tion and the vast majority of general practitioners.

It is surely time, after the catastrophic medical exodus of 1965, for the administration to wake up and increase rather than decrease our hopes for the future.

I am not a devotee of any particular mode of remuneration, but it would appear on the face of it that areas of high morbidity would attract much-needed recruitment of medical manpower if doctors were paid for the services they actually performed—that is, item-of-service payment.

This single administrative step would do more than anything else to level up the quality of medical care. The Treasury has obstructed this common-sense and just proposal long enough.

Mr. Minister, please may there be an urgent sense of reality in a rapidly deteriorating situation in general practice.—I am, etc.,

London S.E.3.

HOWARD REEVE.

REFERENCE

¹ Taylor, Lord, *Good General Practice*, 1954. Oxford.

Review Body

SIR,—The Review Body report is at last imminent, and it is essential that we should not lose sight of the main issue when we consider its details: and it needs to be said again now that the main issue is quite simply a very great deal more money to be spent on general practice. That is to say, quite bluntly, a large increase in the income of the general practitioner, without which recruitment will continue to fall; and unless the numbers of family doctors increases our work load will go on getting heavier. It seems to be becoming fashionable to play down the importance of money in relation to our many present grievances, but in the last resort, whatever else needs doing, more money is an essential prerequisite, which would by itself rid us of the two stumbling-blocks barring the way to any improvement in the standard of general practice in this country—namely, lack of reasonable income and insufficient time to do the job as we know it should be done. These two factors are forcing enormous numbers of young doctors, against their will in many cases, to cut adrift from parents, friends, and their own native land in order to obtain an adequate standard of living and working in other countries. Many of these men and women would prefer to stay here but find that they simply cannot afford to do so, and they must be induced to stay by making the rewards and conditions of practice in this country somewhat more commensurate with those which they know they can find overseas. It is fatuous to say that we cannot afford to do this: we all know that unless such a state of affairs is reached soon the standard of medical care will be as inadequate all over the country as it already is in many areas now.

Furthermore, in view of the increasingly rapid deterioration in the position we must resolutely disown the undertaking made on our behalf by our negotiating team that we, a dwindling number of practitioners, hold ourselves responsible for an ever-increasing population of patients. For one thing, it

would be quite dishonest to pretend that we are able to do so; secondly, it would enable the Government to go on shelving its responsibility for the situation which successive Governments have themselves created by their short-sighted determination to get more and more for the expenditure of less and less; and thirdly, because this undertaking runs directly counter to the statement in the "Charter." We cannot any longer accept a situation where the Government rocks the boat and we are blamed because the passengers get wet and the crew jumps overboard.

Finally, we must be at pains to discount all the crocodile tears and protestations of sympathy from the Minister—he claimed on television recently that he has "coped with a crisis in general practice," but we must in this context remember that his criteria differ from ours, and that his success lies in the fact that the general-practitioner service costs less now than it did when he assumed office, by virtue of the smaller number of doctors in practice, while "production" has gone up not only because of a greater population, but also because by removing the prescription charge he has persuaded patients to consult their doctors more frequently even than before. His recent statement belittling the extra work this has caused, "only one extra prescription per head of population," shows quite clearly that friendly words from the Minister are as good as a kick in the teeth from anybody else. *Pertinax* (2 April, p. 857) asserts that Mr. Robinson "has in a remarkable way gained the confidence of the medical profession." It would indeed be remarkable if he had.—I am, etc.,

Scarborough.

C. H. NEAVES.

SIR,—I believe we are on the eve of accepting a reformed N.H.S. several degrees more bureaucratic and absurd than the one in which we are now struggling.

Having advised by a large majority that the pricing go ahead, there is little we can do but accept the Review Body's award, while quietly hoping that the Government will let us off the hook by referring it to the Prices and Incomes Board.

The realization of truth that swept over the profession at Swansea came too late to be other than an embarrassment to our negotiations and an opportunity to the Ministry to expose our weaknesses. Soon after we were voting, virtually without discussion, that the pricing go ahead.

Personally I believe that the Medical Guild project was mistaken from the beginning.

To stand up to the Ministry of Health effectively we need highly cohesive local organizations, nay fellowships, prepared to act on their own if necessary.

To win over the public we need to eschew private schemes, insisting on a reformed N.H.S.

To reform the N.H.S. we need a single objective: the right, if we choose, to charge the patient in certain instances—that is, where the initiative for the visit or consultation rests with the patient. Visits and consultations made on our own initiative as follow-up should be paid for by capitation fee as at present.

To get this we shall have to use considerable moral force. We shall have carefully to

shun those politicians who wish us to collect revenues. We shall have to fight only if we have the necessary backing in our local associations based on geographical neighbourhood. We shall have to be absolutely loyal to each other until our objective is obtained. We have, I believe, failed this time, but sooner or later we shall try again.—I am, etc.,

Bishop Auckland,
Co. Durham.

