per patient for England was only 89.37p in February 1977, so that had all practitioners conformed to Dr Marsh's final pattern of prescribing the saving would have been only 4.87p per patient, rather less than a third of that achieved by Dr Marsh and his colleagues.

Furthermore, the saving per practitioner would depend on list size, and as the national average is only about three-quarters of the average for Dr Marsh's practice the overall saving must be reduced in proportion. This gives an estimated overall saving of £2.5m.

In other words, some of us are already trying to rationalise our prescribing.

J E BACKHOUSE

Middlesbrough, Cleveland

SIR,—I was interested to read Dr G N Marsh's article (12 November, p 1267). In it he uses detailed figures and tables to show a percentage decrease of items prescribed and change in cost of prescribing after reorganising his practice as described. The figures are taken from five partners. It is footnoted that partner E changed during the year discussed and that "some of the differences may be attributed to that."

It is clear from the tables that partner E's figures are the most significant of all the partners' and have most effect on the results. A more accurate result would have been obtained if E's figures had not been included at all. If that had been the case table I would have shown a percentage decrease in the number of items prescribed of 13% (not 19%) and table II a percentage increase in cost of prescriptions of 9.5% (not 4%). E's effect on the overall results is of the order of 31% in table I and 42% in table II.

I am not criticising the overall paper, which still shows a considerable saving in the treatment of minor illness. I am criticising the presentation of this paper as a scientific treatise when it has such easily challenged figures.

A INWALD

London N19

Scattering of starch powder

SIR,—The report by Drs B Dunkley and T T Lewis (26 November, p 1391) on a meningeal reaction to starch powder in the cerebrospinal fluid (CSF) draws attention to the tendency for starch powder used with surgical gloves to be scattered in unwanted places.

We have frequently found starch particles in imprint preparations of lymph nodes, spleen, and liver biopsy material removed at operation and even in smears of centrifuged deposit from specimens of pleural fluid or CSF aspirated by an operator wearing surgical

gloves from patients who have not previously had a pleural tap or a lumbar puncture.

Clearly when surgical gloves are put on there is usually a wide scatter of starch powder, with particles settling slowly on exposed surfaces, including uncovered biopsy samples, glass slides, and media or containers, while any article actually handled by the glove-wearer is likely to be directly contaminated with starch granules. Cytologists should be familiar with this common artefact in biopsy material; with Romanowsky stains the granules appear green and their nature may not be immediately recognised, but their strong positivity to the PAS stain and striking appearance under polarised light are quite characteristic (see figure).

F G J HAYHOE
R J FLEMANS

Department of Haematological
Medicine,
University of Cambridge

Offensive self-description?

SIR,—It is sad that an advertiser in your "Partnerships (wanted)" column (22 October, p xi) should feel that describing himself as a WASP will increase his chances of finding a suitable position; sadder still if he is right.

However, I do not think that your journal should allow itself to be used by the cynical in search of the prejudiced and I am surprised that this advertisement's potential offensiveness to members of a multiracial association did not lead to its refusal by your staff.

R S MACDONALD

London W4

Head-worn hearing aids

SIR,—It was gratifying to read Minerva's comment about the issue of head-worn hearing aids (19 November, p 1362) and to console oneself with the thought that if no one else seems to care, at least Minerva does.

A stream of Department of Health and Social Security papers since the 1960s has stated the facilities and establishment necessary to provide proper audiology units, although the emphasis is only on hearing aids and not equally on the diagnostic functions. We provide something like 750 aids per year, also an exchange, repair, and advice service. We have over 3000 registered users of body-worn aids for changeover to head-worn aids, and possibly as many for changeover who are not registered. All applicants for aids are examined as outpatients, since there is often pathology in the deaf which requires treatment. The same applies to the unregistered patients, some of whom have had Medresco aids for 12 or 14 years and whose new aid may need changing to the other ear. The staff to cope with this very heavy work load consists of one junior audiology technician and one trainee technician. At the present rate it could take somewhere between 10 and 20 years to effect the changeover while continuing to supply "first time" aids.

The problem, as always, is money. To put the picture properly in perspective we have to consider our own part in the recently published "Strategic Plan for the Period to 1986," in which the ENT department is scheduled to suffer a 52% cut in inpatient services and 25% in consultant sessions.

Perhaps those thousands who at present stand little chance of obtaining one of the new aids should write to the Minister for the Disabled to invite his own suggestions as to how the centre could "make its own arrangements."

