pressure sores are superficial, so that Op-Site is an important addition to the present methods of treatment. Although its use is at present restricted to hospitals, I understand that it is being considered for prescription on EC10.

M A NASAR

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Levodopa in senile dementia

SIR,—Further to our previous paper (4 March, p 550) we wish to report briefly the effect of continued treatment with levodopa in five of the patients with senile dementia who had shown a favourable response in the original trial. After a break of one month 750 mg of levodopa was given daily for a further six months. Five control patients with senile dementia matched for age and sex were selected and both groups were rated monthly on the Crichton Intellectual and Behavioral Rating Scales. The intellectual but not the behavioural rating was blind.

As in the original trial no marked changes were apparent in behavioural ratings in either drug-treated patients or controls. Although the mean intellectual scale scores declined a little in the drug-free period between the original and the more extended trial, they improved again when drug therapy was resumed so that mean scores for the drug-treated group over the six-month period were comparable to the scores during the active preparation phase of the original trial. There were continued slight improvements in intellectual functioning in three out of the five experimental subjects during the six-month treatment period. Of the two patients who did not show improvement in terms of mean scores, one showed a very spectacular decline in functioning between the last two ratings and the other showed a very steady deterioration in both intellectual and behavioural function.

In conclusion, although on average the original small gains made in intellectual performance in the drug-treated group appeared to be maintained over several months, the clinical relevance of these findings may be questionable. We are doubtful whether levodopa should be recommended for the routine treatment of this condition at present.

KATE JOHNSON
A S PRESLEY
B R BALLINGER

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Annual General Meeting of the Royal Society of Medicine

SIR,—May I use the courtesy of your columns to ask as many fellows of the Royal Society of Medicine as possible to come to the Annual General Meeting on 11 July to discuss the following two motions:

- (1) that the Council be required to consult each individual fellow by postal circular before major policy decisions are taken, especially with regard to the society's property, journal, library, or finance;
- (2) to amend Bye-law XIII.9 to read: It shall be the duty of the Executive Director to submit to the President each year, for presentation to the fellowship before the Annual General Meeting for discussion at the Annual General Meeting, a

report on the activities, property, and finances of the society.

I put these forward because I believe that major changes have been made in our society without the fellows being properly consulted, however long the problems may have been discussed. I do not think it is right that major decisions should be rubber-stamped by poorly attended special meetings. Similarly I believe that, as in most other bodies, the RSM should prepare an annual report for discussion at the Annual General Meeting and not, as at present, publish it in the autumn.

W F WHIMSTER

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of the Section of
Pathology, RSM

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GMC's finances

SIR,—I have in an idle moment been glancing through the General Medical Council's Annual Report for 1977. I wonder how many members of the BMA are aware that of the £634 716 paid in annual retention fees no less than £125 053 (19.7%) is actually spent on their collection. Could the BMA advise the GMC how to reduce this proportion?

Incidentally, the cost of maintaining the register is only £78 692.

MARY PACK

Andover, Hants

Medical Act 1978

SIR,—Dr E Kandiyali (10 June, p 1554) has expressed the anxieties of overseas doctors and particularly junior hospital doctors regarding the limited register which will be set up by the Medical Act of 1978. We hope that we can give some reassurance.

When the new arrangements start overseas doctors already on the temporary register will fall into two groups—consultants and others. The former will have the right to full registration under the Act on the basis that they have already satisfied appointments committees of their ability to assume ultimate responsibility for a patient.

Other hospital doctors can apply for limited registration at any time up to six months from the end of their existing temporary registration. In their particular case limited registration will not be restricted to the five-year "permitted period." The transitional arrangements in part 1 of schedule 5 of the Act protect their position. In the normal course of events they will apply to the GMC for full registration. As Dr Kandiyali says, the criteria are ill defined in the Act itself; they are left to the General Medical Council.

That is in line with BMA policy, which is that the standards for registration should be set by the reformed GMC—that is, by the profession and not by Government. Doctors on the limited register will be eligible to stand for election to the GMC and to vote. Even more important, they will have the right to appeal to a Review Board for Overseas Qualified Practitioners if the GMC denies them full registration. That board must include at least one overseas graduate and the GMC must take note of its opinion.

Those doctors who come to this country after the Act is operative will know before they leave home that their limited registration

will be restricted to five years, but they too will have the right to apply for full registration and to appeal.

