most of us have tried not to get involved in, vaguely hoping that we would always be prepared to give the job to the best candidate while admitting that, if all other things are equal, a local candidate should have the advantage. As things are at present, however, we are being asked to accept two quite different standards. It would seem that a very high standard is being required by our own medical schools even before admission and is being rightly maintained throughout training, yet at the same time we are asked to accept overseas doctors for postgraduate training who have in some cases obviously not been trained to anything approaching these criteria.

It did seem that with the advent of the Merrison proposals these inequalities would be removed. It is therefore profoundly disturbing to learn that these have not yet been incorporated in the Bill before Parliament, and I urge that the full influence of the BMA be used to see that the full Merrison proposals are implemented as soon as possible.

DAVID J TURNER

Great Yarmouth General
Hospital,
Great Yarmouth, Norfolk

Skill and differentials

SIR,—As you know, there has been an increasing amount of controversy, particularly within the trade unions, concerning the lack of reward provided for men, such as the Leyland tool-room workers, who have had the foresight to undergo a fairly long course to become skilled in one particular branch of their occupation. Such workers are increasingly finding that people who have not taken the trouble to be skilled or carry out jobs involving neither skill nor responsibility are being paid virtually the same as themselves.

With regard to my own specialty, ophthalmology, this has recently come home to me as on looking through a copy of the ophthalmic opticians' journal, *The Optician*, I was surprised to find that, in the advertisements for ophthalmic opticians, there were quite a number advertised at £10 000 pa with profits and with car provided and also with assistance in house purchase, together with non-contributory pension and profit-sharing. When I analysed 10 of these advertisements I found that the average wage for an ophthalmic optician was £8300, but many included a free car and what are termed "fringe benefits." Opticians can obtain this type of remuneration while in their twenties and I think it is scandalous that young consultant ophthalmologists, often not appointed until they are well into their thirties, now earn at a maximum £8100 and have to provide their own cars, etc. The BMA has pointed out that the purchase and running of a car takes up some 25% of a consultant's salary. It would appear that the gross average salary for opticians with a car provided is thereby ranging from £10 000 to £12 000 pa, while a well-qualified and skilled ophthalmic surgeon is earning £6000. The knowledge of this is causing a considerable amount of discontent among ophthalmologists, and not without reason.

The profession was promised that "in order to avoid any unseemly wrangling over pay," the Government would recognise the opinions of an independent Review Body. As far as I can see, this most recent Review Body ought to have published its findings and recommenda-

tions irrespective of whether or not there was a Government pay policy. If a Review Body has to consider Government pay policies obviously it cannot be said to be independent.

Finally, although ophthalmic opticians are worthy and useful members of society, I think it must be agreed that their skill and training vis-à-vis that of a consultant ophthalmologist, and also their value to the community, must of necessity be much less.

JOHN MCLENACHAN

Manchester

Supply Board Working Group

SIR,—In your necessarily brief report of the proceedings of the Joint Consultants Committee (5 November, p 1234) the account I gave the committee of the early meetings of the Supply Board Working Group is capable of misinterpretation.

The purpose of my statement was to inform the committee that Professor M D A Vickers of Cardiff had agreed to act as an alternate member to myself on the working group under Mr Brian Salmon. In answering a question about being the only user on this group I made the point that, while nominated by the JCC, we were acting in a personal capacity and the JCC as such would have to consider its attitude to the eventual report when it was sent by the Department of Health and Social Security for comment.

Naturally both Professor Vickers and I hope to influence the working group to accept the profession's view on the question of medical

equipment. It was not my suggestion that in the unlikely event of a minority report being necessary this would be drafted by the JCC. Far from it: the confidentiality of all documents will be preserved at all times. Nevertheless, were such a major step necessary, and I sincerely hope it will not be, both Professor Vickers and I would keep the chairman of the JCC apprised of our intentions.

I would like to express my personal thanks to Professor Vickers, who is bearing the brunt of attending a very large number of meetings.

E B LEWIS

Hythe, Kent

New consultant contract

SIR,—I note from letters in the journals concerning the new consultant contract that some "whole-timers" sincerely believe that our negotiators are only acting on behalf of "part-timers."

As a whole-time anaesthetist on the Negotiating Committee may I say that the committee is very aware of the need to improve the situation of the whole-timer and the new contract is intended to do just this?

However, I believe that a contract which recognises, and rewards, the work that a consultant does is infinitely superior to a "slush money" contract that effectively depresses the value of all consultants' work, which in essence is the present situation.

J M CUNDY

Bromley, Kent

Points from Letters

Emergency in emergency departments

Mr M FLOOD (St James's Hospital, London SW12) writes: I was interested in the letter from Mr Cyril Slack (19 November, p 1359) about the possible breakdown of the service in emergency departments in our main hospitals. . . . If a policy were adopted at all accident and emergency departments that the only patients to be seen were those brought in by either ambulance or the police and ambulant cases of trauma requiring the service of the hospital, then the work load in these departments and consequently their staffing requirements would be greatly reduced. Any patient presenting him or herself at an accident and emergency department should be either admitted as an emergency, treated because only the department has the necessary facilities to treat that patient, or referred straight back to the general practitioner. . . . If this policy were to be followed throughout the country many more accident and emergency departments could be closed or work on an alternate shift basis. For example, in this district we have two major district hospitals, St James's and St George's, less than a mile and a half apart with full accident and emergency facilities and the full attendant back-up services of radiology, pathology, etc, fully staffed 24 hours a day, seven days a week. . . . It would be no great hardship to close one or other of these casualty departments alternately, certainly at night, and genuine accidents and emergencies would not suffer by being taken direct by ambulance to the one that was open. If this policy were extended to the closure of other departments

on an alternate 24-hour basis the savings in stand-by duty and overtime for junior staff would be enormous without any detriment to the true accident and emergency service.

Allergic bronchopulmonary aspergillosis

Mr J R BELCHER (London Chest Hospital, London E2) writes: The original and still classical paper on allergic pulmonary aspergillosis was written by Hinson, Moon, and Plummer¹ of the London Chest Hospital in 1952 after presentation to the Thoracic Society. . . . As your leading article (3 December, p 1439) made no reference to the crucial original communication I think that it is right to remind your readers of the names of the people who first described this fascinating condition and of the hospital where they worked.

¹ Hinson, K F W, Moon, A J, and Plummer, N S, *Thorax*, 1952, 7, 317.

Pierced-ear hazard

Dr G CAPLAN (Manchester) writes: I would like to report an interesting hazard of the current fashion for pierced ears. A girl of 9 years had an infected swelling in the lobe of her ear at the site of the piercing. She had been wearing ear-rings with a small plastic backing, which was paper-thin, about 1/4 in in diameter, and had embedded itself completely into the lobe of her ear and had to be removed. I have also been told of two other examples of this.