J W STEPHENSON

ENT Unit,
Farnborough Hospital,
Farnborough Common,
Orpington, Kent

Emergency in emergency departments

SIR,—Our association has been formed to foster and improve all aspects of immediate care.

The letter from Mr C C Slack (19 November, p 1359) informing us of the inadequacy of many of the junior doctors at present employed in the accident and emergency departments and his warning that many of these departments may be closed in the near future should of itself be sufficient reason for the profession and the public to ask HM Government and the Department of Health how such a sorry state of affairs has been allowed to develop.

An insight into only one aspect of preventable deaths is detailed by Mr D W Yates in his paper, "Airway patency in fatal accidents" (12 November, p 1249). He shows that in an urban area over a five-year period (his table II), of 53 people with low injury severity scores dying within 72 h of accident, 12 with obstructed airways died before admission, and 17 with obstructed airways died after admission to an accident and emergency department.

A study was made by the Medical Commission on Accident Prevention during 1975-6 at the request of the Department of Health and Social Security and undertaken by Mr Alfred Dooley. This included an evaluation of the level of care in the area of the North Riding Road Accident After Care Scheme in comparison with that in the rest of rural North Yorkshire on the basis of mortality during the years 1972-6. His report to the commission dated April 1976 and addendum of March 1977 indicated a difference in level of care equivalent to a reduction of about 50% of later deaths in the scheme area.

Immediate care is the provision of skilled medical help at the scenes of accidents or other medical emergencies no matter where they occur. Immediate care schemes, including hospital flying squads and resuscitation units, comprise doctors and nurses, ambulancemen, police, firemen, and other rescue services which help to provide immediate care. Training is mutual and call-out is simultaneous for all services.

In 1977 there were 73 schemes operating with over 1200 participating doctors (about one-fifth of the total of rural general practitioners in the UK). The majority of schemes are registered charities, the doctors giving their time and service voluntarily. This work is not covered by the National Health Service.

Surely the time has come for an overall improvement in all aspects of immediate care to be fostered by HM Government and for departmental deviousness and infighting with statistics to cease. Guidelines have been propounded by Mr Dooley.¹

It grieves many to see the way in which the National Health Service is hamstrung through lack of finances and through maladministration. Standards can still be maintained if the

Starch granules in a splenic imprint from a patient with Gaucher's disease; the same field is stained consecutively with Romanowsky and PAS stain and shown under polarised light.

good will of volunteers can be supported in a practical manner.

KENNETH EASTON
Chairman,
British Association of
Immediate Care Schemes

London SW7

¹ Dooley A, in *Rescue—Emergency Care*, ed K Easton. London, Heinemann, 1977.

What price the ambulance?

SIR,—I would congratulate Dr J G M Howat and Mr E L Kontny (12 November, p 1298) on providing a comprehensive and interesting analysis of the transportation methods adopted in Nottingham.

I would point out, however, that as a comparative cost exercise some anomalies exist. To compare the various costs of providing either ambulance or hire car transport, consideration must be given to the high cost of providing "emergency" and "urgent" cover within the budget of the ambulance resources. The cost per mile stated in the article for the ambulance service is inclusive of the cost of providing cover on a 24-hour basis, seven days a week. The ambulance service is a labour-intensive industry and administration costs are low. To deploy ambulance resources on a daily basis for clinic and day care demand without the burden of providing 24-hour cover would provide statistics more comparable with the costs quoted in the article.

As a matter of interest I have studied data for my service and the following statistics emerge for a one-year period.

(a) No of paid hours for "emergency cover"	305 760	} ratio 2:3
(b) No of paid hours for "clinic cover"	211 152	

The costs for these hours calculated at current rate of pay with additions for 1976 and 1977 pay awards and inclusive of employers' contributions for superannuation and National Insurance are:

Emergency	£476 527
Clinic	£326 799

Calculating a mean clinic-patient figure at average miles per patient produces a cost per clinic mile of 25p per mile for all clinic patients. This figure could be reduced still further by a comprehensive planning policy created by total co-operation of departments responsible for the demand.

L PORTER
Chief Ambulance Officer,
Gwent Area Health Authority

Pontypool, Gwent

Raising the wind for practice premises

SIR,—The best advice that could be given was not in your "Briefing" (26 November, p 1432) describing how capital can be raised to build a doctor's surgery. When compared with the alternative of borrowing from a bank, borrowing from the General Practitioner Finance Corporation is unduly expensive and commits the doctor to heavy costs over an unduly long period.

