There are many clinicians, whereas there are fewer radiologists year by year.

M LEA THOMAS

Department of Radiology,
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SIR,—Dr M J Brindle (12 August, p 514) is to be congratulated on his attempt to air the problem of excess work load in radiology departments. We feel that the problem will not be solved simply by performing a set number of examinations per radiologist. A more rational solution is to reduce the number of unnecessary and inappropriate investigations performed, as suggested by Goldberg.¹

The limited resources of radiology departments could be used more efficiently if greater discrimination were used in requesting radiological investigations. Dr Brindle quotes the example of the local casualty consultant demanding skull radiographs on all head injuries no matter how trivial. Our experience² has shown that less than 2% of post-traumatic skull radiographs were abnormal, and that the vast majority of these investigations did not significantly change subsequent clinical management.

It is surely time for an overall reassessment of routine radiological requests in the light of their potential value. Routine requests not based on clinical indication have a very limited value. Re-education in the appropriate use of radiological and other imaging techniques is required if we are to maintain the present standard of radiological service.

B EYES
A F EVANS

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¹ Goldberg, B, *British Medical Journal*, 1977, 2, 1274.
² Eyes, B, and Evans, A F, *Lancet*, 1978, 2, 85.

Money for old rope

SIR,—It is difficult to tell from Dr S P Deacon's recent letter (5 August, p 437) whether he is taking on his shoulders the burden of all trainees or whether he is reflecting his own role and experience, as Dr S P Linton was challenged to do by Dr J Tudor Hart (8 July, p 130). Some of the more general points have been dealt with by Dr J C Oakley (19 August, p 573).

Perhaps, as Dr Deacon's recent trainer, I could express some views on the vocational training scheme as experienced over the past seven years. Those who attended workshops and teaching courses to become trainers did so because they enjoyed the intellectual stimulus of mutual learning experience. Improvement in the standards of general practice as a whole was the aim. There had been no mention of training grants or any other financial reward at that time.

My experience with nine trainees has shown

them to be conscientious, but at some stage nearly half have expressed anxieties about being "exploited." This I suppose is understandable when people are engaged in the same task. It has usually been quickly resolved by the trainee determining his own rate of consultation and work load. Mutual trust helps. The figures in the table below do not suggest "the dreaded exploitation."

W SAGAR

Boston,
Lincolnshire

X-ray services for GPs

SIR,—Dr M J Brindle (12 August, p 514) fails to appreciate the harm done to the morale of experienced GPs by the withdrawal of, in particular, the urgent open chest x-ray service, which has existed in this district for more than 20 years. To obtain "some sort of approval from a consultant" means wasting time on endless telephone calls to secretaries, who know that their chief's clinics are overbooked for weeks.

The most damaging factor, however, is that a waiting list of eight weeks will soon come to be accepted as perfectly normal in radiology, and GPs will become inured to delay and will adopt a laissez faire attitude towards illness as a whole, because of the difficulty of obtaining a vital diagnostic service quickly. A further inevitable result of such waiting lists is that staff will be needed "to monitor" them, produce statistics about them, and boast about their length to the DHSS.

Patients are worried at having to wait so long for x-rays and they regard it as yet another symptom of the deterioration of the NHS.

J D WIGDAHL

Gayton Road Health Centre,
King's Lynn,
Norfolk

Farcical overtime rates

SIR,—Last week at 4.30 in the morning, after I had started work at 9 am the previous day and had given no fewer than 11 emergency anaesthetics, a long overdue penny finally dropped. My hourly overtime rate of 56p was not just a pittance but also a deep and hurtful insult. It is true that junior doctors' salaries have risen, but so have those of others, and there are several factors that make "overtime" a particularly relevant claim for better rewards.

Overtime comes into operation after the basic working week has been fulfilled, and the remaining hours of the week are trebly precious—firstly, for sleep; secondly, for relaxation; and, thirdly, for maintenance of house, home, car, and study needed in one's profession. As the overtime hours mount up, the proportion of time needed for sleep increases and the time available for other things decreases rapidly. It is at this point that money rears its ugly head, and the poor doctor has to employ richer artisans to perform

tasks that would otherwise be DIY projects. This is where he gets a shock. There is no glint of dishonesty or deception when they coolly ask for £2-£5 an hour, double time at weekends, and cash if possible.

I maintain that an overtime rate of 30% of time is both farcical and abhorrent. If the Health Service wishes doctors to work at night and unsocial hours then it must be prepared to pay no less than double time. Junior doctors should realise that no health system will pay one penny more than it has to, and that passive acceptance of such low rates is tantamount to a conspiracy to defraud and devalue the profession.

ADRIAN ROGERS

Exeter,
Devon

"Caithness and Sunderland Division"

SIR,—As far as I know high-speed rail travel from the south stops at Edinburgh, nor is the delivery of Her Majesty's mail noted, these days, for its rapidity. So this would not be easy.

No doubt the members of the Sunderland Division, whose title is printed four times in your issue of 19 August (p 581) would welcome the chance of the fresh air such an amalgamation would bring, but I am sure you have raised their hopes unfairly.

W H GOSSIP

Dundee, Tayside

* * * We have apologised to the disappointed Sunderland Division, as well as to the Caithness and Sutherland divisions, for our gross geographical error. A corrected notice about the amalgamation of the two Scottish divisions was published last week (p 646).—ED, *BMJ*.

New consultant contract

SIR,—The Secretary's rejoinder to Dr F Hampson's letter (19 August, p 573) is a sad effort. It appears to be the established pattern that many letters critical of the new contract are followed by an editorial footnote. Do you fear that your readers might be capable of forming their own judgment on your correspondence columns? In the face of Dr Hampson's reasoned argument and compelling reasons for all consultants being paid the same basic salary, all the Secretary can say is that having breached one principle another might likewise be flouted by "special arrangements." Is it naive to think that principles are to be held rather than circumvented? The Secretary's last line on Dr Hampson's likely personal response to a shortage specialty payment is entirely gratuitous and typical of the special pleading that is so pathetic.

D E B POWELL

Bridgend General Hospital,
Bridgend,
Mid Glamorgan

Consultations by four doctors in mixed urban-rural practice with list of 8300

Consultations	Dr X	Dr Y	Trainer	Trainee
Average No per week (over busy 4 weeks):				
At surgery	205	165	153	106
New visits	18	23	19	11
No in weeks when trainer on holiday (quieter period):				
At surgery	196	129		115
New visits	19	16		12

Correction

Six months in South Africa

We regret that the name of the author of the above letter (19 August, p 571) was misprinted. It should have read Stephen Szanto.