state with an acute abdomen and slight jaundice. She continued to go downhill in spite of resuscitation, and this is not surprising considering her haemoglobin was 19%. At operation I found bile-stained ascites and a dilated gall-bladder. There was no other abnormality except that she had *Ascaris lumbricoides* in the bowel. I drained the gall-bladder and the peritoneal cavity. She was making very good progress when on the tenth day the sister in charge sent for me and demonstrated a live ascaris, waving its head in the fresh air, having emerged from the drainage hole from the gall-bladder. We got this worm out and the wound healed, but three weeks later she began to develop a high temperature. Eventually the skin became red and softened. I incised it and evacuated a dead ascaris from the underlying liver, after which, and with treatment for the worms, she made an uneventful recovery and was discharged.

In this case the one ascaris had climbed up the cystic duct while another had gone up the common hepatic duct.

—I am, etc.,

Victoria Central Hospital
Surgical Unit,
Wallasey, Cheshire.

ROBERT COHEN.

Professional Patients

SIR,—I would like to draw attention through your columns to what is becoming an increasingly common state of affairs in psychiatric practice, and one which I am sure most psychiatrists are familiar with, but

which as far as I know has not been very much discussed in the medical press.

I refer to those people whose main role in life has in fact become that of a patient. Some of these people seem to have adopted this role almost as a conscious choice in distinction to following some gainful occupation or profession. They spend a great part of their life supported by the welfare state in one way or another and receive psychiatric care, usually under a succession of different psychiatrists and/or mental hospitals. They become very sophisticated in psychiatric terminology and expertise, and are also very knowledgeable in the ways of mental hospital life. In many of them the original causes of the disability have long since ceased to operate, but a mode of life which these originally enforced has now become a habit which is often quite pleasant and is not readily relinquished for the more arduous task of fulfilling a normal adult role in society.

We are familiar with the ideas of iatrogenic illness in physical medicine and institutionalization in mental-hospital practice, and I think we must consider these patients products of the extension of the social and psychiatric services under the National Health Service and to that extent the result of "treatment." I feel that it is a problem which requires study, both to define its actual extent and to suggest ways of dealing with it.

—I am, etc.,

West Park Hospital,
Epsom, Surrey.

T. L. DUNN.

Practice Expenses

SIR,—Your leader "Practice Expenses" (26 September, p. 769) sets out the position fairly, but I would nevertheless be grateful if you would allow me to amplify several points in view of the widespread misunderstanding in the profession, both as to the scope and effect of the proposed payments for ancillary help.

Firstly, your negotiators have done exactly what they were instructed to do—namely, to redistribute the expenses portion of the Pool so that, where possible, direct payments are made for expenses incurred. In addition to the two resolutions you quote from the 1963 Annual Conference of Local Medical Committees (*Supplement*, 18 July, p. 33), two similar resolutions were passed at the 1964 Annual Conference, one of which stated: "that this meeting is seriously disturbed that no concrete proposals have yet been brought forward for the more direct payment of practice expenses." You will also remember that the original case to the Review Body did contain a no detriment clause, but at the Special Representative Meeting on 25 March 1964 (*Supplement*, 4 April, p. 115) a motion by Birmingham was carried: "that the paragraph relating to the no detriment clause be left out of the Summary of Evidence to the Review Body." Evidently the profession accepted the unreality of such a stipulation within the framework of our present remuneration set-up.

Secondly, nothing in these proposals interferes in any way with the present arrangements, whereby any money paid by a doctor to his wife for work done in the practice (and accepted as such by the Inland Revenue) is paid back to the expenses portion of the

Pool in full. The question of the wife who does a great deal of work in the practice is a difficult one, and is still under discussion.

Now as to the alleged hardship which this scheme may bring to individual doctors. Undoubtedly those who employ no ancillary help will get less in that part of their gross remuneration which represents expenses, though I do not think the drop in any specific case will be great. On the other hand, those who have been carrying the cost of ancillary help for years will get more. Surely this is fair? As the scheme expands, however, more money will come back to the expenses Pool, and even these doctors who employ no help will get an increase in their indirect payments. In my view if there is even a moderate extra employment of ancillary staff in the next 18 months any alteration in the capitation fee is most unlikely.

In your third paragraph you state: "There are doctors who for one good reason or another may be unable to employ ancillary help, yet their expenditure in other directions may be high." This puzzles me, for by and large the doctors who have high practice expenses have good premises and tend to use secretarial and other help more lavishly than most of us. The only group I think you can be referring to are those who live in areas of exceptionally high cost—e.g., central London. They, in general, are practitioners who make use of ancillary help. Their plight is very real and they must be helped in some way, but their problem is totally unrelated to the present proposals.

I believe that the direct repayment of ancillary help, as suggested, will encourage many doctors to engage help for the first time

and many groups to make use of help additional to that which they at present employ. This can only be to the benefit of patient and doctor alike.

