to be evaluated by the GP contemplating retirement. The timing of retirement in relation to the circumstances of a particular year and the date of retirement in any one year may materially affect his income, as does a decision to retire before or after age 65.

The subject seems to be of ordinary arithmetician to be of remarkable complexity, and any GP BMA member at or approaching retirement age who is in doubt about his position would be well advised to contact the Secretary of the Superannuation Committee at BMA Scottish Office, 7 Drumsheugh Gardens, Edinburgh EH3 7QP.

N B EASTWOOD

Lowestoft, Suffolk

Ophthalmic services for the elderly

SIR,—In the BMA's draft memorandum of evidence to the Royal Commission (29 January, p 299) it is stated (para 3.24) under "Care of the elderly" that "we would welcome . . . improved services for those at home." It is not commonly realised by the profession how restrictive the present ophthalmic provisions are under the General Ophthalmic Services. The NHS will not provide even a magnifier except with a hospital signature, and eye outpatient departments overflow with elderly people with non-progressive visual defects. Coupled with the fact that no fee is payable except to consultants for domiciliary visits, the housebound of all ages are frequently totally neglected visually.

If the GOS regulations were relaxed so that ophthalmic medical practitioners were permitted to do other than refraction work and "perform tasks for which they have been trained" (para 5.31) the way would be open to establish local eye clinics in the community which could then extend their activities into the home where needed. In short, professional advice would go to the patient instead of his being compelled to visit hospital and many chronic visual problems could be monitored up to the point where hospital investigation or treatment was really necessary.

The Department of Health and Social Security should be persuaded that their present regulations represent a disservice to the patient and a waste of professional advice in every neighbourhood.

P A GARDINER

Guy's Hospital,
London

Easing the squeeze

SIR,—In response to the present pay policy squeeze many companies during the past year or so have "reorganised" their staff to enable them to reimburse their managements against some of the effects of inflation.

In an article entitled "Tax on talent" Cockman¹ says that we are now being faced with a situation in which a high standard of living cannot come from a high salary and demonstrates this with graphs. Cockman recommends that companies, to remain successful, should "realign" their direct remuneration and other benefits within the constraints of tax and pay-code regulations in order to ease the squeeze. Benefits suggested include capital accumulation schemes, pensions, personal counselling, education and housing assistance,

insurance policies, and employment contracts and conditions.

Unfortunately, few of the above conditions are within the remit of our independent Review Body, but it is to be hoped that it will note and take into account all these extraneous factors. Since its last report was written entirely in line with Government policy² perhaps the coming report could be much more realistic and the Prime Minister should be advised as to the correct and just level of "comprehensive" remuneration of doctors. This should be an independent opinion of the Review Body and the report written regardless of what other biased bodies, such as the Government and TUC, regard as expedient. It would then be up to the Prime Minister, who has expressed his personal concern, to accept or reject the report.

BRYAN O SCOTT

Radcliffe Infirmary,
Oxford

¹ Cockman, R, *Sunday Telegraph*, 30 January 1977.
² Review Body on Doctors' and Dentists' Remuneration, *Sixth Report 1976*, para 60, p 32. London, HMSO, 1976.

Earlier retirement?

SIR,—I am glad to note that the Coal Board has conceded the demand of coal-face workers, who have spent many years in an atmosphere laden with coal dust, to retire at the age of 60—with handsome pensions.

Could not our munificent Government consider the plea of the doctors, who spend their entire lives in a germ-laden atmosphere, to be able to retire at the age of 60—with adequate pensions? Looking at the obituary notices in the *BMJ* it is obvious that many doctors do not even live to see the daylight of 65.

ERNEST WANT

Nottingham

SIR,—Underground miners claim for pensions payable at 55 years on account of the physical hardship of their work. Surely there is an equal claim for general practitioners to retire at 55 years owing to the mental stresses of their work. The ability to keep on making quick-fire decisions day in day out claims a percentage of doctor alcoholics and depressives. Members of the police forces have an option on retirement after 25 years' and 30 years' service, irrespective of age. The present option for retirement at 60 and 65 is too rigid. In the late 1940s the banks retired early a number of their senior managers to allow promotion and new entrants. A surplus of doctors is currently forecast. The option of retirement at 55 for those who wish it is worthy of consideration.

J CHISHOLM

Nottingham

Assessment of GP trainees

SIR,—As general practice vocational trainees we should like to comment on the topical subject of evaluation. We were disquieted to learn of the introduction locally, without prior discussion, of trainee assessment as formulated by Byrne.¹ This subjective form of trainee assessment can be an unfair reflection of ability and could become a permanent embarrassment.

In principle we are not averse to assessment with the following suggestions: (1) exclusion of emotive terms such as "acceptable/unacceptable"; (2) flexibility in drawing up the terms of reference of the criteria to be assessed; (3) access to mutually agreed professional arbitration; (4) no permanent individually named records must exist on completion of the training scheme; (5) trainee assessment of trainers and training practices should evolve in a constructive manner.