M. J. CLAY.

SIR,—The delay in announcing the Review Body's decision on pricing the contract, caused by the General Election, has been a great boon to general practitioners. It has jolted them back to the reality of the fact that medicine is inextricably bound to politics in the N.H.S., and at the same time has given them a breathing space to view the real issues that will be at stake in the coming weeks.

Some of us had become mesmerized by George Brown's prices and incomes policy and had almost begun to believe that we were personally responsible for the present economic situation. We were prepared to accept whatever price the Review Body decided to place on our services without a murmur. We had lost sight of the fact that our present clash with the Government (and clash it is in spite of Mr. Robinson's recent reassurance on television that he had "coped" with the problem) is not just another petty pay claim but a last-ditch stand to put right the injustices of the past 18 years and to decide once and for all whether general practice has any future within the N.H.S. This is what the Charter was about and this is what the new contract should be about.

The British Medical Guild does not hold 18,000 resignations merely to extract an extra 5 or 10% from the Government. The issues are much greater than this, and we must face them with honesty and courage, because this is our very last chance.—I am, etc.,

Sanderstead,
Surrey.

M. M. A. SHIPSEY.

Postgraduate Training Posts for Overseas Doctors

SIR,—May I comment on the views expressed by Dr. W. M. C. Allen (26 February, p. 545) and Dr. P. K. Chakrabartty (19 March, p. 740)?

To say the least it is extraordinary that the head of a department of radiology in India should have sought an appointment as registrar in England. Whatever the purpose it could not be postgraduate study. Dr. Allen, however, is not correct in generalizing from this instance, and suggesting that the majority of Indian doctors in Britain are, similarly, not genuine postgraduate students. Perhaps a visit to the examination halls may convince him otherwise.

What is deplorable is the hankering after British qualifications, which has resulted in the influx into Britain of a large number of Indian doctors who, in order to support themselves, take up the unwanted jobs in British hospitals and so provide a variety of blackleg medical labour. I do not think that this is a situation consistent with self-respect.

There are now enough facilities in India for postgraduate study in nearly every branch of medicine; moreover, Indian postgraduate qualifications are essential for higher appointments in our teaching hospitals. In the circumstance, the only legitimate study overseas would be for acquiring special skills and not degrees or diplomas. This would entail the availability of clinical appointments in specialist teaching hospitals, which is not the case in Britain from all available accounts, including Dr. Chakrabarty's.

The restrictions on obtaining foreign exchange for overseas study are designed to make the best use of this scarce resource by ensuring that only those fitted for such study are able to proceed. A beneficial "side-effect" is that since the end of last year the medical influx into Britain has come to an end.—I am, etc.,

Bombay,
India.

J. S. MIRANI.

Out-of-hours Calls

SIR,—In view of the interest in the B.M.A. Emergency Treatment Service at the present time, it may be worth publishing these figures of out-of-hours calls.

From August 1965 to January 1966 we recorded calls done from 6 p.m. on week-nights to 7 a.m. the following morning, and from 12 noon on Saturday to 7 a.m. on Monday, these being the hours when the Emergency Treatment Service functions. Six industrial practices are involved: 13 doctors caring for 35,500 patients. Midwifery calls are excluded, as they are done by the patient's own family doctor. Visits to the general-practitioner casualty department are counted.

The number of night calls was remarkably constant in spite of a 'flu epidemic in December.

August 4.6, September 3.9, October 4.5, November 3.7, December 4.5, January 4.15 calls per night for 13 doctors, averaging 4.3 calls for 13 doctors or one call for three doctors per night. Calls per 13 doctors for each of three week-end sessions (Saturday 12 noon–6 p.m., Sunday 7 a.m.–12 noon, and Sunday 12 noon–6 p.m.) are shown in Table I.

TABLE I.—Calls for Thirteen Doctors for Each of Three Week-end Sessions

Month	No. of calls/ week-end session
August ..	4.1
September ..	5.9
October ..	3.9
November ..	4.9
December ..	8.9
January ..	6.6

Table I shows that in contrast to night calls, week-end daytime calls vary considerably according to season, and the peak in December corresponds with the 'flu epidemic mentioned. This indicates the difference between "emergency" night calls and calls at week-ends, which include both emergencies and less urgent calls, especially upper respiratory infections.

Table II shows the times at which calls were received. The increase in calls between 9 p.m. and 10 p.m. appears to represent a

desire to call the doctor and resolve the problem before retiring for the night.