Last year the Representative Body resolved that the BMA should seek, through a reformed GMC, a system of registration for overseas graduates which is fair in operation. Getting the Act passed was merely the first step. The law now requires the GMC and the Department of Health and Social Security to consult with the BMA and others on the various detailed rules for its working and for the conduct of elections. These must then be approved by the Privy Council or by Parliament, as the case may be.

Dr Kendiyali's presence on the working party, and our own inclination, will help to ensure that justice is done to those he represents.

JOHN HAPPEL

Alresford, Hants

JOHN MARKS

Joint Chairmen,
BMA Working Party on the GMC

Boreham Wood, Herts

Shortage specialties: radiology

SIR,—Dr J L C Dall (3 June, p 1489) clearly highlights the serious deficiency of academic appointments in the shortage specialties. In comparison with whole-time equivalents in general medicine and paediatric medicine he points out that only 4% of senior posts in geriatric medicine are academic appointments against 19% in each of the specialties of general medicine and paediatric medicine. He indicates that the problem is even more serious in radiology, where only 2% of the 736 consultants in England and Wales hold academic posts.

It is relevant to compare radiology with other service specialties and particularly with laboratory medicine. In England and Wales there are a total of 1401 consultants in pathology, haematology, biochemistry, neuropathology, etc, and 32% of these posts are academic appointments. The position is the same for senior registrars, where 5% of posts in radiology are academic appointments against 28% in laboratory medicine, 44% in general medicine, 32% in general surgery, and 37% in paediatric medicine.¹

Radiology has expanded rapidly over the years and the specialty now plays a major role in diagnosis and patient management. The specialty now includes ultrasound with its many exciting developments; nuclear medicine in some departments; and now computerised tomography. Many doctors request these sophisticated investigations and have unrestricted use of expensive resources. It is now even more important that these rapidly emerging techniques are properly and critically evaluated. Moreover, it is equally important that there is not only continuing teaching of clinicians requesting the investigations but also of trainee radiologists who will be responsible for their quality. Such evaluation and education should properly be the role of adequately funded academic departments with the necessary time and expertise.

There are many excellent young trainees in radiology who are well suited to academic careers. It is essential that they be given such an opportunity in well-funded academic departments. On a recent visit to Australasia as the Rohan Williams Travelling Professor it was alarming and of serious concern to Britain to see the large number of able UK-

trained radiologists who have emigrated, and the position is similar in North America. While it is true that many have gone because of greatly increased incomes and improved working conditions, there is a significant proportion who hold academic appointments which are less well paid. It would greatly benefit the NHS if these young and able radiologists remained in this country.

There is a very serious imbalance in the proportion of academic posts in radiology when compared with the more established specialties of laboratory medicine, general medicine, and paediatric medicine. The position is even worse where senior registrar grades are concerned. It is difficult to comprehend why this imbalance should continue and even more difficult to justify when there is such an obvious and urgent need to increase the number of academic posts in radiology.

J K DAVIDSON

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¹ Data from Statistics and Research Division, Department of Health and Social Security, Hospital Medical Staff—England and Wales, September, 1977.

New consultant contract

SIR,—I would like to join Mr John Stewart (20 May, p 1353) in expressing my personal concern regarding certain fundamental aspects of the new consultant contract, which, although it has the potential to improve consultant remuneration and terms of service, can only achieve this with good will and correct pricing. My concern about the problem stems from three major uncertainties in respect of the document.

Firstly, there is an uncertainty with regard to pricing. The BMA negotiators take the optimistic view that the basic contract (10 notional half-days (NHDs)) will be priced at least at the same level as our current whole-time 11-NHD contract, thus making extra NHDs worked a bonus rather than a necessity in order to receive adequate remuneration. The Review Body in its Eighth Report¹ on the other hand clearly takes the opposite view (para 27, p 18) and states that some consultants whose work load may not justify extra NHDs can expect to receive less than their current 11-NHD salary. The only possible way this could be averted would be a financial bonanza to consultants by the Government in the form of extra money, and we all know how likely this will be in the foreseeable future.

Secondly, as it is obvious that the whole success of the operation in terms of financial benefit revolves principally round the question of extra NHDs, I would feel very much happier if there were a satisfactory independent appeal mechanism to assure consultants that justice will at least be seen to be done with regard to the revoking of extra NHDs by the employing authorities. As the new contract stands we could very easily see a repetition of the family planning fiasco when funds run out.

Lastly, but not least, I am extremely concerned that the BMA negotiators do not find it possible to assure us that acceptance of the priced new contract will be conditional upon a second ballot of all concerned. At a recent open meeting of consultants in the northern region held at Newcastle upon Tyne the only two excuses offered by certain representatives

of the Central Committee for Hospital Medical Services were of the prohibitive cost (around £8000) and that this particular criticism amounted to "nit-picking." As can well be imagined this did very little to allay the genuine fears and anxiety of those present.

