocating that the BMA should resign from the Commonwealth Medical Association. I can hardly believe this is true.

As a past president of the BMA, I had the privilege and pleasure of being the first president of the CMA—a body formed and sponsored by the BMA. The CMA has since its inception faithfully supported the principle and standards—clinical, scientific, and ethical—of British medicine. We should not have to remember, but perhaps in this day and age we do, that Commonwealth medicine is British medicine. For the "senior partner" to resign on the specious excuse of saving the paltry sum of (I believe) £400 is surely evidence of a policy so petty, mean, and frighteningly parochial as to be almost incredible.

At this particular time in our history neither this country nor for that matter its medicine (which I trust the BMA still feels its responsibility to represent) has so many friends we can afford to throw them away with gay abandon. Are trust, tradition, and friendship to be casually thrown away for a few "pieces of silver"? I sincerely hope Council will rapidly have second thoughts on this matter and expunge this disgraceful item from the ARM agenda.

PORRITT

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SIR,—As the first vice-president of the Commonwealth Medical Association and as the chairman of the Overseas Committee which advocated that the BMA should found this organisation, I am greatly distressed to find that a proposal to the ARM to withdraw from the CMA has been put forward by Council (7 April, p 19 of Annual Report of Council).

It is true that the days of Empire are past but there has been the constant and continuing close relationship of what were former colonies and dominions to this country. A very great degree of friendship and collaboration has remained. These developments arose from the evolution of independent states and were right and proper, but for the UK to cast off former friendships is indicative of our waning national spirit in a country which once deserved the term great. We are casting and destroying our heritage, discarding our friends, and regarding our interests as limited to the UK. Something which has taken decades to build up is going to be destroyed at a stroke and may never be revived. The BMA in future will be seen as concerned with parish-pump politics and home trade-union activities.

I am aware that the CMA involves expense and it might well be that in days of financial stringency curtailment of its activities may be necessary, but to abandon it is both unwise and in my opinion dishonourable. If this is our point of view then we cease to deserve the regard, affection, and respect with which hitherto the BMA has been regarded by other

members of the Commonwealth and I would be ashamed of the Association.

ERIC C MEKIE

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PPP plan for BMA members

SIR,—I am delighted to see that Mr J G W Gelling (14 April, p 1022) is sympathetic to the problems I mentioned earlier (24 March, p 826). My only regret is that he has not sufficient courage of his convictions to extend the concession to all patients in the plan and not to a selected few, which seems to be rather arbitrary and unfair. I would hasten to add, however, that my criticisms were not directed at PPP specifically, and indeed I did state that all provident associations have some form of restriction on outpatient fees. I have certainly no complaint about the PPP plan as a whole, which compares well with the others.

Mr Gelling goes on to ask how the private diagnostic investigation facilities are to be provided, but this is not the problem which currently affects me. At present in the Guildford area I can provide private diagnostic facilities in my own specialty but with an increasing number of patients opting to have outpatient investigations on the Health Service it is doubtful if the provision of such services, which inevitably involve the provision of expensive apparatus, will continue to be an economic proposition. When setting up new laboratories I have no doubt that some form of capital support would be required and there would certainly be a role for private enterprise, whether from the provident associations or from elsewhere. However, in that case also a reasonable return for the money invested would be expected and indeed might be more rigorous in this context, as it would be a commercial enterprise expecting a competitive amount of interest on the capital involved.

The local area health authority has just ruled that access of private patients to the newer facilities being provided in our new hospital when it opens later this year will not be allowed. It therefore seems that this form of test will not be available privately as there would be inadequate use privately to warrant the expenditure and it will not be available at the local hospital on a private basis either. Surely this is yet again a warning that in due course investigation facilities will become a National Health Service prerogative unless we take action now. Once the investigations are entirely under the NHS private medicine will be at jeopardy except for those few illnesses which do not require modern technological investigation.

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The new consultant contract

SIR,—The following statement has been signed by 83 clinical scientists, with honorary consultant status, working in Medical Research Council units and university and medical school departments throughout Great Britain.

"We wish to bring to the profession's attention our condemnation of the proposed consultant contract. We assume, perhaps naively, that we will be offered the same salary as our full-time NHS colleagues who choose to opt out of the right to do private practice. In addition, some additional payment for not being able to complement our salaries by

doing domiciliary visits would be advisable if academic work is not to suffer. However, despite these safeguards, it is clear to us that the salaries of consultant medical academic staff must fall behind those of our NHS colleagues as it will prove impossible to assess an academic's worth in terms of 'sessions'."

"We do not favour extra-duty payments or 'banding' for on-call commitments as this will be unworkable and divisive in our context. If the present proposed contract is implemented, it is hard to see how any young doctor will be able to consider a research career. Many established clinical scientists will also be unable to come to terms with this situation and either return to full-time NHS appointments or leave the country. We urge all those who value clinical research in this country to vote against the consultant contract. If the profession does not accept the contract, then the BMA should negotiate a straightforward increase in salary."

The signing of this letter by a large number of clinical scientists who hold honorary consultant appointments underlines their fear that medical research will suffer if the proposed consultant contract is implemented. I believe that the relatively high standard of medicine and surgery in this country is partly due to the close association of clinical research with routine clinical practice in both our medical schools and our peripheral hospitals. The proposed contract will increase the drift of potential medical scientists away from research, with disastrous consequences.

Some may think that the short-term gains in income are worth a "Yes" vote but it is becoming clear that the long-term implications are not so attractive.^{1 2} I hope the above letter, signed by some of our eminent medical scientists, will persuade your readers to vote against the contract and will encourage the BMA to seek alternative ways of improving remuneration and conditions.

A D B WEBSTER

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¹ Booth, C C, *et al*, *British Medical Journal*, 1979, **1**, 755.
² *World Medicine*, 24 March 1979, 39.

* **In its annual report the Medical Academic Staff Committee made the following comments on the implications for clinical academic staff of the NHS consultants' new contract: "The introduction of the new consultant contract without adequate preparation being made for clinical academic staff would have the most serious repercussions on academic medicine. . . . The overall remuneration in terms of payment for work done and fringe benefits is even now considerably greater in the NHS than in the academic medical world. There will be greater differences with the introduction of the new consultant contract. The Clinical Subcommittee is convinced that comparability for those holding honorary contracts must include remuneration for work such as emergency recalls and domiciliary visits undertaken for the clinical care of patients. The committee has discussed the type of contract [and] feels that [it] should be of the same type as the present contract in that it should not be work sensitive. . . . It is impossible to ensure that medical academic staff receive identical sums of money for doing the same work as an NHS equivalent. It should not be impossible to ensure that there is equality of remuneration within a range of plus or minus £500."—ED, *BMJ*.