There is inequity in the present method of distribution of practice expenses. We do not seek to perpetuate but to remove this injustice. Surely no one can cavil at this. These proposals may go only a small way towards remedying the sickness that assails general practice to-day, but their prompt acceptance will leave the way open for the consideration of badly needed and more radical changes.—I am, etc.,

Saxilby, Lincs.

A. M. MAIDEN.

SIR,—I regret that your leader on practice expenses (26 September, p. 769) may have increased rather than removed the misunderstanding of the position by many doctors which was revealed in earlier correspondence. The instruction given to the General Medical Services Committee by the 1964 Conference in this matter was unequivocally in favour of a more direct method of reimbursement of practice expenses, and the Minister's statement, published in the *Supplement* of 26 September (p. 135), is correct in all respects.

Doctors appear to have two fears: (1) that the new proposals may adversely affect the Pool computation in respect of money which they properly pay to their wives for services rendered by those wives in general medical practice; and (2) that the new proposals may jeopardize the existing capitation fees.

It cannot be too strongly emphasized that 100% of practice expenses as determined by the Inland Revenue has been, is now, and will continue to be credited to the Pool. These expenses include money paid by doctors to their wives. Doctors are thus already reimbursed generally for that expenditure through capitation and other fees. There is little variation in the volume of work done by the doctor's wife from one practice to another, and no appreciable variation in the sum allowed by the Inland Revenue as a legitimate practice expense. Therefore reimbursement of such expenditure via capitation fees is equitable generally. The G.M.S. Committee is seeking to safeguard the position of the exceptional case in which the doctor's wife works full-time within the practice premises, and, in an earlier speech, the Minister indicated that he too was anxious to meet this type of case.

The basic reason for direct reimbursement of expenditure on other ancillary help is the fact that the volume of ancillary staff employed varies very much from one practice to another. Some doctors employ a great deal; others none at all. Thus the existing uniform reimbursement through capitation fees penalizes those doctors whose expenditure on ancillary staff is high, and, moreover, gives to those doctors who employ little or no ancillary help a greater share of the expenses element in the Pool than is just. Peter is in fact robbed to pay Paul, despite the fact that the total sum disbursed by the Exchequer is correct.

Under the new scheme a considerable part of the cost of ancillary help (in most cases about 66½%) will be directly reimbursed, thus minimizing the hardship of those who presently employ ancillary staff, and doctors may rest assured that *all* the money which they expend on improving the service to their

patients by employment of ancillary staff will be reimbursed through the Pool mechanism either directly or indirectly, for the difference between direct reimbursement and the total salary paid will be added to the Pool for distribution through capitation fees.

In any estimation of the effect of introducing this scheme upon the current capitation fees it is important to remember that we negotiated last summer an agreement whereby in future, in contrast to the past, the expenses element of the Pool for any year will be related to expenditure by doctors during that same year. It can be estimated with confidence that a reasonable response by family doctors to the encouragement to employ ancillary staff will secure (a) a sum of money directly reimbursed, as new money, and (b) will maintain the capitation fee at the present level. If every doctor who does not now employ ancillary staff were to engage a full-time secretary/receptionist then it is probable that, over and above the substantial direct reimbursement, the capitation fee would increase.

The new scheme is the result of difficult negotiations extending over many months, and represents the maximum of direct reimbursement for the cost of ancillary staff which can be achieved without prejudicing the position of the doctor as an independent contractor and without risk of the imposition of intolerable restrictions upon his freedom. It is but the first of a series of improvements which the G.M.S. Committee is seeking. The second has already been announced (*Supplement*, 26 September, p. 135) in the shape of improvement *grants* towards the cost of practice premises. We are well advanced in discussion of a scheme which would more equitably distribute the cost of providing practice premises.

May I remind the profession that as recently as March 1964 it rejected, in a somewhat different but nevertheless relevant context, a proposal for a no detriment clause? Failure to accept speedily the proposed scheme for ancillary staff would prejudice our negotiating position in regard to other important matters.—I am, etc.,

Sunderland.

IVOR M. JONES.

SIR,—I do not share the Minister of Health's optimism over practice expenses. He seems to be confident that "several millions will be added to the Pool eventually" if sufficient doctors employ ancillary help. We have all experienced several millions disappearing from the Pool over the last two years to pay for such things as smallpox vaccination records during the last epidemic which resulted in no final payment for distribution being made to general practitioners. Similar to a public company not paying a final dividend to its shareholders the Ministry of Health has become suspect in its financial dealings with general practitioners.

Now for the first time there is the proposal that there should be a reduction made in the capitation fee per patient. There is a real danger here of creating a precedent which might encourage a future Minister of Health to do the same again—especially in a time of economic difficulty.

I am further concerned about the possible damage to the B.M.A. itself, because some members, whose loyalty has not ceased over the past difficult twelve months, may con-

sider leaving the Association when they find that their income has fallen at a time when the B.M.A. will possibly be asking for an increase in the subscription rate. May we not see a weakening of our strength at a time when we should stand united?

