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

what not a few people consider an unworkable and inherently invidious and corrupting system. This is because there can never be objectivity about it. There can be degrees of objectivity, but the fact is that this money is subtracted out of the total pool available to the whole hospital consultant side of the profession; it also affects their retirement salaries and so on. Therefore to give the chosen their extra amounts of money in fact involves it coming out of a pool which is available for the whole profession. A scrutiny of the tables of distribution seems to show that those in the most power on these committees and historically strongest find it right to issue the largest proportion of awards to their specialties. This is not surprising and no doubt is felt with the strongest justification to be right.

This whole matter of attributing distinction is extremely difficult. Of course some people are better than others, but the selection of the favoured may often be determined by personal acquaintance, lobbying, and advertising. On the other hand should people already doing very well with private practice and so on have these extra sums artificially added on at others' expense? The fact of the matter is that in a society that is still to some extent free those consultants who do good work become well known and their private practice increases. This is as it should be and is a genuine reflection of people's feelings about results achieved. It is fair as opposed to the system of committees distributing these moneys. Naturally they will tend to distribute these to people they know well and consider excellent. There may be others who do not publicise themselves who may be doing just as good work. The system is never going to work fairly for all these reasons and it breeds corruption in the sense of self-pushing in at least a few cases and all that goes with any system of awards by privileged courts. It breeds division in the hospital side of the profession which their general practitioner brothers have not had to put up with. In my view the general practitioners have had a nobler sense of what is right and proper even though those with the drive to power had to forgo the power to distribute money and prestige to chosen colleagues.

Although one realises that it makes one highly unpopular with the establishment, I feel that one has a duty to the future health of medicine in the UK to continue to attack a system that one feels is squalid; and not for base reasons.

HARRY JACOBS

Severalls Hospital,
Colchester

Points from Letters

Vertigo in children

PATRICIA M SARTER (Nantwich, Cheshire) writes: Dr A B Alexander (19 November, p 1356) is obviously correct in assuming that children enjoy the labyrinthine stimulations of swings, roundabouts, etc. However, I would not agree that they would therefore enjoy the vertigo produced by internal derangement or disease of the labyrinth. In personal experience it is most unpleasant as an adult and was, as a child, frankly terrifying.

Dr B E SCHLESINGER (Boxford, nr Newbury, Berks) writes: Vertigo in children (leading

article, 5 November, p 1173) . . . can be a concomitant of cyclical vomiting. Over 40 years ago the late Dr W G Wyllie and I wrote about this under the heading of "The periodic group of disorders in childhood."¹ Of 80 children we investigated with this syndrome, 12 suffered from attacks of faintness and dizziness amounting to vertigo. This was severe enough to force the child to sit down to prevent overbalancing. Occasionally there was headache with temporary failure of vision for five to 10 minutes, in which everything went dark, but consciousness was not disturbed. . . .

¹ Wyllie, W G, and Schlesinger, B E, *British Journal of Children's Diseases*, 1933, 30, 1.

Vertigo and the pill

Dr H MACLEAN (Johnstone Bridge, Lockerbie, Dumfriesshire) writes: With reference to the letter from Mr J Siegler (26 November, p 1416), one should remember that vertigo is one of the common manifestations of anxiety.

Dietary fibre and coronary disease

Dr A D ROBERTSON (Falkirk) writes: It was with considerable interest that I read the article (19 November, p 1307) by Professor J N Morris and his colleagues, suggesting that lack of fibre in the diet was a main cause of coronary thrombosis. There is nothing really new in this theory. . . . The question, "Why has Scotland such a high incidence of this disease?" is frequently asked and the answer given is animal fat. Personally, I firmly believe that the wrong question is always raised. The query should be, "Why has Scotland now got seven times as much of this disease as pre-war?" I do not believe that the consumption of fat has risen to such an extent over these years to account for such a dramatic increase. If, however, one accepts the fibre theory the answer to this question fits in most completely. Prewar the common Scottish breakfast included porridge made from coarse meal, soaked overnight. The main meal frequently included home-made soup, thick with a good supply of vegetables and pulses. Now it is flakes (if that) and creamed tinned soup. . . .

Why smoke a pipe?

Mrs JANE M BATEMAN (Harlow, Essex) writes: Dr J A McM Turner and others (26 November, p 1387) raise the interesting question why primary pipe and cigar smokers smoke at all, since they appear to absorb insignificant amounts of nicotine because of their habit of not inhaling. After 35 years of marriage to a primary pipe smoker I find this phenomenon no longer the enigma with which the authors conclude their paper. I am convinced the pipe is merely the equivalent of a baby's dummy, since it appears to give the same satisfaction whether or not the tobacco is in fact ignited.

Oust the louse

Dr A J SINGER (Reed and Carnrick Research Institute, Kenilworth, New Jersey) writes: . . . Because the company with which this institute is affiliated is the manufacturer and distributor of a pediculicide containing gamma benzene

hexachloride (GBH) as the active ingredient, we are particularly concerned both with the subject and also with two statements which appear in your leading article (22 October, p 1043): firstly, that ova are not killed by organochlorine insecticides without repeated applications, and, secondly, that head lice have developed a resistance to these agents. Firstly, studies from our entomology laboratory show that GBH is totally ovicidal to *Pediculus capitis*, *P. pubis*, and *P. corporis*. Clinical experience amply confirms our laboratory findings when properly applied in the 1% concentration. Secondly, to comment on the occasional reports of resistance of lice to GBH has become a frustrating exercise. The worldwide literature documents only the solitary findings of Maunder as cited in your article. . . . According to Gratz¹ resistance of head lice to GBH has not been reported elsewhere in the world, despite the fact that it is probably the most widely used pediculicide for *P. capitis* and *P. pubis*. . . .

¹ Gratz, N G, *Scabies and Pediculosis*, pp 179-190. Philadelphia, Lippincott, 1977.

"Curing" minor illness in general practice

Dr K B THOMAS (Portsmouth) writes: If Dr G N Marsh (12 November, p 1267) adopts a policy which must surely make for a high rate of prescribing and which is certainly not universal—namely, of allowing receptionists to accept requests for repeat prescriptions for new episodes of previously treated minor illness—and if he then abandons this policy, a decrease in his prescribing rate is not surprising. . . . On the more significant question of giving no treatment to patients with minor illness at consultations, no figures at all are provided. I would like to know how many patients attended with minor illness and how many were made better. Statements like "some patients have been delighted with this new style of consultation" are no substitute for hard facts.

Computed tomography and the NHS

Mr P H LORD (High Wycombe, Bucks) writes: Dr Derek Meyers (26 November, p 1404) tells us that, while only two of Brisbane's four major hospitals have computed tomography brain scanners, radiologists in private practice have installed two whole-body scanners in the town. The population of Brisbane is 800 423 (1971 census). One cannot help but reflect that all the hospitals in Great Britain and Northern Ireland between them have only 41 such instruments and wonder whether we would be in this situation if our Health Service had not been nationalised in 1948. . . .

GPs' self-respect

Dr D C WILKINS (Clanfield, Hants) writes: Dr Conrad M Harris (12 November, p 1282) writes of "a growing self-respect among general practitioners." In 25 years of general practice I have lacked knowledge always, confidence and money often, but self-respect never—nor have I ever been aware of this lack among my colleagues. Do I detect (not for the first time) a neurosis in general practice's "olive grove of Academe"?