Time-expired Senior Registrars

SIR,—There have been numerous letters and reports dealing with the problems of general practitioners, hospital consultants, senior house medical officers, and senior registrars (12 March, p. 678); but the problems that beset some hospital registrars have not been much publicized.

Once upon a time a well-qualified and experienced registrar could expect to progress up the specialist ladder without too much trouble or delay. Now, however, it is the experience of many of us that our higher qualifications and clinical experience are not necessarily the important factors when we are being considered for promotion.

Some of us are older than the "expected age" of registrars because (a) we studied for higher qualifications after returning from national service and (b) we have continued year after year as registrars while "time expired senior registrars" were unable to move on to the consultant posts. Now that there has been some movement of these senior registrars to consultant posts, we expected that the older, well-qualified, and well-experienced registrars would be given some preference of promotion. But time and time again we have witnessed the appointment of younger and less experienced candidates to senior-registrar posts.

Those of us who have continued as registrars for years without any financial increments, doing responsible work for our patients, for our consultants, and for our employers the regional hospital boards, know that there is ample justification for the creation of more senior-registrar posts and cannot understand why this has not been done. The usual excuse that there are not enough places in the teaching hospitals for more senior registrars to rotate to is quite untenable. The large non-teaching hospitals are in every way just as good training grounds for registrars and senior registrars as the teaching hospitals.

The training and experience of the older long-service registrars are being thoughtlessly wasted and these registrars are being driven to the depths of despair by the disregard which appointing committees pay to them. Surely this terrible situation can be rectified without further delay?—I am, etc.,

LONG-SERVICE REGISTRAR.

Training for General Practice

SIR,—What an admirable article was "Training for General Practice," by Dr. M. J. Whitfield (12 March, p. 663).

The article does, of course, beg certain questions about the best methods of entry into general practice today.

If the "trainee period" is, as Whitfield demonstrates, a little-used system of rather variable quality, and so poorly paid, with so little to recommend it, has it indeed any real place? Can anyone demonstrate great advantage to this scheme?

Secondly, is the College of General Practitioners right in its strong recommendations (which few seem to have criticized) for so extensive pre-general-practitioner house appointments, studies, and diplomas prior to such a trainee period?

Indeed, nothing in fact could be more disheartening for a potential entrant into general practice, extensively qualified by supplementary diplomas and house appointments, than to be plunged into the mediocrity of present-day general practitioners, who tend increasingly as age advances to rely on a wealth of experience to camouflage increasing loss of interest and academic obsolescence?

The effect on our young entrant, unable to exercise much of his highly gained knowledge and techniques, is one primarily of frustration. Increasing irritations of heavy work, poor liaison with hospital departments, and sneering junior hospital staff unwilling to accept a general practitioner as knowledgeable, and the lack of simple tools of diagnostic aid and special treatment centres, lead only and relentlessly to the dissatisfaction so constantly voiced through these columns.

What we really need now is a new attitude to the further training and stimulation of all our general practitioners; a planned progressive continuation course for all ages and experiences complemented by the new facilities and opportunity the new Charter must bring. It is vital to further the abilities of young and old alike, and together to put away entirely the present tendency to treat the young entrant to general practice as inadequate. Indeed, it may well be that the very doctors who are looked upon as so in need of help and training have most to offer to general practice in keenness, fresh approaches, and vitality—essential ingredients to any expanding specialty. So let us move forward together, not in classes, towards the now comprehensive health care centres so many of us visualize.

To perform the tasks required of a general practitioner (comprising the early detection and referral of serious and curable disease, after-care of invalid patients, and psychiatric, symptomatic relief of trivial illness, and simple community health) one really needs an active doctor who can perform the basic skills of medicine and surgery with simplicity, sound basic knowledge, and a thinking mind. Are these qualifications not enough for entry into general practice today?—I am, etc.,

Wittering,
Peterborough.

C. J. LYDEN.

Private Certificates

SIR,—The provision of private medical certificates to friendly societies and to unions that run sick-pay schemes for their members has been provided for since the N.H.I. Act by the insurance office sending a Form BF30 to the society or union with the prior permission of the workman. In these cases the general practitioner is not involved because the form contains all the information that the doctor writes on the N.H.I. certificate.

All that is needed now is that this Form BF30 be sent to employers by the national insurance office, with prior permission of the employee. It is now up to the B.M.A., in conjunction with some employers' federation, such as the Federation of British Industries, to ask the Ministry of Pensions and National Insurance to agree to this.

While it may leave certain certificates to small employers or the self-employed to be given by the general practitioner, the number of certificates saved would be enormous. The

payment of wages on production of a private certificate is so often dependent on national insurance being drawn at the same time that the tie-up between the two certificates should be effected by the insurance office.

