sultant status. The irony of the situation is that we hear repeatedly that there is lack of trained doctors suitable for consultant appointments and that no more consultant posts should be advertised for the time being. This implies that none of the medical assistants in accident and emergency currently in post is considered suitable for a consultant appointment. The question is who took that decision. I have a strong suspicion that this policy is propagated by consultants in other specialties who are anxious to keep control of the accident and emergency departments. I happen to know personally a number of medical assistants who are excellent doctors, and who in spite of the restrictions which their status imposes on them have been doing a marvellous job in many parts of this country.

I think it is time the profession shows more concern for the treatment which a group of our colleagues are suffering and whose status makes it difficult for them to argue their case. This should be a matter of concern for all of us. I am aware of the fact that time and time again articles have been written in the *BMA News Review* and other publications, but so far nothing constructive has been done to solve this problem fairly, which I am sure is causing a lot of anxiety to a number of doctors and their families.

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Isolated communities and their doctors

SIR,—Ever since the Rural Practice Fund replaced the old milage scheme in 1963 there has been progressive loss of general practitioners serving isolated communities. The Rural Practice Fund was intended to benefit rural doctors, but evidence has amassed to show that the real benefit was to doctors practising in small towns serving country areas. Thus today it is not uncommon for patients living in country areas to have to travel 10 miles (16 km) or more to country town group practices.

The Rural Practice Fund was specifically designed "to compensate the doctor working in a scattered practice for his proportionately greater expenses and few patients." But enlarging the qualifying radius disproportionately increased the area (πr^2) in which units could not be claimed. There are few direct roads in the country and to visit patients living three miles apart often means a journey of ten miles. A single-handed doctor has to serve the whole area but semirural partnerships are able to divide up the area, with consequent improvement in efficiency. In fairness, we believe, a two-man partnership should have a four-mile radius without entitlement to any milage units, a three-man partnership a five-mile radius, and so on. Fewer units to distribute would mean more money for each unit.

There can be no doubt that the application of the rule for fringe-urban practices created an injustice. It subsidised partnerships to invade the countryside and encouraged the absorption of practices which had become non-viable because of the rule. The situation continues today, though there are now few isolated practices left to be absorbed.

The problems of the single-handed isolated country doctor were nicely described in 1975 by the chairman of the Rural Practices Com-

mittee. Commenting on the trend to partnerships in the country areas he said, "Most of the single-handed [village] doctors left are unable to join partnerships for geographical reasons and so have difficulty in making rota arrangements. Locums are increasingly hard to find and in any case are expensive. So, often the single-handed doctor has to soldier on with inadequate off-duty, little or no holiday, and insufficient time for postgraduate study." A survey of isolated practices in 1977 confirmed these views, and the present position has been clearly described by Scott.³

Surely what is required is an independent inquiry into the distribution of the Rural Practice Fund. Since its inception in 1963 rural doctors have been worse off than they were before, relatively, and a good case can be made for saying that it has adversely affected rural communities. Indeed, recent public discussion has pointed to the value of the village doctor along with the post office and school in maintaining the communal life of small villages. If there is to be a new charter for general practice then the wrongs which have existed since 1963 must be corrected. The New Charter Working Party has suggested many sensible improvements for general practice as a whole. We welcome the recommendations concerning special locum arrangements for isolated practices and a new look at the "linking of some practices in rural areas,"⁴ but consider that these alone cannot redress the balance.

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¹ *British Medical Journal*, 1963, 1, 13.

² Wilson, M A, *British Medical Journal*, 1975, 1, 108.

³ Scott, G, *World Medicine*, 1979, 14, (9), 42.

⁴ British Medical Association, *Report of New Charter Working Group*. London, BMA, 1979.

The new consultant contract

SIR,—The new consultant contract embodies the new concept that private practice will be open to all practitioners. If the maximum schedule of 13 sessions were allocated then the practitioner would be able to carry out private practice. Only when 14 or 15 NHDs are worked would private practice be precluded. No doubt the CCHMS envisaged that most practitioners would opt for 11-13 NHDs so that further remuneration from the private sector would supplement the diminishing returns of the NHS salary. This seemed a fair compromise as the decision to opt in or out of private medicine would go and the division between full-timers and part-timers be removed.

The workings of the Health Services Board regarding the new contract has escaped many of those writing to the *BMJ*. Consultants in some specialties—for example, radiology, radiotherapy, and pathology—require facilities available only in NHS hospitals. If during the time when statistics were collected by the Health Services Board no consultant in these specialties was part-time the facilities would

not appear to have been used for private practice and would be revoked.

