be allowed to continue is the totally unreasonable exploitation of professional vocation regardless of work load while remuneration is increasingly devalued by restrictive application of an 'industrial, work-based, non-professional' pay policy related to the basic working week. Certainly the new proposals should be carefully considered. Mr Kingsley Williams was present when Mr Bolt emphasised that all consultants and senior registrars, regardless of BMA membership, would be consulted by ballot after being given all details of the proposed contract and a dispassionate review of its contents.

"With regard to Mr Kingsley Williams's final paragraph, there is overwhelming support throughout the profession for the concept that consultants should be paid for work done, and not for work not done, and that they should be as free in the use of their time outside their contractual commitments as are general practitioners and junior hospital staff—or, indeed, certain non-medical whole-time clinical hospital staff."—ED, *BMJ*.

SIR,—A local survey of opinion of holders of whole-time contracts yielded 22 replies. Only three of those replying wholeheartedly endorsed the new proposals, while 18 preferred their present contract with more money with a continuation of a financial differential (special commitment allowance, 12; extra notional half-days, 6). They also felt that there could be attractive incentives to permit concentration on NHS work.

The majority of whole-time contract holders in this health district wish to continue with their present contracts but for more money. If the new proposals are priced it is vital that the "no detriment" clause means no financial disadvantage or coercion to change contracts for the much-needed increase in salary.

A N G CLARK

Geriatric Unit,
Brighton General Hospital,
Brighton, Sussex

SIR,—We are again in the throes of negotiations on the consultant contract. My opinion and that of many of my colleagues is that there is little wrong with the existing contract except the grossly inadequate level of remuneration.

To continue tinkering is to play into the hands of successive Ministers who have regarded the new contract as an exercise in the redistribution of the money available for consultant salaries. In any redistribution it is only possible, as Robin Hood found, for some to get more if others get less.

D J B ASHLEY

Morrison Hospital,
Swansea

Decline of visiting

SIR,—In the 1977 James Mackenzie lecture Dr D J Pereira Gray (7 January, p 53) gave personal annual visit/patient rates which will no doubt be presented to the Review Body in the evidence of the Department of Health and Social Security along with the previously published figures from Fry¹ and Marsh.²

Although many practitioners have stated that these figures bear no relationship to their own visiting rates, they have expressed their rates in very generalised, non-statistical form.

I have examined my own "list book" for 1 January–31 December 1977. The practice has 9080 patients whose care is shared equally by three partners. I recorded that I went to 3319 calls, an approximate visit/patient rate of 1:1 (Dr Pereira Gray, 0:35). The figure is approximate, as a survey over a two-week period showed that more than one patient was seen at every fifth visit. This would give a corrected rate of approximately 1:3. During the same year 89 calls were made personally between 11 pm and 7 am, exclusive of maternity calls, dental haemorrhage, and road traffic accidents. This alone gives a visit/patient rate of 0:02, which is a fifth of Fry's 1972 reported 0:1 for all calls.

I would maintain that these rates bear more relationship to those of the average northern GP than any recently published.

IAIN A MACRAE

Seaham, Co Durham

¹ Fry, J, *Journal of the Royal College of General Practitioners*, 1972, 22, 521.

² Marsh, G N, *British Medical Journal*, 1968, 2, 633.

Consultants' motoring costs

SIR,—In copying his predecessor Mr Ennals has allowed the negotiations on the consultant contract to continue in good faith almost to completion and then has destroyed the negotiations by a sudden reversal of his Department's policy. His statement in Parliament on 10 January clearly shows that he is committed to this decision and I do not believe that the consultants will be able to unite to do anything about it.

However, I believe that both whole-time and part-time consultants will readily unite to force at last a realistic reimbursement of the expenses incurred in providing and maintaining a car for use on NHS business. The present allowances entirely ignore the cost of providing transport when on call for emergencies and do not cover the extremely high costs involved in servicing and depreciation nowadays.

As was suggested by Dr R D H Ryall (22 October, p 1089) the time has come for a complete withdrawal of their cars for use on NHS business by all consultants in one or two areas for a limited time. The local taxi service could probably cope and patients would not suffer. A well co-ordinated action should show rapidly and very clearly to the Department of Health and Social Security the extent to which we subsidise the NHS at present. As a starter I suggest this health district, where almost every consultant has duties each day in more than one of the 17 hospitals and, because of the low level of junior doctor staffing, more than the average amount of emergency work is done by consultants.

ROGER HOLE

North Ormesby Hospital,
Middlesbrough, Cleveland

Emergency in emergency departments

SIR,—If I may be allowed to add to the lengthy correspondence on this subject, surely the prime issue relates to what purpose casualty, accident and emergency, or emergency departments are supposed to serve. If their prime purpose is to serve as major accident centres, then they should probably be planned on a population catchment area of between a half

and one million. If, however, they are to provide general practitioner services open 24 hours a day to the general public, then they would need to be supplied at a frequency of one department to every 100 000 of population. This, surely, is the basic issue.

If one goes for the first concept, then a number of problems resolve themselves immediately. One does not need so many smaller departments such as that at Tynemouth where Mr C C Slack (19 November, p 1359) works; these could be closed and resources concentrated in larger and perhaps more efficient units. This is very different from concentrating the whole range of emergency medical facilities. A smaller number of departments would, of course, require a smaller total number of staff and could provide a better service.

However, if we take the other extreme, of departments which are essentially providing a general practitioner type of service, then we are entering the very dangerous field of undermining the position of the general practitioner by removing his *raison d'être*.

PAUL R J VICKERS

Gosforth,
Newcastle upon Tyne

Deputy as auditor

SIR,—It is indisputable that one of the major problems in the maintenance of high standards in general practice is the absence, in most cases, of the probing professional eyes of a colleague—it has always been hard to maintain a strong pull on the bootstraps of one's intellect and diligence.

In this area, where deputising doctors are, in the main, fellow practitioners, I find it a salutary influence in my management of patients that my efforts may at any time be scrutinised by a colleague; similarly when working as a deputy there is pleasure to be had in noting the omissions of another.

So what about raising three cheers for the good deputising doctor as medical auditor?

DEREK WILKINS

Clanfield, Hants

Family planning costs

SIR,—Recently two correspondents have written commenting on the apparent difference between family planning clinic costs and the contraceptive service payments to general practitioners (17 December, p 1609; 7 January, p 53). I am saddened and disturbed that some of our colleagues should still be confusing a GP's gross payment with his final net income. In order to make a fair comparison the cost of providing ancillary clinic staff, premises, and the necessary area health authority administration should be added to the clinic doctors' fees. The GP has also to provide a continuous service 365 days a year and locum cover when he is absent. He has also to be available to deal with queries, problems, and complications arising from contraceptive measures initiated at family planning clinics.

If all these factors were to be taken into account I would be very surprised to find that the GP service was more expensive.

R F F MARTIN

Birmingham