There is another way of doing it. In this area, our local medical committee informed the education authority that we would no longer be giving certificates for absence from school. I would suggest that if any local medical committee has not done likewise, it should do so.—I am, etc.,

Llandrindod Wells.

H. J. HOUGHTON.

More Secret Funds?

SIR,—A general practitioner's pension, it will be remembered, is calculated as a percentage of his earnings throughout his professional life. The belief that this basis of calculation is disadvantageous is probably well founded.

Accounts, and only accounts, would show simply and directly whether this is true.

For the first seven years of the N.H.S. there was a loss on the Service superannuation account of about £80m. No separate accounts were published for the general-practitioner section, but there are good grounds for believing that no loss during that period was made on the general practitioners' account.

The results of the second seven-yearly valuation—that is, for 1955–62—have only recently been published.¹ Again no separate accounts have been given for the general-practitioner section.

Please note that:

(1) the figures have certainly been calculated;

(2) the basis of calculation for general practitioners' pensions is quite different from the rest;

(3) for 12 years of these first 14 of the N.H.S. the whole cost ("employer's" contribution as well as "employee's"—the former through the Central Fund) was paid by practitioners.

Has the profession asked for a separate valuation balance sheet for general practitioners? If so, with what result? If not, why not?—I am, etc.,

Nottingham.

RUSSEL FREARS.

REFERENCE

¹ Report by the Government Actuary on the National Health Service Superannuation Scheme 1955–62, 1965. H.M.S.O.

*. We are informed that the B.M.A. has asked the Ministry of Health for a separate valuation balance sheet for general practitioners, and the Ministry's answer was that it would be "unreasonable to ask the Government Actuary to undertake such a considerable task."—Ed., B.M.J.

Salaried Service

SIR,—With respect to Dr. D. D. Cowen's letter on the above (26 March, p. 805) it is not necessary to look as far afield as Hungary to see a salaried G.P. service in operation. The District Medical Officers in the Republic of Ireland are paid by salary for medical services in respect of that part of the population

entitled to free general medical services. Maternity fees are paid on a fee-for-item basis as in Britain. Incidentally the present thought in the Irish Health Service is to provide some choice of doctor.

I understand the capitation system, I understand the Pool system, I understand how a fee for service might work (but cannot see how a family can have the option of calling in a different doctor—that is, G.P.—for each individual illness) but I do not profess to understand the concept of a salaried service being provided by one or a group of G.P.s other than on a purely territorial or district basis. Is this concept going to end choice of doctor on the part of the patient and the right which we have under the capitation system of asking the impossible or incompatible patient to choose another practice, and the right in the last resort of compulsory removal? There would appear to be many advantages in payment by salary with appropriate increments for years of service, and one has often heard one's colleagues say that "the Ministry of Health are in favour of a salaried service." I do not think I have seen anywhere in the *B.M.J.* or elsewhere any account of how a salaried service would be administered. I would be glad to have some opinions from your readers.—I am, etc.,

Southsea.

J. J. BRENNAN.

Family Care Service Ltd.

SIR,—The letters from your correspondents Dr. M. C. Flasher and Dr. B. R. Samuels (26 March, p. 804) illustrate the confused thinking which has sent several doctors rushing for their pens since the launching of the Family Care Service.

The difficulty in understanding the contributions system with its very small consultation charges arises from an incorrect comparison with a direct item-of-service method of private practice. Obviously no doctor is going to provide private treatment for 2s. 6d. per consultation! Under the F.C.S. scheme the doctor's remuneration comes from the regular contributions—the consultation charges are made as a deterrent against over-utilization.

Let us ignore the income from the consultation charges completely and take an example considering only the contributions of 13s. per adult and 7s. per child per month—average 10s. per person per month. On a list of 2,000 patients this produces a gross income of 10s. by 2,000 by 12=£12,000. This is the doctor's income, not the consultation charges. From this one-third is allowed for the provision of drugs—£4,000—leaving £8,000 for expenses and remuneration. The cost of drugs qualifies for full tax relief. Add to this the small amount for consultation charges and we have a very realistic remuneration for a general practitioner.

The scheme has great advantages over the much quoted item-of-service system. The patient has no unlimited liability for fees during illness, and the doctor is paid regularly through F.C.S. Ltd. regardless of whether his patients are ill or well. There is little or no risk of bad debts and the doctor has no bills or accounting to do.

The response from patients in the first few weeks has been most encouraging. This is an

unknown field and doctors report a surprising degree of interest from even working-class practices.

To your correspondents I would say "Think again, gentlemen, this time slowly and carefully."—I am, etc.,

GERALD C. BISS,
Chairman.

Family Care Service Ltd.,
London S.E.10.

