study and they were followed up to obtain data on place of birth and date of migration. Eighteen of them had died and four could not be traced through hospital records, electoral registers, telephone directories, or other means. From the remaining 26 cases the required information was obtained, and 78 sex- and age-matched controls (three British migrants without Paget's disease for each case) were likewise followed up. Data were obtained from 54 of these controls.

The average age of the patients at migration was 31.0 years compared with 32.1 years for the controls, and the proportions of cases and controls migrating under any stated age were similar. Among the patients 27% emigrated from the north of England (an area of high prevalence of Paget's disease), 65% from the south, and a small proportion (8%) from Scotland, Wales, or Ireland. Among the controls the corresponding percentages were 28, 59, and 13.

These results give no support to the suggestion that British migrants to Australia who develop Paget's disease originate from areas of higher prevalence within Britain or leave at a later age in comparison with migrants who do not develop the disease.

M J GARDNER
P B GUYER
D J P BARKER

General Hospital,
Southampton

Spinal cord transection in utero

SIR,—(28 October, p 1231) Dr Gillian P Chapman has made a presumption which is not borne out by the facts of the case to which I referred (16 September, p 835). The antenatal history of the case in question was very suggestive of spinal cord damage which occurred before birth and the neurological findings are not necessarily incompatible with a spinal cord transection sustained shortly before birth.

I BLUMENTHAL

Bradford Children's Hospital,
Bradford

Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—As a teacher deeply concerned with postgraduate surgical education I was horrified to read in Professor A W Wilkinson's letter (4 November, p 1301) that the Royal College of Surgeons of Edinburgh proposes to impose yet another examination on surgeons in training—this time towards the end of their senior registrar appointment. To do so would be to inflict serious damage on a training programme which, with the help of the Joint Committee on Higher Surgical Training, is producing young surgical consultants of considerable distinction.

If a senior registrar will have to spend most of his period of higher surgical training in preparation for a terminal examination how can we also encourage him to engage in research leading to a Master of Surgery thesis? How can he be prevailed upon to spend a year abroad—perhaps in the USA or in a developing country—or spend a period of training in depth in some particular aspect of

his chosen specialty, in microsurgery for example?

By all means let us supervise our surgeons in specialist training, as most of us do already, by regular, meticulous, and critical counselling sessions, but—please—no more examinations!

HAROLD ELLIS

Surgical Unit,
Westminster Medical School,
London SW1

The Safety Net and preregistration posts

SIR,—The Safety Net system for allocation of preregistration posts (21 October, p 1136) is to be applauded as an advance in efficient staffing. The table of expected medical school outputs compared with preregistration posts is particularly useful in highlighting the London area as an overproducer of doctors. It was a pity that data about influx of doctors from outside England and Wales could not also be incorporated. It could certainly be argued that overseas graduates and those from Eire and Northern Ireland should not expect to find posts in England and Wales, though figures for migration would be interesting.

The position in Scotland is different: 620 doctors are expected to graduate from Glasgow, Edinburgh, Aberdeen, and Dundee in 1978 compared with 2595 in England and Wales. This gives a graduation rate of doctors per head of population twice as high in Scotland as in England and Wales even if a wastage rate of 9% is allowed on these Scottish figures. Despite the rather more lavish provision of medical facilities in Scotland there is still a considerable excess of graduates who must expect to seek posts in England. In Dundee, for example, there should be more than 100 graduates this year with 63 approved preregistration posts in the area. Furthermore, many graduates from Scottish medical schools are English students who intend to practise south of the border, having moved north for training purposes only.

Surely Scotland, which is an integral part of the NHS, should feature in all statistics about distribution of posts and resources if meaningful assessments are to be made.

MALCOLM C BATESON

Gloucestershire Royal Hospital,
Gloucester

Remuneration of NHS occupational health physicians

SIR,—Early this year I was appointed occupational health physician to build up an occupational health service for the York Health District. The remuneration offered was, pro rata for three sessions per week, that for the clinical assistant grade, and though this is considerably below the BMA's recommendations for doctors working in this specialty I accepted because I required only a part-time job and it was the type of work, with the right challenge, that I wished to do.

On inquiring from the BMA about these low levels of remuneration paid by the NHS I was informed that the BMA "have been pressing the Government for the past five or six years to do something about this unsatisfactory state of affairs, but at present the progress we

have achieved is limited to commenting on a draft circular purporting to lay out certain guide lines for the establishment of an occupational health service." But since the Tunbridge Report was published in 1968 the Department of Health and Social Security has given encouragement to the NHS to set up occupational health departments. Many health districts have done so and more are starting a service, so that matters have gone well beyond "laying out certain guide lines for establishment of" a service.