G I B DA COSTA

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¹ Review Body on Doctors' and Dentists' Remuneration, *Eighth Report, 1978*. London, HMSO, 1978.

Housemen's pay

SIR,—So much for the new contract bringing fair rates of pay. By accepting that the basic 10 units of medical time (UMTs) has no concealed element for overtime the Review Body has now valued my on-call commitment (as a preregistration houseman) at 56p per hour.

I think it is time my sleepless nights are paid for. We should record the average number of hours actually worked in a night or weekend on call. For each hour worked we should be paid at least 150%¹ base rates plus a nominal sum for each night and weekend we have to be available.

Perhaps we should regard the Review Body's recommendations as a productivity deal? A night on call is 4 "A" UMTs; this is the cash equivalent of 1.2 base UMTs or 0.8 premium (150%¹) UMTs. 0.8 premium UMTs represent 3h 12 min. That is how much work we are paid to do in a night and I suggest that when we have done that much we should switch off our beeps, unplug the phone, and go to bed. If that is not the kind of productivity deal the Health Service needs we had better reject the Review Body's report and think again.

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*.*The Secretary writes: "The Hospital Junior Staffs Committee of the BMA is not in any doubt that the Review Body's recommendations have serious implications with regard to the pay of junior hospital doctors and dentists. It is for this reason that this year's HJS Conference, which will be held on Saturday 24 June 1978, will be debating whether the Review Body system can benefit junior hospital doctors and dentists in the future."—ED, *BMJ*.

Joint consultative committees

SIR,—After at first advising doctors not to become members of joint consultative committees the BMA is now advising members to send representatives. This volte-face needs further explanation and discussion.

Doctors occupy a unique position in the Health Service, as the whole purpose of the service, facilities, equipment, and staff of all grades is to help doctors treat their patients. They are therefore both managers and staff.

The advantage of taking part in these committees would be that the doctors will usually side with management (if it is a good management) and avoid unanimous resolutions of the staff side about things like private beds, bank holidays, etc. But other points should be thought about and clarified: (1) Is it desirable for doctors to sit on equal terms

with "other trades" on the *staff side* of these committees? (2) What is the relation to the present medical organisation like medical executive, advisory, and staff committees? (3) Is it worth while to spend time on yet another committee occupied mainly with relatively trivial matters of no medical interest?

G BEHR

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Future of British anaesthetics

SIR,—With reference to the letter from Professor M D Vickers and Dr M Rosen (3 June, p 1491) I would like to make the following points.

Everyone knows that an anaesthetic registrar (and I was one) does *all* the emergency anaesthetics at night in an average district general hospital. To be one you need to have done one year's anaesthetics and preferably have the DA. If a hospital practitioner is going to do the work of a registrar why does he need *more* training than that which any registrar in anaesthetics has had?

I left anaesthetics for a number of reasons and entered general practice, but the main reason was that the idea of earning my living giving routine anaesthetics for routine cases was simply not on. It is work that can be, and is in many countries, done by nurses. Consultant anaesthetists have, in my view, three choices: (1) to allow more and more general practitioners into their departments; (2) to do more and more routine work themselves; (3) to allow nurses to give anaesthetics which they supervise.

The simple fact is that giving a routine anaesthetic is so simple that you do not need to be a consultant to do it. Everyone knows that. Why, oh why won't anaesthetists admit it?

D C HOGG

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Bristol

SIR,—Professor M D A Vickers and Dr M Rosen (3 June, p 1491) doubt that general practitioners would be able or willing to largely replace those at present in the peripheral anaesthetic training grades, but they do not suggest an alternative.

The ever-increasing use of deputising services in general practice reflects not only the ever-increasing burden on the medical profession in general but also an increasing reluctance to reside in an inner city area or outside the catchment area of "good schools." Most consultants work in the bigger cities, so how much less able or willing will they be to cope without their own "deputising service" provided by the soon-to-be-squeezed-out registrars and senior house officers. Surely none would be better suited to fill the gap than those ex-registrars and ex-SHOs who had been forced by a shortage of senior registrar and consultant posts into general practice (and the hospital practitioner grade).

I stand corrected on the requirements for the FFARCS. Nevertheless, in view of the high failure rate in the examination one suspects that the mean, in practice, is closer to four than to the minimal three years.

P K SCHÜTTE

Cirencester, Glos