We feel the criteria of assessment should be less rigid to preserve our professional integrity. As we all know, we have our strengths and weaknesses.

K E G REEVES
on behalf of
Derby Trainee Group

Derbyshire Royal Infirmary,
Derby

¹ Byrne, P S, *Update*, 1976, 13, 1207.

Doctors and pressure groups

SIR,—Gallup has enjoyed the co-operation of medical practitioners of all kinds and specialties for many years in carrying out many research programmes related to the medical field. We are proud of our reputation and pleased with the co-operation that we obtain from the profession. It is therefore distressing to see in the letter from Professor R W Beard and Mr D B Paintin (12 February, p 448) criticisms of individual questions in our latest project and also suggestions of general bias in the questionnaire. This was not our aim and we believe that it has, in fact, not occurred.

From over 500 returned questionnaires received so far over the last two weeks more than 95% of respondents seem to have been able to express their opinions fully and without reservation. Questions 1 and 2 of the survey are as follows:

- (1) Do you think that abortion:
  - (1) Should be available on demand?
  - (2) Should only be allowed in particular circumstances?
  - (3) Should never be allowed in any circumstances?
- (2) What are your reasons for this view? (If you are in favour in particular circumstances, please indicate these circumstances.)

Here, as in 13 other places in the questionnaire, space is provided for any kind of qualification or elaboration of the answers given in their own words and it is here that Professor Beard and Mr Paintin could have stated what they state in their letter. They claim that the phrase "abortion on demand" does not express their view; they could still have answered in another way. It does express the views of other gynaecologists who have answered the questionnaire and clearly it is an important category which must be enumerated.

The Lane Report,¹ commenting on the two main surveys conducted amongst gynaecologists, states that "abortion 'on demand' was favoured by only 4% of the consultants in [the Royal College of Obstetricians and Gynaecologists 1969/70] survey, whereas 19% of consultants in the 1972 Institute for Social Studies in Medical Care Survey favoured abortion on demand." Clearly the phraseology we employed—abortion on demand—is both standard and informative. To provide comparable trends both with these studies and with its own surveys on abortion among the general public, nurses, and doctors continuously over the past 10 years Gallup has kept to the wording of question 1, and can therefore provide comparisons across different sectors of the population throughout this period.

Professor Beard and Mr Paintin state their view that "abortion should be performed at the request of the woman once she has had adequate counselling." Our surveys reveals that other gynaecologists also share this view but seem to have been able to express it as "only allowed in

particular circumstances" (question 1) and then given details in question 2 of the circumstances—for example, after adequate counselling, etc. From the 500 questionnaires Gallup have coded 18 separate categories of reply to question 2 ranging from fetal abnormality to contraception failure. Why Professor Beard and Mr Paintin object to doing the same may be attributed to the fact that in their criticisms of the first question they ignored the second, an integral part of the first.

The problems and controversies surrounding the issue of induced abortion are enormous, bringing in medical, ethical, religious, social, and other dimensions. It is impossible to cover all relevant aspects in any one inquiry. The main thrust of our inquiry was towards the views of gynaecologists in their day-to-day work with the decisions and problems they have to face. Stressing these aspects means leaving out others. To do this does not imply bias but is merely to recognise the limits of what can be done when inviting voluntary co-operation from busy professional people whose good will must be measured against the time available.

It is impossible for anyone co-operating with us to get a total picture of the survey as yet—indeed, it is impossible for us to do so until we have gone through the complicated process of analysing and reporting on the results. Such a report will come about and will be published. As always, Gallup will provide a fair and comprehensive report on the survey it is conducting. Only at that time can any of the fears and criticisms raised by these gentlemen be allayed, as I know they will be.

Your leading article (12 February, p 407) stresses the entirely voluntary aspect of co-operating with Gallup. We have cause to be grateful to your profession for their past and present co-operation in many projects, including the current one. I do want to take this opportunity of expressing my thanks to all members of the medical profession who have helped us in the past, are helping us now, and may help us in the future in our inquiries.

NORMAN WEBB
Managing Director,
Social Surveys (Gallup Poll) Ltd

London NW3

¹ Report of the Committee on the Working of the Abortion Act, vol 2, p 26, para 51. London, HMSO, 1974.

Points from Letters

Hospital practitioner grade

Dr P L MULROONEY (Editor, *The Consultant*, Ascot, Berks) writes: . . . The opposition to this grade has been widespread among hospital doctors. It has, most emphatically, not been confined to or orchestrated solely by the Hospital Consultants and Specialists Association. It may be that the HCSA, by virtue of its close contact with members and its ability to act quickly in response to their opinions, has given the lead in voicing the disquiet of hospital doctors. . . .