Dain Fund

SIR,—The members of the Bristol Local Medical Committee were sorry to learn of the death of Sir Guy Dain. They heartily agree with the *B.M.J.* in referring to Sir

Guy as "one who made a unique contribution under the National Insurance Scheme and the National Health Service" (5 March, p. 616). They know full well how near to Sir Guy's heart was the Dain Fund, and as a mark of their lively appreciation of the tremendous services which he rendered to the Association and the profession they have sent a cheque for 95 guineas to the Dain Fund.

The committee hope that other L.M.C.s will find themselves able to make similar contributions to the Dain Fund as a mark of their appreciation for Sir Guy's notable service to the profession.—I am, etc.,

A. C. EDWARDS,
Hon. Secretary,
Bristol Local Medical Committee.

Points from Letters

Review Body

Dr. J. FINDLATER (Carnforth, Lancs.) writes: Something like one-fortieth of our careers has already passed awaiting the outcome of the negotiations with the Minister to save general practice from extinction. Without doubt, one has to marvel at the political brilliance of the Minister of Health, in taking the heat out of last year's confrontation and holding out like a latter-day Fabius Maximus. He has now reached the triennial review for all N.H.S. sections, and the temporary sanctuary of a general election. . . . Apparently the politicians can face with a fair degree of equanimity continued deterioration to the brink of collapse. It is after all apparently at our expense. But it is disquieting to have the pious editorial "In the National Interest" (5 March, p. 557) preparing us to accept little more than the "patent sincerity of the Minister" about general practice. Blessed are the apparently meek; they shall inherit golden opinions. After the first error, when he blandly asked why doctors were so querulous, his mellifluous voice and mild appearance have assuaged the desperate. But what about the actions to date? The campaign to educate the public has had no significant effect. His great contribution to the well-being of us all has been the removal of prescription charges, pooh-poohing while he carefully laid this straw on the camel's back the anguished protests from the ugly old beast. In forcing this matter he was either insincere, which is patently not so, or in rejecting advice he showed his judgement of practical matters completely out of kilter and should admit it, or be judged the vocational stamina of the camel to a T, and elected to be harsh and unfriendly to us.

It is surely important to realize that the Minister of Health is simply the politician administering a nationalized monopolistic scheme to provide services for the electorate, under the orders of the Cabinet. It is not to be expected that the Minister should have any particular feeling for the profession, let alone any section of it. If he has, it is an interesting observation.

Origins of Homosexuality

Dr. CLIFFORD ALLEN (Mold) writes: It is difficult to know why some psychiatrists cling to the idea that homosexuality has a genetic, endocrine, or other organic basis when one considers that it is sometimes curable by psychotherapy and at least 30 psychiatrists have claimed cures. Dr. J. A. Hadfield's carefully recorded cases show what can be done with proper treatment (12 March, p. 678). In my monograph¹ I described 14 apparent cures and four social cures. Hadfield states that he has not treated

a lesbian, but I have had a number. When they wish for a cure they are just as responsive as males.

I do not think that revulsion from the opposite sex through conditioning is the explanation of all cases, and often homosexuality results from the failure of a mental mechanism which may be called "bridging." A man is able to love women because as an infant he had an emotional attachment to his mother (and women *vice versa* to the father). This attachment forms an emotional bridge between the sexes.

REFERENCE

¹ Allen, C., *Homosexuality*, 1958. London.

Working Capacity of Women Doctors

Dr. M. ELFRIEDA HAPFOLD (Manchester 22) writes: The various statistics on "working capacity of women doctors" (12 February, p. 409, and 5 March, p. 610) have called forth some useful discussion. We have yet to see what happens to these younger women doctors. Will this particular generation learn anything while bringing up the larger families described? Will they have a contribution that is useful if different from that of their elders? Will the statistics show it?

Skin Discoloration and Phenindione

Dr. I. S. MENON (Royal Victoria Infirmary, Newcastle upon Tyne) writes: Feder and Auerbach¹ have reported six cases who developed a dark blue-tinged bilateral purple discoloration of the feet, especially the plantar surfaces and sides of the first two toes, after oral coumarin drug therapy. This was sometimes preceded or accompanied by a red-tinged violaceous nondescript discoloration of the thenar and hypothenar eminences of the hands. In one of their patients only hand changes were present. The authors call these lesions "purple toes," because toe lesions were most striking.

REFERENCE

¹ Feder, W., and Auerbach, R., *Ann. intern. Med.*, 1961, 55, 911.

Tonsillectomy

Dr. I. KENNEDY (Jubilee Hospital, Francis-town, Bechuanaland) writes: Apart from the possible psychological trauma in small children, what is the objection to the use of the time-honoured rectal drip to keep children hydrated? If this was set up after the anaesthetic was begun even this objection would fall away.