Revocation of facilities for use of private patients virtually precludes private practice in those specialties requiring NHS equipment. A keystone of the new contract has now been removed by the Health Services Board. The division would still exist between the specialties which have a revocation order against them and those that do not. The holders of the old contract would not be vulnerable but new appointees would be virtually appointed as full-timers (on negotiated NHDs) as they would have no access to NHS equipment necessary for their private practice. I feel that this seriously erodes a fundamental concept of the new contract. A further ballot is now necessary after pricing so that remuneration can be agreed in the wake of the Health Services Board revocation proposals.

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SIR,—Further to the letters of Dr D E B Powell (24 March, p 825) and Mr Russell Hopkins (14 April, p 1022) concerning recall fees, I agree with Mr Hopkins that it has been a scandal since the advent of the NHS that the surgical specialties have been imposed on in this way. However, the statement that "Pathologists make several thousand extra pounds a year for their medicolegal work carried out during normal working hours" requires qualification.

Some of my colleagues do in fact get away with this and good luck to them. However, there are others, particularly those attached to the Home Office, whose peculiarly skilled and difficult work takes place mainly out of working hours but who, none the less, feel it only right and proper to give up sessions if undertaking this or private work. Needless to say, many of these unhappy individuals find that the unique responsibilities of their appointment de facto bar them from NHS awards, while their natural—indeed essential—wide interests expose them to remorseless and relentless pursuit by the demarcation squads of the Royal Union of "Pathologists."

Compared with our whole-time colleagues, we are indeed amateurs in at least one sense of the word.

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Peripheral hospitals and the new career structure

SIR,—I take Mr R T Booth's point (13 January, p 128) about the importance of equating service and training posts, and so far as the Guy's regional obstetric and gynaecology programme is concerned I do not feel the balance is too uneven. If one concedes that each district should have a maternity unit within the complex of the district general hospital, there are in the South-east Thames Region three teaching hospitals and 13 district hospitals, making a ratio of 1:4.3. The Guy's programme—contrived, I may say, with the full participation of my regional colleagues—involves Guy's and four regional hospitals

(Lewisham, Dartford, Pembury, and Greenwich), which means that if the other two teaching hospitals in the region wished to do likewise it would not be difficult to involve all the district hospitals in the South-east Region in training rotations.

I hope that these figures make it abundantly clear that, far from trying to drive a wedge between the teaching and regional hospitals (as will undoubtedly occur if emotive words like "self-styled centres of excellence" and "rejects" continue to appear), our programme is designed to bring together units within the same region. This much, I am pleased to say, the programme has achieved.

What, hopefully, it will also achieve for those in post is a period of stability during the difficult years when postgraduate specialist examinations have to be faced, often at a time when young families are being settled into school. The programme thus provides an alternative to the traditional training for those seeking such stability, so offering a choice. One may ask, "Is this a bad thing"? Personally I would have said not.

Finally, I wish to point out that it was with considerable dismay that my regional consultant colleagues read Mr Booth's letter—this reply to which they have seen and endorsed.

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Junior hospital staff—grass roots representation

SIR,—It has become apparent over the last few years that the peripheral representation of junior hospital medical staff is unsatisfactory. This was brought home particularly forcibly at the time of the attempted initial introduction of the new contract for junior medical staff when the isolation of the Hospital Junior Staff Committee from the "grass roots" resulted in errors that eventually caused the resignation of the juniors' negotiators.

The furore which surrounded the introduction of the new contract resulted in the setting up of a system of communications with the periphery based on an ad hoc system of linkmen. This worked reasonably well at that time. However, we find ourselves once more in relatively quiet times and there has been considerable decay in the linkman system; consequently there now exists a grave deficit in the ability of the HJSC to feed information down to individual junior staff and also, perhaps more importantly, in the reverse direction. Evidence of this gross state of decay can be seen in the poor communications which surrounded the recent manoeuvring for direct negotiations with the DHSS. I hasten to add that this is no criticism of the central HJSC secretariat or the committee itself, both of which function excellently within themselves.

