patient described on p 58 of my book who responded dramatically to combined treatment by lumbar sympathectomy and radioactive phosphorus. It is interesting that the patient described by Professor Fitzgerald and his colleagues responded so well to phlebotomy.

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¹ Whitby, L E A, and Britton, C J C, *Disorders of the Blood*, 10th edn, p 503. London Churchill, 1969.

² Eastcott, H H G, *Arterial Surgery*, 2nd edn, p 213. London, Pitman, 1973.

Oxytocin and neonatal jaundice

SIR,—In his study of neonatal jaundice following the use of oxytocin to accelerate labour (4 September, p 564) Dr P Boylan obtained results which, as far as they go, agree with our own.¹ His conclusions are, however, at variance with ours. One would not expect the mean bilirubin concentrations to differ significantly between the study and control groups while the frequencies of hyperbilirubinaemia ($>170 \mu\text{mol/l}$ (10 mg/100 ml)) are as low as 10.2% and 7.3% respectively (Dr Boylan's figures). This fact we have pointed out previously.²

Because his study was restricted to patients receiving less than 10 units of oxytocin to accelerate labour it is hardly surprising that he was unable to demonstrate an increased incidence of hyperbilirubinaemia following its use. In our own study the incidence of hyperbilirubinaemia was directly proportional to the total dose of oxytocin used to induce or to accelerate labour but was not related to the duration of labour. Hyperbilirubinaemia occurred least often in those babies whose mothers had received less than 10 units of oxytocin to accelerate labour but affected one-third of babies when more than 20 units of oxytocin had been used. This association was statistically significant. However, in an identical study³ in which prostaglandin (PG) E_2 was substituted for oxytocin there was no evidence of a relationship between the incidence of neonatal hyperbilirubinaemia and the dose of $PG E_2$ used to accelerate labour.

We cannot therefore agree with Dr Boylan's conclusion that "oxytocin does not have a deleterious effect on bilirubin metabolism in the newborn." The balance of evidence currently available is weighted firmly in favour of a positive association between neonatal jaundice and the use of oxytocin in labour.

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¹ Beazley, J M, and Alderman, B, *British Journal of Obstetrics and Gynaecology*, 1975, **82**, 265.

² Alderman, B, and Beazley, J M, *British Medical Journal*, 1974, **3**, 624.

³ Beazley, J M, and Weekes, A R L, *British Journal of Obstetrics and Gynaecology*, 1976, **83**, 62.

Clinical academic staff and new NHS consultant contract

SIR,—Meetings are now taking place in all districts to discuss proposals for a new NHS

consultant contract. We urge all clinical academic staff of honorary consultant status to attend these meetings to give their views.

If broad parity of remuneration between NHS and honorary consultants is to be achieved quickly and effectively we hope that only minor changes to the final form of a new NHS consultant contract will be needed to suit the requirements of university clinical academic staff. Clinical academic staff therefore should play a full part in the current discussions if they wish to achieve a comparable and satisfactory contract for themselves.

A discussion paper has been prepared by the Central Committee for Hospital Medical Services (11 September, p 655) and all clinical academic staff are urged to obtain it without delay. Supplies of the paper have been posted to the office of every dean of a medical school or postgraduate institution.

Your opinion on the discussion paper or on the nature of an ideal contract for clinical academic staff holding honorary consultant contracts will be welcome and useful in our discussions with the University Grants Committee; it should be addressed to Dr John Dawson, Secretary of the Full-time Medical Teachers and Research Workers Committee at BMA House.

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Full-time Medical Teachers and
Research Workers Committee, BMA

BMA House,
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Splinter organisations

SIR,—How right Dr D L Gullick (18 September, p 701) is to echo Marlene Dietrich, "When will they ever learn?"

In my experience, of my fellow consultants who are loudest in their complaints against the BMA few have taken any active part at divisional level and none has offered himself for election to office. They think and speak of the BMA as an inefficient "them" rather than as an "us" with claims on a loyalty and financial support that is withheld. (The relative sizes of the two defence trusts reflect sadly on consultants' self-interest and political maturity.)

The excuse used to be that the BMA was a general practitioner-orientated organisation. Since the restructuring of the Annual Representative Meeting this has become untenable and if it ever did have any substance it was only because, in the absence of adequate consultant interest, GPs naturally filled the void thus left. It may be true that doctors, individualists by training and inclination, find it difficult to rally under one flag, but our GP colleagues have done it and enjoy corresponding influence. There is still some time left for consultants to achieve the same unity—but very little.

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SIR,—As, two years ago, I received perceptive and courteous replies from Dr D L Gullick to several queries I am surprised by the content of his letter (18 September, p 701).

Membership of the BMA, Hospital Consultants and Specialists Association, or National Health Service Consultants Asso-

ciation is not, of course, mutually exclusive, but disenchantment with the policies of the first two organisations has, in fact, called the third into being. All will agree that successful negotiation with the Department of Health will depend on unity of the profession. Such unity will only be achieved if our negotiators are seen to be acting for all sections of the profession; in the negotiations of two years ago the interests of the whole-time consultant seemed forgotten. I would suggest that the BMA could ratify its claim to represent all major interests by adding the following item to the Central Committee for Hospital Medical Services' discussion paper on the consultant contract (11 September, p 655).

Whole-time commitment—In consideration of a formal agreement by a consultant to restrict his or her professional services to NHS work an additional two NHDs will be applied to the basic contract.

Inclusion of such a provision, which can be amply justified, would protect the interests of those many consultants whose specialty is essential to the hospital service but does not lend itself to remunerative private practice. Its inclusion would go far to ensure that the consultant body would be truly united behind its negotiators and could also increase BMA membership among the currently disaffected.

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Consultant contract

SIR,—The arguments about the consultant contract and medical remuneration continue to rage. The public largely consider the consultants to be rich and greedy and those consultants undertaking private practice to be richer and greedier than their "whole-time" colleagues. We are shy of admitting that our discontent lies not only in our terms and conditions of service but also in the poor level of our remuneration.

Some years ago, the BMA in their wisdom negotiated the current "maximum part-time" contract. How many people outside the profession, even among other hospital staff, know that this is a complete misnomer? The so-called maximum part-time consultant is committed to exactly "the same amount of NHS work as his whole-time colleague." Many consultants opt for this form of contract not only for the right to private practice but to maintain a degree of independence even though they know that they will have to work longer or harder than their "full-time" colleagues in order to earn the same income. Surely it is time to make the true salary position clear—as do our Australian colleagues. The basic rate of pay for consultants should be stated as £6165 with private practice privileges or with an additional £1371 in lieu of private practice. At present the Health Service is getting a marvellous bargain in its numerous "part-time" consultants who in fact work full time and fulfil an on-call commitment for a salary which is less than the highest basic rate for a senior registrar and now commonly less than the total salary earned by many senior registrars or some registrars.

If the current state of affairs is allowed to persist there will be even fewer junior medical