The financial difficulties of all great institutions are only too well known to those concerned with them, and clearly priorities have to be determined when making economies; but I cannot help feeling that for the BMA to withdraw from the World Medical Association at this time would inevitably deliver a very severe blow to the reputation of British medicine, and that of the British Medical Association in particular—a body that should be regarded as a world leader.

J RICHARDSON

British Supporting Group of the
World Medical Association,
London W1N 6DE

SIR,—It is with great regret that I read (24 March, p 835) that the Council of the BMA has recommended that the BMA should withdraw from the World Medical Association and the Commonwealth Association. Surely at such a time as this, when the world is "shrinking" and countries and peoples are drawing closer together, this is a short-sighted policy.

The medical profession is under attack on many fronts and needs desperately to achieve international solidarity. Serious ethical questions arise today which need to be discussed and explored at an international level. It is in such areas that the WMA has been such a hopeful venture. It perhaps is not too much to say that for the medical profession a world organisation is a necessity. Yet the major national bodies seem to be largely indifferent, or at least uncommitted. First the Americans withdrew. No sooner are arrangements made which seem likely to win them back than the British threaten to withdraw. For what reason? Because they may save £18 000, a sum equivalent to the annual cost of one senior executive perhaps. It seems ludicrous that we should withdraw from a world body to save such a petty sum. Isolation will not pay. This is an age for wide visions. If, as has been suggested by some, the WMA has not been a very effective body until now, the answer is surely to make it one, not to withdraw and leave it to its fate. Sooner or later, the WMA must become, and I am convinced will become—whatever we do in Britain—a body of great significance. The movement of the times is in its favour. We suffered greatly by being too late in entering into the EEC. Let us not make this mistake again with the WMA.

On the question of the CMA, it seems that we are to save £400. Words fail me. Have we really lost faith in the benefits of our Commonwealth and abdicated from our historical leadership role in it?

I sincerely hope the BMA will reject decisively these two recommendations as being entirely unworthy of us.

D M MACKAY

Ross Institute of Tropical Hygiene,
London School of Hygiene and
Tropical Medicine,
London WC1E 7HT

SIR,—I refer to your report of the Council meeting held on 14 March under the section headed World Medical Association (24 March, p 835). I must take issue with my old friend Dr Brian Lewis, who is quoted as saying that the WMA is a "sounding board for windbags." Such unparliamentary language in a debate in Council is to be condemned, but coming from the lips of the chairman of the Representative Body it is deplorable, particularly as at the 1978 ARM no fewer than three motions were

passed for referral to the WMA at its next assembly, held in Manila in November 1978. I refer to the motion on SI units for blood pressure, which was carried at the assembly with three abstentions; condemning the use of psychiatry as a means of controlling political dissidents, which was passed unanimously; and the motion on the persecution of doctors who attend to sick and wounded persons who are politically undesirable—again passed unanimously.

I had the privilege of attending the Manila assembly and I only wish that Brian Lewis and other Council members had been there, for I feel certain they would have come away with a totally different impression from that which they appear to have held at the time of the Council debate. Under the control of Mr Walpole Lewin, chairman of the WMA council, the assembly was conducted in a masterly fashion, the new constitution was adopted on the first day, and the remaining days were devoted to matters of real concern to the medical profession worldwide.

Does the chairman of the Representative Body really believe that that body would have asked for these motions to be considered by "windbags"? I am confident that the RB in 1979 will reject the recommendation of Council that the BMA should withdraw from the WMA.

PETER WILSON

London W1

Claims for emergency recall fees and confidentiality

SIR,—Following the advice given to consultants and SHMOs in Hospital Circular 93 on the completion of claim forms for emergency recall fees, we should like to offer this further guidance:

(1) The validation entry may be made in an official hospital record or the patient's notes. If the entry is made in the patient's notes or other clinical record, the inspection of these records by a medically qualified person for validation of the claim must be carried out in the presence of the responsible consultant or SHMO. He must ensure that access is given only to that part of the record which is essential for the validation of the claim. This does not absolve the validating officer from responsibility for keeping confidential any clinical information that he may obtain from the record.

(2) Exceptionally, clinical information relating to a patient may be inferred from the association of the name of a hospital, or the specialty of a consultant, with the name of that patient on the claim form. In such circumstances, consultants and SHMOs are advised that they should not include the name of the patient on the form but should retain a personal record of such cases to allow validation should the claim be challenged.

DAVID BOLT
Chairman, Negotiating
Subcommittee of CCHMS

M J G THOMAS
Chairman, Central Ethical Committee

BMA House,
London WC1H 9JP

The new consultant contract

SIR,—We should like to reply to some of Mr David Bolt's comments (24 March, p 824) on the letter from some Northwick Park Hospital

and Clinical Research Centre consultants (17 March, p 755).

Many of us have objected to the reduced professional status the new contract would bring both before and in the ballot, and warned our colleagues how this might be implemented by the DHSS. Our letter was in response to the document sent to consultants by the DHSS, which confirmed in terms of crystal clarity that all our fears have been confirmed. We agree it is late in the day—but hopefully not too late for many members of the profession to appreciate how disastrous the implementation would be.

Mr Bolt finds it "sadly immoderate" when we stated that "no apprentice in the 18th century ever had to sign so enslaving an agreement." The sadness is that our statement is true. He regrets that we did not invite him again to try to explain the benefits the contract would bring. He has very kindly already visited Northwick Park Hospital twice and failed to convince many of us.

Our letter was written to you, Sir, as the matter has gone beyond the CCHMS. Our hope is that careful study of the proposed implementation of the new contract will convince the profession of the disaster now threatening it.

C C BOOTH
Director,
Clinical Research Centre
JONATHAN LEVI

Northwick Park Hospital and
Clinical Research Centre,
Harrow, Middx HA1 3UJ

SIR,—I write to support strongly the plea of Dr D Hunter Smith and others (31 March, p 895) that all future consultants, irrespective of when they are appointed, should have the option of being able to take up the present type of open contract. I write as one who has no vested interest in this matter as I will indeed be able to retain this option.

MAURICE SILVERMAN

Department of Psychological Medicine,
Queen's Park Hospital,
Blackburn, Lancs BB2 3HH

New GP charter

SIR,—The report of the GP Charter Working Group comes at a time of steady decline in living standards of general practitioners, and it presents several ideas for improvement, but in my view it falls at the final hurdle. We need a radical new proposition concerning our method of remuneration—one which, if accepted by Government, could also be applied with little additional work to our hospital colleagues.

The item-of-service list of 40-odd items in appendix B does at least indicate recognition of the importance of work-related income. There are already several item-of-service claim forms, all different in size, shape, and layout; and it is unwise to propose even more. What we require is a single claim form and an agreed list of items, each with its code number, so that after the receptionist has completed the personal details all the doctor has to enter is a number and his or her signature. It may sound complex, but it is easy—I used a system of this sort for two years in Australia. Although direct payment by patients did operate in Australia, the scheme is in no way dependent on this