In 1974 my partners and I approached the manager of the bank in which we kept our current account in respect of a loan for a substantial surgery building project. There was no difficulty in securing the full amount required. We were charged 2% above bank rate and asked to make monthly repayments

at a rate which cleared the loan in five years. As security we were asked to deposit the deeds of the surgery with the bank.

The short period of the loan reduces substantially the total amount of interest paid. While the repayments are higher on a short loan, the bank manager was prepared to be flexible about the period and indicated that if we could not meet the repayments necessary he would be prepared to consider a further loan at the end of the period. In the event the fall in bank rate has made it more than likely that the full amount of the loan will be paid off well before the end of the period.

In contrast, the GPFC conditions were much more onerous. The interest rate was high (17%) and irreducible over the whole of the term despite fluctuations in bank rate. The period was long (20 years) and there was a condition in respect of endowment assurance. My partners and I were unwilling to commit ourselves to such a high rate of interest for such a long time.

Any independent contractor shops around for the most advantageous terms when raising capital, and general practitioners should be no exception. It is possible to obtain better terms from a bank than from the GPFC and I feel that any partnership contemplating a major investment should consider this source of capital.

As a corollary it is worth observing that if a local bank, with their knowledge of local conditions and the doctors' general financial standing, will not finance the project, then it is probably not soundly based and the doctors would be ill advised to proceed.

P J BARBER

Warrington, Lancs

Clinical competence and the Ombudsman

SIR,—I have read in the national press of proposals to extend the powers of the Ombudsman from investigating complaints by patients about the administration of the NHS to include complaints about the clinical opinions of hospital doctors. This is the recommendation of the Commons Select Committee on hospital complaints.

Should such a proposal be implemented the consequences would be far-reaching and serious for the doctor and the patient. At present a doctor's clinical opinion is the only means by which he can honestly and conscientiously advise and treat his patients. It is based on many years of experience combined with study, discussions with colleagues in learned societies, or while visiting their hospitals at home and abroad. No clinician is infallible and the patient is at present free to seek a second opinion if dissatisfied.

Fear of sanction by a lay person or of having to obey orders imposed by militant trade unionists who have no knowledge of the problems involved will destroy a doctor's clinical judgment and reduce him to a mere servile technician. I hope that all my colleagues will appreciate the seriousness of such a threat and combine to resist this move at all costs.

J SIEGLER

Liverpool

SIR,—Recent reports indicate that yet another tier of investigation of doctors' competence is

to be introduced into the NHS in the shape of the Ombudsman. Already family practitioners may be subject to scrutiny by no less than four committees, councils, or courts and it seems that hospital doctors shall not be left out. It is to be hoped that our representatives will reject this further attempt to interfere with our clinical freedom, particularly as there are already several mechanisms in existence to monitor our clinical competence.

It should be pointed out to the Department of Health and Social Security that, while calling for economy of investigation and prescribing, if they set up procedures which allow patients to bring frivolous and unnecessary complaints without penalty the only answer so far as the doctor is concerned is to practise defensive medicine with its consequent increase in cost.

R R DRURY

Swindon, Wilts

Medical salaries

SIR,—I note that Mr Rudolph Klein, who contributes papers about the National Health Service in your journal, has been airing his views about the possible future direction of medical salaries (9 July, p 136). His case appears to be that because the demand for places in medical schools is high and more doctors are in training than can be usefully employed, therefore salaries of medical practitioners will fall according to the simple market model of perfect competition in which supply of and demand for a product go into equilibrium when the price is right. In situations of over-supply the price is usually low.

I am no more an economist than is Mr Klein, but I would have thought that someone who takes as great an interest in the NHS as he does would be aware that there is not a true market for the employment of doctors in Britain. As the demand for doctors is controlled by a monopoly employer it can hardly be said that there is freedom of demand.

I can only assume then that Mr Klein's remarks are to be taken as an incitement to doctors to create a more perfect employment market—one in which their salaries would more closely mirror the doctor's own assessment of his value. I am sure we would all be delighted to take up this, as experience in countries in which there is a more perfect market of medical manpower employment suggests that the price of doctors would rise more steeply.

Perhaps we should take Mr Klein's implied advice and all resign from the NHS—we have only our low salaries to lose.

DAVID YOUNG

St Chad's Hospital,
Birmingham

Distinction awards

SIR,—It often seems to be the case that anyone who comments adversely on this system is thought to be attacking the desire for fairness of those who administer it. This no doubt arouses additional opposition in so far as those sitting on the committees are themselves recipients of these moneys.

Those in receipt of the system may well feel that any criticism is an assault on their own merits or fairness in attempting to work