I wonder what experienced trade-union negotiators would think about the Minister's proposals? Has anyone thought of asking them? I doubt if they would accept them, as they appear to aim a body-blow at the general-practitioner membership of the Association.—I am, etc.,

Mangotsfield, Glos.

T. D. RICHARDS.

SIR,—In the three *B.M.J.s* for 5, 12, and 19 September I can find only one correspondent, Dr. V. W. M. Drury (19 September, p. 754), who has given his wholehearted support to the current proposals regarding payment for ancillary help. This, Sir, is a sad reflection on the general practitioners and their comprehension of the Pool. We are supposed to be a learned profession, but when it comes to simple arithmetic and a sense of fair play it would appear that we are sadly lacking. The present proposals are long overdue. All that is suggested is that the expense factor be more fairly distributed and that those employing a receptionist or other help be given more money for this extra service. Those that do not employ help are merely having part of their expenses cut, which in any case was never due to them. My partner and I will be out of pocket, as we employ one receptionist between the two of us—my single-handed colleagues will gain slightly if they employ help.

The outcome is not as good as was first thought, but at least it is justice—albeit a little rough.—I am, etc.,

Bristol 4.

J. P. TELLING.

SIR,—Not so long ago the leaders of our profession were instructed that payments for all services other than general medical services should be removed from the Pool calculation. They now suggest that expenditure on ancillary help—which is desirable—should be a prior charge on the Pool. When will our negotiators realize that extra services or extra expenses require more money? The times are past when those of us who do extra work and have ancillary staff have to be paid by those who do not.—I am, etc.,

Dundee.

KENNETH I. M. HOGG.

Our Greatest Need To-day

SIR,—Lord Brain in his address to the British Association spoke of our greatest need to-day—the need to acquire the power of looking ahead, forecasting, and preparing for the consequences, and, speaking of overwork in the professional part of our population, he asks, "Should we not now be preparing for this by expanding the opportunities and incentives in medicine, nursing, and teaching to encourage more people to work in these fields?" This question brings the profession and Parliament face to face with the problem of social balance, which Professor Galbraith¹ defines as a satisfactory relationship between the supply of privately produced goods and services and those of the State. The situation

to-day in hospital pharmacies is an example of failure to look ahead and of social imbalance.

The Ministry's sample statistical inquiry into the migration of doctors should be examined in the light of this wisdom. The horses, some of our best thoroughbreds amongst them, have gone and have been ably counted by Drs. Seale² and Abel-Smith³; therefore, rather than look again in the empty stables, would it not be more appropriate to our greatest need to inquire of those who still remain whether they contemplate going in the next quinquennium and why? Such a survey might show that, as the stable doors have no bolts, it has become a matter of great urgency to sweep away the rotting manure and to replace the tumbledown structures with new; it might also give a positive answer to Lord Brain's question.—I am, etc.,

Tonbridge, Kent.

P. RICHARD DAY.

REFERENCE

- Galbraith, J. K., *The Affluent Society*, 1958, p. 198. Hamish Hamilton, London.
- Seale, J., *Brit. med. J.*, 1962, 1, 782; and 1964, 1, 1173.
- Abel-Smith, B., and Gales, K., *British Doctors at Home and Abroad*, Occasional Papers on Social Administration No. 8, 1964.

Charges for Patients

SIR,—The Representative Body deserves praise for recognizing at last some of the serious faults of the N.H.S. and for demanding remedies. Provided that Council does not succeed in persuading itself and the B.M.A. that the resolutions passed at Manchester do not mean what they say I shall in future pay my B.M.A. subscription willingly and proudly. Dr. A. L. Bussey (15 August, p. 442) is absolutely right when he points out that "the business of the B.M.A. is to guide Government and people in matters of health. . . . This mandate must extend . . . to the broader issue of provision of health services." It is deplorable that Dr. R. M. Franklin (5 September, p. 635) should conclude that because neither political party would impose consultation charges a fee-per-item method of payment is out of the question and that salary is the only practical alternative to the capitation fee. To agree to what we know to be wrong and to continue to sacrifice standards of medical practice to ignorance, prejudice, and political opportunism is unworthy of British doctors. Quality in medical care must be preserved. To ensure this, demand must be restrained and the doctor must have an incentive to give of his best. The only way to restrain demand and yet preserve the patient's freedom is to arrange for him to pay in proportion to the service he requires.

More fundamental is the effect of the present system on the doctor-patient relationship. The doctor accepts a capitation fee and promises to give an undefined service. Is he to give service only to the total value of the fees paid (forgetting his conscience)? If so, how is it to be distributed between his patients? Or is he to do what he thinks his patient needs, what the patient thinks he needs, or what the patient wants? If he attempts any of these he must sacrifice his income or his health and certainly his family. The conscientious patient is in a corresponding difficulty. He does not know whether and how far he should "trouble" his doctor, and not infrequently postpones seeking advice longer than he should (while the irresponsible