Surely occupational health requires the same standards of knowledge and medical care whether it be undertaken in industry, shops and offices, or in the NHS, and the remuneration should be the same. Why should the DHSS set a level of remuneration for occupational health doctors in the NHS so much lower than is paid in other ministries—for example, the Ministry of Defence? If industry or commerce advertised occupational health posts below the BMA recommended scale of salaries action would be taken and the advertisements possibly banned. Why is not the same done for NHS occupational health posts? Surely a ban on such advertisements might be a lever with which to press the DHSS to start thinking realistically and take action to bring such salaries into line with those paid outside the NHS.

The BMA seems to have spent five or six years getting nowhere in this matter and it is time more positive action was taken.

JAMES GREGORY

Ripon, N Yorks

Clinical medical officers

SIR,—Dr Shelagh Tyrrell (28 October, p 1233) is far from being the only clinical medical officer who is concerned by your recent report (7 October, p 1038) on the Working Party on Community Health Doctors with its suggestion that we should revert to being "Jacks of all trades."

What appears to have been lost in the present discussion about our future is its origin, which was the response to the Court Report. The Court Report was about improving services for children. The Secretary of State's reply recommends the development of an integrated service for children within available resources. One of the recommendations of the Court Report that has received unanimous acceptance is that those doctors who work in the future child health service should all be adequately trained and experienced. If time and money are to be spent on reaching the required level of expertise, then it is wasteful to expect the doctor at the end of it to spend a proportion of her time in totally unrelated activities, such as geriatrics or occupational or port health.

In arguing for an adequately trained and staffed child health service I do not deny that there are other areas of community health work which merit similar consideration. But these also need their own expertise and training and neither one will benefit from dilution with the other, with the possible exception of the child health/family planning combination.

I for one would like those negotiating on our behalf, however selected, to bear in mind that we are not all solely concerned with our future career structure, important though this

is. I would also like to know that I will be working in a first-rate service, the child-health component of which lives up to the ideals expressed by Professor Court and his committee.

GILLIAN BRYANT

Cardiff

Private practice and the reduction of pay-beds

SIR,—I would appreciate the opportunity to make some comments on the letter from Mr John J Shipman and his colleagues at the Lister Hospital, Stevenage (4 November, p 1304). The letter contained some misunderstandings which appear to be widespread and it might be helpful to consultants generally to have them cleared up.

In the summer of 1975 the then Secretary of State issued a consultative document which, if translated into legislation, would have eliminated all facilities for private practice from NHS hospitals within two years. The concerted action of the profession (in which the Central Committee for Hospital Medical Services took a major part), supported by the Independent Hospitals Group, persuaded the Prime Minister to seek a compromise through the skilled mediation of Lord Goodman. The resulting agreement was incorporated in legislation in 1976 and the Health Services Board was set up, with complete independence, to control the phasing out of facilities for private practice from NHS hospitals. The board's remit requires it to maintain facilities for private practice where there is demand for them until alternatives can be created, while taking into account the efforts made to create such alternatives, in areas where it is practicable to do so. In addition the Act, reflecting the agreements made in the Goodman proposals, allows the Secretary of State to authorise the ad hoc admission of private patients to NHS hospitals after removal of all authorised private beds when the patients concerned require specialised facilities not available outside.

It may seem unnecessary to state the facts set out above at this stage, but it is clear that many consultants do not understand them and assume that removal of authorisations for private facilities in hospital is the result of some on-going negotiation between the Joint Consultants Committee or CCHMS and the Health Services Board. Such is not, of course, the case. The board operates independently within the instructions given to it by Act of Parliament and there is nothing that any professional group can do to resist its activities. Every communication sent out by the board is closely scrutinised by my committee and suggestions and criticisms are sent to the board, supplemented from time to time by deputations, which the board is always willing to meet. On occasions special representations are made to the board on behalf of individual hospitals where there is particular reason to fear serious consequences if proposals are implemented, while advice is regularly offered to the consultants in hospitals affected by the board's activities on how best to present the case for preservation of threatened facilities.

It surprises me that in a letter from someone as experienced in medicopolitical matters as Mr Shipman there should appear the sentence, "There has been no statement made that if demand increases the number of beds will be increased," since he must surely realise that

the Act of Parliament specifically excludes any new authorisation of private beds. Indeed, one of its less satisfactory features is the irrevocable nature of any actions taken by the Secretary of State upon the recommendations of the board, which are binding upon him. Even acknowledged mistakes cannot be rectified once the board's proposals have been implemented. Nevertheless, it is worth remembering that had Mrs Barbara Castle's proposals been converted into legislation we would already have lost all access to NHS facilities for the private practice of medicine. The view of Mr Shipman and his colleagues that "negligible effort has been made to counter this attack on private practice" hardly fits the realities of the situation.

