arrangement, which will I hope reassure those of my colleagues who are opposed to patients actually paying for part of their health care costs.

There is, however, a far more important principle than the administrative details of a uniform claim form, and it is obscured by the long list of possibilities in appendix B. Each time a patient consults a doctor, at home or in the surgery, whether this is initiated by the patient or the doctor and whether the patient is a temporary resident or not, young or old, with a trivial or serious complaint, an encounter takes place at which the doctor uses his or her skills to provide a service to the patient. Two minutes is enough for diagnosis and treatment of tonsillitis or scabies, or the review of a hypertensive case. It can take 20 minutes to elicit the history and examine properly the patient with spinal pain, half an hour or more to determine the relevant features of a depressive illness; further examples are unnecessary, for I hope the point is clear. What should be recognised, and I believe the working group has failed in this, is that every consultation, regardless of its content of listening, physically examining, and technically testing or treating, is an item of service for which payment should be made to the doctor.

We have reached a watershed in general practice after 30 years of the NHS and I urge my colleagues to think very seriously about this proposition, and press their local LMCs to carry it to the special conference. The design of a claim form, the duration of consultations for which different payments would be made, the inclusion of other special procedures from appendix B, and the size of the consultation fees are very important details which would require to be worked out in negotiations with the Health Department; but contemplation of the details should not at this stage be allowed to obscure the fundamental concept which I have outlined. We have an opportunity with the charter to introduce this enduring and truly work-sensitive feature into the remuneration of general practice; it would be a pity not to try.

R M MILNE

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Nurse training

SIR,—The introduction of the EEC nursing directives on nurse training and GNC policy based on them will have very considerable financial implications for hospitals with training schools. In the Peterborough Health District the cost, when the policy is fully implemented, will at present-day prices be some £124 000.

This money represents the cost of the extra salaries of staff to be employed to meet the new regulations; they are:

18 staff nurses	@ £4 000 =	£72 000
2 nursing auxiliaries	@ £3 200 =	£6 400
8 state-enrolled nurses	@ £3 550 =	£28 400
3 community nursing sisters	@ £5 750 =	£17 250
Total		£124 050

This sum of money represents, for example, the annual development money for the health district for the current financial year.

The DHSS has stated that no extra money is to be made available to cover the cost of implementation of the regulations. The Medical Executive Committee is most concerned that there would seem to be no alternative but to conform to the regulations, thus

taking a large amount of money from an already overstretched budget.

G G CRABBE

Chairman,

Medical Executive Committee

Peterborough District Hospital,
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Ophthalmic services in the NHS

SIR,—The apparently low fee for sight testing by an ophthalmic medical practitioner (OMP) which concerns Mr C Cockburn (24 March, p 825) and others is not difficult to understand.

There are about 950 OMPs in the National Health Service, 28% of whom are also consultant ophthalmologists. As there are about 380 consultant ophthalmologists in the Service about 70% of consultant eye surgeons undertake work as OMPs. It would therefore seem reasonable that the remuneration for these two activities be kept in line.

A full-time consultant ophthalmologist at the top of the incremental scale receives payment of £24.41 per notional session. In his outpatient clinic he is expected to make far-reaching decisions concerning the medical and surgical treatment of a considerable number of patients to help those he can and to support those with irremediable eye disease. An OMP undertaking a session of 11 sight tests receives a net payment of £23.10, and with expenses £30.25. Responsibility for abnormalities other than refractive errors have to be referred elsewhere. The present situation is therefore that it is financially slightly more rewarding to work as an OMP than as a consultant ophthalmologist.

Any increase in OMP remuneration would result in an increased differential adverse to the consultant and would highlight the low esteem in which the NHS holds its senior doctors. Yes, Sir, something can be done. Recognise the value of the consultant in all specialties and the rest would follow.

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*.*The Secretary writes: "While we accept that the remuneration of a consultant is far too low, we could not agree that it would normally be possible to undertake 11 sight examinations under the general ophthalmic services in the equivalent of an NHS session (three and a half hours). An independent timing study has shown that the total average time involved for each examination (excluding administration time by ancillary staff) is in the region of 24-25 minutes. The number of tests which could normally be carried out in an 'NHS session' would therefore be eight and not 11. This would give a 'sessional rate' of £16.80."—ED, *BMJ*.

SIR,—May I amplify the point raised by Dr J L Reis (24 February, p 559) and Mr Charles Cockburn (24 March, p 825) concerning the discrepancy in remuneration of ophthalmic opticians and ophthalmic medical practitioners under the General Ophthalmic Service?