The bulk of the membership of the HJSC consists of representatives from each of the regional hospital junior staff committees (RHJSC). In many regions, particularly in the metropolitan area, meetings of this key committee are very poorly attended. Admittedly they would function more effectively with improved secretarial services, and since this defect has been perceived at BMA House one hopes that it will gradually be remedied. This effort will come to nothing, however, if there

are no clearly defined representatives from each hospital to sit on that committee. It would seem sensible that every hospital have at least one voice on the RHJSC. We have tried a system of elections from individual groups of hospitals in this region and found it to be unworkable. Representation based on linkmen is somewhat arbitrary and undemocratic, as well as being ineffective because the lists of junior linkmen rapidly go out of date. The POWAR scheme is proving very slow to get off the ground and there are grave doubts about whether it will ever function effectively. It seems to us that the obvious choice for the link between individual hospitals and the RHJSC is the mess president. There are a number of advantages in such a choice. He (or she) is often the most senior of the junior staff; he is readily identified by the junior staff of the hospital; he is readily identified by the administration; and he is readily identified by the BMA secretariat. The system would require the creation of no new posts in our already over-bureaucratic Health Service and, since mess presidents are usually elected, the requirements of democracy would be satisfied. An added advantage would be that such a system based on the mess president would require the minimum of servicing.

One of the objections which could be made to such a system is that the mess president is not always interested in medical politics; indeed his qualities as a medicopolitician may not enter into the reckoning during his or her election. If one stipulates, however, that the mess president is entitled to delegate this duty to a deputy, then these objections are overcome and young blood could continue to gain entry to this forum.

Finally, we would stress that this system would meet the criteria for grass roots representation which are patently not being met at present—namely, that there should be a clearly defined responsibility resting with clearly designated members of the junior hospital medical staff to ensure adequate communication between regional committees and individual doctors.

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Ancillary staff reimbursement and the Glanvill case

SIR,—I am writing to you with information about the present position in the Glanvill case concerning the reimbursement of salaries for GPs' related ancillary staff.

The Medical Protection Society's legal advisers have been told by the solicitor to the Department of Health that, entirely without prejudice, if the department's appeal does not succeed an amendment to the Statement of Fees and Allowances to give effect to the judgment will have to be considered. If Mr Justice Talbot's ruling is upheld intact, family practitioner committees would be advised that they should consider their claims for payment from 28 July 1978 and not reject them merely on the grounds that they were out of time under paragraph 52.14 of the statement. If Mr Justice Talbot's judgment is not upheld precisely in its present terms but the appeal is not fully successful the DHSS would have to consider the situation and decide what

action to take in the light of the terms of the Court of Appeal decision. Our view therefore remains that those doctors who are likely to seek reimbursement of the salaries of related ancillary staff for qualifying duties should continue to keep accurate records of such work and carefully retain all records from 28 July 1978.

The DHSS has also applied to expedite the appeal hearing and we understand that the Court of Appeal has noted the urgency of the case. No date for the hearing has been fixed yet.

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Supply and demand in the NHS

SIR,—Dr A H Snaith's criticism of the value of waiting list size as a measure of NHS efficiency in meeting demand (28 April, p 1159) is welcome. Figures of surgical activity in the three districts of this area during the last five years support the conclusions he derives from national figures. The only relationship between changes in surgical waiting list size and the availability of beds is inverse.

Indeed, the inverse nature of this relationship may not be fortuitous. Dr Snaith's reference to the "clinical iceberg" must be taken as referring to untapped demand rather than need. One of the districts in this area provides 50% more surgical beds per unit of population than the other two; these beds are fully occupied and the length of time patients stay is about the average of the area. It may well be that each occupied bed carries with it a quantum of waiting list numbers which depends on the apparatus of referral.

The provision of surgical beds depends on a number of countervailing forces—for example, available resources, the clinicians' perception of need, public demand, and the general practitioners' interpretation of availability. The demonstrable variation between numbers and use in this area suggests that the relationship between waiting lists and anything else should be interpreted locally, and that the use of waiting lists on anything other than a very narrow basis for interpretative purposes is misguided.

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Methuselah and the surgeons

SIR,—Professor Hugh Dudley, Personal View (5 May, p 1210) tells us how excited he was to hear J K Slater say in a Harveian Oration in Edinburgh "20 odd years ago" that he had talked "to an old man who had talked to a man who knew a man who had spoken to John Harvey." Now William Harvey died 322 years ago, so either those men must have lived to about 130, or Professor Dudley went to the lecture about 100 years ago—or it was a Hunterian Oration he heard.

We need not be too severe on Hugh Dudley for trying to hijack the patron saint of physicians—he is a surgeon and doubtless means well—but you, Sir, you are a fellow of this college.

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