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,
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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

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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,
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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

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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

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

Dechmont, West Lothian

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.

DAVID MOSS

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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.

P JOAN BISHOP

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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