We are told by the DHSS that the sight testing portion of the fee paid to the doctors is actually higher than that paid to the ophthalmic opticians but that the total payment per test made to the latter has to be more because of their greater overhead expenses. Now that ophthalmic opticians are allowed to practise alongside the doctors in medical eye centres one wonders whether these opticians are still

paid the higher fee. If they are then I agree with Mr Cockburn that it is a scandal.

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Accident and emergency services

SIR,—Mr Walpole Lewin's report to the Joint Consultants' Committee on the staffing of accident and emergency departments has provoked considerable interest. The JCC poses several questions for consideration by regional staff committees (18 November 1978, p 1447). As a group undertaking specialty training in this new discipline at senior registrar level, may we offer some pertinent comments on these questions in the light of our collective experience?

Should all accident and emergency departments have effective consultant supervision? Yes. We should like to see these consultants trained and accredited in the future in accident and emergency medicine.

Should the accident and emergency departments be staffed mainly by SHOs with senior registrars in suitable departments for training but with no registrar posts? No. The present arrangement whereby we are each working a training programme flexible to our individual needs is a very welcome advance but should be considered a stop-gap measure. The existing programme has its problems. For example, it is difficult for a senior registrar with a surgical background to assume the role of an SHO in medicine. Such a secondment intermittently leaves the accident and emergency department without its senior registrar. Secondment to other departments would be better at registrar level.

Should there be a specialist diploma in accident and emergency work? Yes. As a development, we would like to see faculty status afforded to the discipline of accident and emergency medicine and the responsibility for the entire training programme from house officer through to consultant vested in an appropriate college. A higher diploma would then come at registrar level, as it does with the FFA and the FRCS.

Should there be a moratorium on medical assistant posts in accident and emergency departments? Yes.

Should there be a general policy of having accident and emergency subcommittees? The consultant should have available to him effective representation on the medical executive committee and with other divisions. Where this does not exist we would favour the establishment of accident and emergency subcommittees.

Should the accident and emergency consultant be an "admissions officer" for the hospital? Patients sent up by their general practitioner for emergency admission should be dealt with by the specialist firm on duty. Nevertheless the "admissions unit" should be adjacent to the accident and emergency department.

Should most major departments have short-stay beds in the unit? All major departments should have short-stay beds in the unit under the clinical control of the accident and emergency consultant.

Should most small accident and emergency departments be progressively closed? Most small urban accident and emergency departments should be progressively closed, leaving mainly large departments with over 20 000 new cases per year. Peripheral services should be

provided by general practitioners in community hospitals and health centres, with the district general hospital accident and emergency consultants providing a supportive role.

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Clerical staff in general practice

SIR,—Most general practitioners employ clerical staff and like so many other small employers are not well aware of the irresponsibilities in law.

This has had disastrous effects owing to the Government's pay freeze, as we have been unable to keep our employees' pay in line with equivalent staff employed by the Health Service and carrying out identical duties in the health centres, or to get the 70% reimbursement in the event of such pay rises. The Government has repeatedly stressed its determination to move resources into community medicine, but we are unable to attract new staff of good quality owing to the pay freeze.

I should like the BMA to negotiate more forcefully with the Government on the question of staff pay, and also to prepare a model contract for clerical staff employed by doctors. At present, the BMA has an inadequate model contract, but a new one is required to embrace recent legislation. Furthermore, there should be an advisory note on engaging staff, as small employers would be well advised to keep their staff salaries in line with those in some larger bodies, such as the Health Service, the universities, and so forth. The BMA is, after much heart searching, a trade union. Many of its members are employers and it has not taken its responsibilities as a potential employers' association sufficiently seriously.

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*.*The Secretary writes: "Traditionally, general practitioners have been extremely reluctant to accept any central advice or guidance on either the salaries or the terms of contract for their employees. This has been made clear at conferences of representatives of local medical committees. The General Medical Services Committee model contract for the employment of ancillary staff has therefore been intended as a basic guidance document on which more detailed contracts should be built. We also draw attention to the salary scales for ancillary staff recommended by the Guild of Medical Secretaries. The GMSC has recently been successful in negotiating further flexibility in the restrictions laid down in the Statement of Fees and

Allowances with regard to pay increases for ancillary staff, and is continuing its negotiations both with the Department and with the Central Arbitration Committee."—Ed, *BMJ*.

Points

Haematuria after closed trauma

Dr SIMON BEHRMAN (London W1N 1DA) writes: One point mentioned in your admirable leading article (31 March, p 841) might gain in didactic value by raising it to the status of a dictum, viz, that renal artery thrombosis and renal vein avulsion may be caused by a blunt abdominal injury without giving rise to obvious haematuria. This type of renal trauma may therefore be initially overlooked and only brought to light subsequently by cryptogenic hypertension. This conclusion is borne out by cases in my experience and also by those of others.^{1 2}

¹ Knorr, J, *et al*, *Lancet*, 1976, **1**, 1934.