D E BOLT

Chairman,
Joint JCC CCHMS
Subcommittee on Independent Practice

BMA House,
London WC1

Dispute at Fife Area Laboratory

SIR,—We wish to clarify the recent events which have occurred in the Fife Area Laboratory (11 November, p 1381). Towards the end of 1976, an appointments committee selected an applicant for the post of senior chief technician (now principal MLSO) at Fife Area Laboratory, the vacancy resulting from the retirement of the previous incumbent. The successful applicant asked for and received a job description together with the letter offering him the post. The job description specified his responsibility to six laboratory consultants. Before accepting the post the successful applicant phoned the district medical officer pointing out the difficulties he foresaw in being responsible to six people and asked if it could not be reduced to one person. The DMO then raised this verbally with consultants and the consensus view was that this was a reasonable request and administratively tidy. The DMO regularly attended all laboratory management/divisional meetings and for this reason the DMO was nominated as the link person, but the senior chief technician had to report to consultants. The new senior chief did ask that all consultants and chief technicians should see the job description prior to his taking up the post.

Soon after his arrival the new senior chief technician made it clear that, on the basis of his job description and Whitley Council regulations (the latter unchanged from those obtaining for his predecessor), he was insisting on a technical staff structure with responsibilities parallel to medical staff and no direct responsibility to them. Furthermore, the senior chief favoured arena-type management, not hierarchies. Many problems developed over the ensuing months, with unsatisfactory working relationships between medical and graduate scientist staff on one hand and the technical staff (now MLSO). In mid 1978, as the establishment was raised and exceeded 63, new gradings were claimed. The introduction of some of these promotions (PMLSO and SCMLSOs) brought further disputes—with resultant limited industrial action, ultimatums from MLSOs to the board on the timing of appointments, and appointments being made contrary to the wishes of consultants.

Ultimately, the board accepted that working relationships were so poor that some inquiry was necessary and it set up a working

party to investigate the problems by consulting both sides and to report. After this the Board decided to implement a new management structure forthwith. All duties of MLSOs were to be delegated from the consultant head of the department or from the consultant director for interdepartmental matters. The board's management proposals were largely based on the draft document on management recently issued by the SHHD.

The MLSOs were so angry at this decision that they threatened industrial action if the board's proposals were not withdrawn. This the board refused to do and mild industrial action escalated into total strike at 7.30 am on 13 October. From this time the MLSOs stopped all work, including emergency cover. Only when it was clear that no emergency work was to be done by MLSOs did doctors and graduate scientists indicate that they would attempt to provide this service. The initial strike was to be for 24 hours but in the event continued for eight days apart from a two-hour period on the Monday morning. During the period of the strike the ASTMS had official pickets on all hospital gates and with some success stopped drugs and food entering the Victoria Hospital.

After one week the board agreed to further discussions with ASTMS provided there were no prior conditions to withdraw their management document. In the event, after a meeting on 20 October the board agreed to postpone implementation of their management policy. It was expected that the definitive management document from SHHD would become available by mid November. Agreement was therefore reached that work would be resumed on the basis of the status quo as existed immediately prior to the dispute being restored. Although all staff are back at work the status quo has not been restored in one department and is subject to continuing disagreement.

Before resuming work the consultants and graduate scientists indicated their disagreement with the continuation of MLSO control of laboratory management but considered that this matter should be resolved at a national level. In the interest of Fife patients the doctors and scientists decided to co-operate in the early return to "normal working."

J D BARRIE

J G BEGG

D D KENNEDY

P N EDMUNDS

MAY MCGAUGHEY

B M WILLIAMS

Fife Area Laboratory,
Kirkcaldy, Fife

Royal Medical Benevolent Fund Christmas appeal

SIR,—May I remind your readers who intend to respond to our president's appeal (14 October, p 1092) that we like to distribute Christmas gifts to our beneficiaries in good time. I would ask all societies, groups, and individuals who have not yet done so to send their contributions as soon as possible to the Director, Royal Medical Benevolent Fund, 24 King's Road, Wimbledon, London SW19 8QN.

GEOFFREY BATEMAN
Honorary Treasurer,
Royal Medical Benevolent
Fund

London SW19