of services to provide trainees with adequate clinical exposure to less common conditions. The fragmentation of specialist services will lead to a degradation of training and ultimately a fall in clinical standards.

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1 Bain J. Budget holding: the first 150 days in Calverton. *BMJ* 1991;303:907-8. (12 October.)

Locum consultants

SIR,—John Robb correctly points out the challenges that locum consultants face daily and the unacceptable way in which they are treated if they dare to apply for accreditation or a permanent consultant post.¹ His thoughts on the registration and periodic assessment of locums are, however, muddled, particularly as there are no periodic assessments of permanent consultants. Locums at least have assessments in the form of references for each new locum undertaken.

It would be helpful if locum consultants could form an organisation to protect themselves, particularly as regards pay, but a separate register of locums would be useless. Who would keep it? And for what purpose? Robb suggests that regional panels should be constituted to assess locums, having apparently failed to realise that most locum consultants have had as much training as the permanent consultants for whom they deputise and are far more experienced than they are. Indeed, you have to be very experienced to cope with the vagaries of locum consultant work. After 12 years of it in two specialties I can confirm that.

What is required is the automatic appointment of locum consultants to permanent posts after a few years of successful deputising, in the same way that registrars are appointed associate specialists when their senior colleagues are satisfied that they have earned this.

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1 Robb JDA. Locum consultants. *BMJ* 1991;303:927. (12 October.)

Payments for drugs

SIR,—In his letter Paul Thomas complains that payment is not made to non-dispensing general practitioners for drugs and appliances supplied to patients outwith paragraph 44.5 of the statement of fees and allowances.¹ It is unfortunate that he cites the closure of a Scottish accident and emergency department as being likely to cause difficulty for prescribers required to deal with an increased number of minor injuries. Scottish general practitioners do not receive the so called "bag allowance" for medicines, etc, required for immediate treatment. They are able to order such stock items on form GP10A. As with form GP10, the order is presented to a community pharmacy and the items are supplied directly to the general practitioner for subsequent use.

Thus general practitioners in England and Wales could instruct their negotiators to forego part of the practice allowance in exchange for a stock order facility. This would be preferable to extending the list of items that can be dispensed by prescribing general practitioners for personal administration under paragraph 44.5.

Also on the topic of payments for drugs, Stephen Ash suggests that "the cost of drugs dispensed by hospital pharmacies is . . . substantially lower than that levied by the 'high street' pharmacist, who . . . adds a sizeable mark up to the costs to produce a profit."² Though it may be true that some

pharmaceutical companies sell to hospitals at a "contract" price or at a promotional price, which may be less than list price or the price given in the drug tariff, community pharmacists cannot be accused of adding sizeable mark ups to drug costs.

Payment for drugs and appliances is made according to the drug tariff. If the drug tariff does not state a price the list price of the manufacturer or supplier is used. As discounts are available to community pharmacists the price given by the drug tariff or the list price is subject to a deduction, which averages 9-67%.

It is true that community pharmacists receive a 5% on cost or mark up on the list price of drugs, but this is part of remuneration rather than reimbursement. The 5% on cost could just as easily be paid out as an additional dispensing fee, as it is in Scotland.

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1 Thomas P. Payment for drugs. *BMJ* 1991;303:858. (5 October.)

2 Ash S. How to pay for expensive drugs. *BMJ* 1991;303:926. (12 October.)

Women in general practice

SIR,—Jacky Hayden's editorial on women in general practice carries the subheading "Time to equalise the opportunities"; I agree. Currently female general practitioners are allowed maternity leave. This is a voluntary absence from work taken for personal reasons for anything up to 40 weeks and attracts financial assistance for the costs of a locum for the first 13 weeks. No equivalent opportunity is available to male general practitioners.

If female practitioners are given additional rights and flexibility at the cost of their male colleagues it will make appointing a female partner less attractive; it will not solve the problem, it will compound it.

The only effective solution happens also to be the equitable one. General practitioners' contracts, commitments, and workloads should be reduced to a level that allows doctors of both sexes to have a reasonable private, social, and family life.

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1 Hayden J. Women in general practice. *BMJ* 1991;303:733-4. (28 September.)

Mutual support group for NHS dissidents

SIR,—I have sensed from the journal that there has been increasing dissent about both the direction and the success of recent NHS reforms. Many of those in our own and allied professions who have chosen to speak out because of professional conscience do indeed see themselves as dissidents. Some, like myself, have gone into voluntary exile. Others, such as Graham Pink and Helen Zeitlin, have been expelled from the NHS that they have loved and fought for. Others—most recently Michael D'Souza—remain as a resistance against the forces of hypocrisy and political intrigue which threaten professionalism within the NHS.

I have received correspondence from and corresponded with many of these dissidents. I know how welcome it can be. I suggest that we might organise some form of mutual support group for those who consider themselves to be disenfranchised by the NHS, whatever their profession

or political beliefs. I would not want such an organisation to be political; there are enough of those already. It would, however, serve as a forum for ideas and give mutual support to any who sought it. I would be delighted to hear from any readers who would like to discuss this further.

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Lies, damned lies, and waiting lists

SIR,—In his editorial John Yates discusses trends in and the composition of waiting lists.¹ A further factor that will influence data on waiting times is the recent validation of patients waiting for long periods. In each district patients are being written to in order to ascertain whether they wish to remain on the waiting list for treatment of their condition. If no reply is received they are taken off the waiting list. This will have a dramatic, short lived effect on waiting lists, particularly for those who have been on the lists longest. The effect will accrue from people who do not receive the letter as they have moved address in the interim or who no longer consider the operation to be necessary. In many cases no further inquiry is made after the initial approach, nor is the family doctor's opinion sought over whether the operation remains indicated.

This review will no doubt cause a blip in the statistics, which may be subject to political interpretation.

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1 Yates J. Lies, damned lies, and waiting lists. *BMJ* 1991;303:802. (5 October.)

Special representative meeting and the political process

SIR,—Tony Keable-Elliott's letter on the decision to hold a special representative meeting next year underlines the fact that the BMA is in a "no win situation" in the current political climate.¹ We must remember that it was not the profession's choice to make the issue of health so political. Though it is unacceptable to be "party political," it is equally wrong not to meet our political responsibilities by using whatever means available to allow the public, politicians, and our members to understand the points at issue and where we stand in relation to them. Now more than at any time the association has a chance to affect outcomes. A special representative meeting seems an eminently sensible way of keeping these desperately important issues alive. If the association makes no effort to make its position clear in a pre-election period it will be accused of ducking its responsibilities.

To believe that by presenting a uniform policy to a newly elected government the BMA will be effective seems naive in the extreme, considering our experiences with the present government.

Keable-Elliott refers to the debate in which none of the officers spoke; I doubt very much whether their points would have been any different from those they made in the previous debate, which resulted in a tied vote.

It is easy to complain about the democratic process when it produces the wrong result from a personal point of view. The strength of the democratic process in any "body" is that it can reach decisions that may not be comfortable for the establishment. Non-voting members of council of course do not have constituencies and as such are