to HM69/6 proposes that at senior registrar level the number of part-time posts shall be such that it is neither easier nor more difficult for a candidate to be selected for a part-time post than it is to be selected for a full-time one in their specialty. No one would quarrel with such a provision—least of all the Medical Women's Federation.

"However, the aim of this document will not be carried out unless a new, effective method of funding part-time training posts is instituted. At the moment such posts may have to compete directly for funds with collapsing hospital buildings. Or an employing authority may allocate an arbitrary sum for such posts—and when this has been used all further posts are blocked.

"This contrasts sharply with the position of full-time senior registrar posts. Once these posts are agreed, funding automatically follows. So, if it is really intended that part-time senior registrar posts shall be neither easier nor more difficult to obtain than full-time ones, the present funding mechanism requires drastic revision. The draft document contains no reference to the provision of funds for part-time senior registrar posts.

"The arrangements for allocation of *part-time registrar and SHO posts* are to remain largely unchanged. In their case also no reference is made to funding of posts. The system of allocation of money has been the same for these grades as for part-time senior registrar positions. This means in many cases—no money, so no posts."

In my view no replacement of HM69/6 is worthy of serious consideration unless it contains provision for funding of part-time training posts.

ANNE GRÜNEBERG
Honorary Secretary,
Medical Women's Federation

London WC1

Junior doctors in community medicine

SIR,—Your leading article "Promissory note?" (14 January, p 65) discusses the problem faced by the BMA and the Review Body in obtaining a fair salary for Health Service doctors. May I point out the added difficulties of a numerically small group who are without negotiating strength—the registrars and senior registrars in community medicine?

Community medicine is a new specialty the very survival of which is often questioned. If it is to make a worthwhile contribution to the development of medicine high-calibre doctors must be persuaded to enter the field. The Government has invested large sums in sponsoring and developing training programmes. Unfortunately, it has not invested in trainees. Compared with their clinical colleagues, registrars and senior registrars in community medicine are heavily disadvantaged financially because they are not paid for overtime work. Indeed, those moving from general practice or hospital-based specialties usually take a substantial drop in income. This effectively debars doctors with young families or large mortgages who are dependent on a single salary. Not surprisingly recruitment is poor despite a large number of unfilled consultant posts.

The Expenditure Committee of the House of Commons discussed the problem in their report on preventive medicine¹ and made recommendations. Unfortunately, the Government's reply, *Prevention and Health*,² concentrated on the structure rather than the needs of individuals, apparently contradicting the last Secretary of State's oft-quoted dictum, "People before buildings."

The work of a proper community physician is substantially different from that of a clinician, but the hours and responsibilities

can be as arduous. Nearly four years after NHS reorganisation doctors in the community medicine training grades are still without an agreed form of contract. The Central Committee for Community Medicine set up a 'Trainees' Working Party to resolve the problem. Two important facts have emerged from a survey of trainees. Firstly, 89% prefer a closed contract. Secondly, very few are currently involved in emergency and out-of-hours duties.

Environmental health and infectious disease problems often occur at night and the community physician is responsible for the control of outbreaks. Existing staffing and the need of future specialists to obtain practical experience suggest that registrars and senior registrars should play a part in this work; 96% are prepared to do so if adequately paid. Unfortunately, there is no mechanism by which this can occur. Financial difficulties force many to "moonlight" in order to supplement their basic salaries, and while this may be technically illegal, few are able to give up this source of income to take on unpaid work.

Clearly we have the basis for a productivity agreement under the terms of the current pay code, but to date the DHSS does not appear to have accepted this important principle. We hope that the Review Body will recognise the importance of this matter. Meanwhile, we ask for the support of the medical profession in securing financial parity with other doctors for equivalent effort.

NOEL D L OLSEN
Chairman,
Trainees in Community
Medicine Working Party

London SE11

¹ *Preventive Medicine*. First Report from the Expenditure Committee. London, HMSO, 1977.

² Department of Health and Social Security, Department of Education and Science, Scottish Office, Welsh Office, *Prevention and Health*. London, HMSO, 1977.

Dental anaesthetic fees

SIR,—The fees offered for a dental anaesthetic are indeed derisory. The dentist is expected to present a patient certified fit and properly prepared to receive a general anaesthetic. He must provide a specially set out surgery with trained staff and he is usually too ashamed of the miserly fee to deduct anything from the 40 or 50 pennies that the State offers for the care of a patient's life. Maybe the dentist is expected to subsidise the anaesthetic from the equally miserly fee offered for the extraction.

In my practice I have costed out the exercise. It would pay me to close the surgery and order a taxi at my own expense to take the patient to the nearest hospital or clinic. I do not need to do this because I restrict my National Health practice to patients under 21 years of age. For many years my private patients have subsidised the NHS in this way. But of course the private patient must pay the entire cost of the visit. I hope that doctors who follow the advice given by the BMA (24-31 December, p 1680) will appreciate this.

For years Secretaries of State for Health have followed one another in increasing the tax on dental treatment for the non-priority patient. Now the doctors are joining us; they too cry, "Enough!" And when the present Secretary of State suggests that when we charge a patient a private fee instead of collecting his iniquitous tax we are unethical

it simply shows that, like many of his predecessors, he is a stranger to the meaning of the word.

D N BARBER

Chairman,
East Lancashire and East
Cheshire Branch,
British Dental Association

Manchester

Ban on dental anaesthetics

SIR,—Dr C S Ward (14 January, p 113) refers to the ban on NHS anaesthetics except for cases of hardship in general dental practice which has been recommended by the BMA and supported by the Association of Anaesthetists. He agrees with the proposal that "we encourage the dental practitioners to take on patients only on an independent basis, rather than on the NHS."

Paradoxically, he also apparently believes that NHS practice should continue and that he is supported in this belief since "many (in fact most) anaesthetists doing dental work disagree with this [proposed ban]." The decision of the BMA, however, was supported both by the annual general meeting of the Association of Anaesthetists and a conference representing anaesthetists from every hospital group. If Dr Ward is correct in his view it is surprising that no one else has yet written to tell me so.

MICHAEL ROSEN
Honorary Secretary,
Association of Anaesthetists of
Great Britain and Ireland

London WC1

New consultant contract

SIR,—As one of the majority of part-timers who each week work several sessions in excess of those for which they are paid I do not cease to be amazed at your correspondents with whole-time contracts who, during their uninterrupted weekends, write to you in envious terms of those holding a part-time contract. Perhaps they would like to work the 13 State sessions that I do each week and for this honour surrender £2000 a year from their salary. Surely if a man is worthy of his hire he should be paid accordingly, and if the 10-session contract is reasonably priced, then any criticism of payment for work in excess of this, be it private or NHS, is pure envy and not to be condoned.

Likewise the imposition of financial penalties because private practice is being undertaken in addition to the contracted State sessions is immoral, and it is high time it was tested in court.

JULIAN NEELY

Crawley Down, W Sussex

SIR,—Recently there have appeared letters in the *BMJ* inferring that the proposed new consultant contract will be "unfair" to present whole-time consultants, and that those who wish it should be paid a special commitment allowance for agreeing not to take part in private practice. Speaking philosophically, if one is trying to negotiate a work-sensitive contract there is no place for a payment for *not* doing something. One should concentrate on achieving a proper professional salary for the basic contract with