Many of the arguments against the grade are familiar, but there are two which need more attention. The first is the serious problem which will present in less than a decade when we shall be concerned with the career prospects of the increased number of graduates from our medical schools. A proportion of those doctors must be attracted into the hospital service to train in the specialist fields. They will deserve, and demand, a career in their chosen specialty

and will not submit, as many now have to, to a lack of career prospects. Anything which limits their opportunities will be resented, and cannot be sensible. The acquisition of any significant number of sessions as the prerogative of general practitioners must limit their opportunities. The second argument is no less compelling. Many GPs at the present time have served for significant periods in specialist posts before deciding that their fortunes were best pursued in general practice. But we may find, perhaps within the next year or two, that entry into practice will compulsorily be through the general practice vocational training scheme. This will inevitably mean that there will not be in the future a pool of GPs with adequate training and experience to man the sessions which are now to be reserved for them. We have therefore the illogical situation where the GP lobby is pressing for the introduction of a grade while at the same time taking steps which will make recruitment into it impossible in the future. . . .

Deputising services and the "emergency doctor"

Dr F M OWERS (Birkenhead) writes: . . . Mr J M Thomas (29 January, p 293), who, I suspect, works in a casualty department, is, of course, entitled to state his opinions, but they seem hardly to justify his wish to see deputising services restricted. Arguments for and against the deputising services can surely centre only on the one essential point. The patient should be getting a service which, ideally, is better than, and certainly no worse than, the service he was getting previously. I can speak only with knowledge of the local deputising service from which, in my opinion as a GP, the patient gets a very good service indeed.

Smallpox vaccination for students?

Dr A W BEATSON (Worthing, Sussex) writes: I share Dr G D Smith's misgivings at being compelled to carry out what is potentially a hazardous procedure without any convincing reason for doing so (5 February, p 380). . . . I do not think that Dr Smith goes far enough if he acquiesces in the demands of "the university." My own criterion is that I work for the benefit of the patient and not for any anonymous body such as the university, or the factory, or the school, or, for that matter, the hospital. If any patient consults me bearing advice from a body of people then I demand that he let me know the name of the person whose injunction I am to follow.

Chlorphenesin in bed wetting

Dr A A BARTY (Flin Flon, Manitoba) writes: . . . You point out (leading article, 1 January, p 4) that bed wetting is often the cause of psychological disturbances as well as the result of others. I think this becomes a vicious circle in most cases, compounded by the suffering inflicted on the unfortunate child by his playmates "because you smell." I would like to draw attention to a treatment which I have never seen described in any literature. Chlorphenesin (Mycil) powder 1% on the skin and in the clothing and bedding prevents the formation of ammonia and other odours on

skin and clothing affected by residual urine. The mothers have reported back enthusiastically and gratefully on the child's acceptability in society once more. . . .

Management of appendicitis

Mr F T CROSSLING (Stobhill General Hospital, Glasgow) writes: . . . I was interested to read Mr A W Clark's letter (9 October, p 881) suggesting that appendicectomy wounds be left open and unsutured when grossly contaminated. I agree that basic surgical principles are probably as important as any combination of antibiotics or antiseptics, whether applied locally or systemically, if not more so. It is clearly undesirable to close these wounds securely, so why not try taping? This would avoid local trauma and should afford free drainage of the vulnerable subcutaneous plane.

Health at "O" level

VERA HARTLEY (Burnley, Lancs) writes: Might a mere teacher intrude into your columns to record my agreement with Dr J G Avery's endorsement (15 January, p 164) of your previous suggestion of "health" as an "O" level subject (25 December, p 1551). . . . It used to be that doctors disapproved of the public being educated in any aspect of medicine and it's refreshing now to find a member of the profession advocating it. I think the publication of the excellent "Family Doctor" booklets demonstrates the reversal of this trend, though they are seldom read by those who need them most. Health as an "O" level, or even CSE, subject would perhaps find a wider audience.

An IUCD record?

Mr H E REISS (London NW1) writes: My friend Mr Alan Smith (5 February, p 383) does not hold the record: I have records of five private patients fitted with Lippes loops between June and December 1965. These have all been followed up regularly by me until the present time and still have their original loops in situ. The oldest "survivor" had her loop fitted 11 years and 8 months ago. She was seen last week and is now approaching the menopause but so far refuses to be parted from her IUD.

A conglomeration of containers

Dr J W M HUMBLE (East Molesey, Surrey) writes: The letter from Mr I D Fraser (15 January, p 172) reminds me of an occasion soon after the war when a patient of mine apologised for not bringing the specimen I had asked for. The reason was this. The only container which she could find was an empty bottle which had contained Haig whisky and which still had the label attached. She filled this bottle with her specimen, put it unwrapped in a carrier basket on the handlebars of her bicycle, and set off for the surgery. On the way she stopped to do some shopping . . . and when she came out her bottle had gone. . . . Unfortunately, neither my patient nor myself ever heard the end of this story. . . .