² Osias, M B, *et al*, *Journal of Trauma*, 1976, **16**, 954.

Minor hazards of amniocentesis

Mr D G LIMB (Department of Obstetrics and Gynaecology, Bishop Auckland General Hospital, Bishop Auckland, Co Durham DL14 6AD) writes: Your correspondent Dr R L Neu and others (31 March, p 893) draws attention to the difficulty of differentiating urine from liquor amnii. In fact liquor amnii contains protein and sugar, a fact which will allow very simple differentiation to be made between the two fluids.

Defective colour vision and diabetes

Dr M J PLEYDELL (Oxfordshire AHA(T) Health Offices, Oxford OX2 6JZ) writes: The report on this subject (31 March, p 859) . . . also implies that the health hazards to the public must be taken seriously by all doctors with red-green colour vision defect. Approximately one male doctor in 12 has a red-green colour vision defect and cannot therefore be considered reliable in his interpretation of the standard Clinitest chart. Such doctors should arrange for alternative tests, or for other members of their practice without a colour vision defect to interpret the results. . . .

Prescription for a better British diet

Mr ALAN LONG (Campaign for Real Bread, Vegetarian Society, London W8 6LA) writes: Mr Howard Hanley's wholemeal bread (7 April, p 953) costs more than the white loaf for several reasons. For example, the miller (since Chaucer's time ever resourceful) sells the bran, germ, and middlings into the lucrative market in concentrates for feeding to intensively reared livestock. A little of these valuable offals is also sold at a premium in health-food stores and chemists. . . . Although sales of white bread are declining and those of brown increasing, the latter account for 10% of the market (and wholemeal for less still), so costs of distributing "real" bread are disproportionately high. . . . The confusion and ignorance are illustrated at one hospital, where doctors wished to increase the fibre in the inpatients' diets by offering them wholemeal

bread. The catering service could not manage this simple expedient, so bran has to be prescribed from the pharmacy while the kitchens continue to supply the wards with white bread. The pharmacists have to go to the health-food store to buy the bran that the miller separates in producing the flour to make the depleted white bread.

Molluscum contagiosum

Drs R E BOWERS, T J DELANEY, and P G SLIMMINGS (Cheltenham General Hospital, Cheltenham) write: We were interested to read the epidemiology notes by Dr I B Porteous (31 March, p 898) discussing the rarity of cases of molluscum contagiosum reported to the Communicable Disease Surveillance Centre. Molluscum contagiosum is a common, self-limiting condition recognised and treated, if necessary, by general practitioners and dermatologists. Only the atypical undiagnosed examples find their way to plastic surgery units, histopathologists, and microbiologists. Hence the figures quoted represent only a minute proportion of the total incidence.

Seven rules for hospital planning

Mr HOWARD GOODMAN (Chief Architect, DHSS, London NW1 3DN) writes: Lord Taylor's article (31 March, p 870) on hospital planning is fascinating—I, for one, became so engrossed that I missed my evening classes in brain surgery. The article demonstrates what I believe is the one characteristic common to the architectural and medical professions—that is, our final diagnoses are arrived at despite our lengthy scientific education rather than because of it. Aunt Sallies, red herrings, and chop-logic abound in his article; and yet he arrives, by gut reaction, I suspect, at seven rules that rank alongside Florence Nightingale's "Notes" as essential reading for any aspiring hospital architect. . . .

Confidentiality

Professor M D WARREN (Canterbury, Kent CT4 5AZ) writes: In "Briefing" (10 March, p 698) your contributor writes, "Many doctors think that it is about time the profession sorted out its own attitudes towards confidentiality. . . ." I agree, for the confusion is illustrated in the article, in which the views of a DHSS official "conceded privately" are quoted. . . .

Night visits and car expenses

Dr P D KYLE (Wantage, Oxon OX12 7AY) writes: In present times when decent pay awards are hard to come by may I suggest the following for consideration. (1) Payment for night visits should start at 9.00 pm, not the present 11.00 pm. This would be a reasonable time as most evening surgeries are finished and the visit would be from one's home and not from the surgery during normal working hours. (2) Petrol used in practice business should be reimbursed like ancillary staff salaries. If the Inland Revenue can accept a certain percentage of one's motor expenses for tax allowance I cannot see why the area health authority should not accept a similar percentage for reimbursement. . . .