TABLE II.—Times at Which Calls are Received

Time	No. of Calls	Time	No. of Calls
7 p.m. ..	13.8	2 a.m. ..	6.0
8 " ..	22.8	3 " ..	2.6
9 " ..	15.0	4 " ..	1.0
10 " ..	20.0	5 " ..	1.8
11 " ..	15.2	6 " ..	2.6
12 midnight	13.2	7 " ..	1.2
1 a.m. ..	10.0		

The average call rate was 5.75 calls/1,000 patients/month.

A practitioner with 2,500 patients would expect about 14½ calls out of hours each month. These figures correspond with those in "Present State and Future Trends in General Practice" presented by College of General Practitioners.

These figures may be useful to doctors estimating their E.T.S. requirements.—I am, etc.,

112 Park Road,
Wallsend.

J. O. FITZGERALD.

Facilities for Patients or Doctors?

SIR,—I was astonished to read (*Supplement*, 26 March, p. 82) that the Private Practice Committee, in considering the withdrawal of health visitors' services from emancipated Birmingham general practitioners, had decided that "no useful purpose could be achieved by pursuing the matter further." I can only conclude that the Private Practice Committee serves no useful purpose either.

I agree that the discontinued service is unlikely to be restored in this particular case, but meek surrender in the face of open reprisals is to invite further disaster. May I remind the Committee that the health-visitor service is intended for the benefit of patients, not doctors as their report suggests. Patients pay for these services and are entitled to them whether they chose a N.H.S. general practitioner or a private one.

A militant attitude at this stage may prevent repetition, and the thicker the portion of the wedge, which includes pathology, x-rays, referral of private patients to N.H.S. specialists, and even National Insurance certificates of incapacity to work.

This type of unhelpful action by B.M.A. committees appears to be increasingly common, and is one of the reasons why I am rapidly coming to look upon my B.M.A. membership fee as little more than a convenient method of regularly receiving the B.M.J.—I am, etc.,

London S.W. 1.

JOHN IND.

Ophthalmic Clinics in Industry

SIR,—In your issue of 19 March (*Supplement*, p. 73) under the above heading Dr. R. L. Luffingham was quoted as saying: "It was unethical for an optician to give in the *Optical Register* an industrial firm as his registrable address unless he was a direct employee of that firm." If the *Opticians Register* of the General Optical Council was meant, Dr. Luffingham has been misinformed.

Neither the Opticians Act nor the General Optical Council's notice N.7 contains any ban on giving an industrial address. Indeed, the current *Register* lists several industrial clinics which opticians attend, and certainly not as employees; this would obviously not be so if it was "unethical."—I am, etc.,

Guild of British Dispensing
Opticians,
London W.1.

M. G. AIRD,
Secretary.

Sir Charles Hastings's Vocation

SIR,—I am grateful for the copy of your journal of 12 March with its supplement of excellent photographs of places connected with Sir Charles Hastings. While the centenary of his death is a matter of present concern to your readers, you might be interested in an anecdote of his boyhood, which has been transmitted through the family and which, as far as I am aware, has not appeared in print.

The Rev. James Hastings, his father, took possession of the then lucrative living of Martley, Worcestershire, in 1796. It had been purchased for him in 1791 through the good offices of his wife's family, the Pagets of Chipping Norton in Oxfordshire, a wealthy banking family, who had also bought the advowson of Bitterley in Shropshire, which cure the Rev. James Hastings was serving in 1794 when his son Charles was born in the near-by town of Ludlow.

The early years of James's incumbency at Martley were uneventful, but in 1806 he sustained a head injury while hunting, which incapacitated him for the next 50 years until he died in Worcester in 1856 at the age of 101. During this period he was designated in the ruthless language of the legal documents "a lunatic," and the parish of Martley enjoyed no incumbent for the whole of that period, being served by curates-in-charge.

After the accident in 1806, so the family tradition relates, the rector sat at the foot of the great oak staircase in the Elizabethan hall of the rectory and refused, in spite of family persuasions, to go to bed. Only one member seemed to have any influence with his father and succeeded in leading him upstairs. This was Charles, now 12 years of age. Was there inherent in this boy some specially sympathetic facility in dealing with the sick and did he discover his aptitude at this tragic point in the family fortunes? At any rate, soon afterwards, he began to learn the trade of a doctor with an apprenticeship at Stourport-on-Severn and entered upon that remarkable career which is sufficiently well known to your readers. I have often wondered whether that fortunate consummation for British medicine had its origin in the tragedy which befell the Hastings family, which hitherto had known only the calm rustic pleasure of an opulent squarson's children. We may be sure that the memory of the tragic father seated on the lowest step of the old staircase could never have been erased from the mind of the eminent doctor. The engraving of the well-known portrait painted in 1839 by Benjamin R. Faulkner still hangs on the staircase wall at Martley Rectory above the place where he persuaded his deranged father to go to bed.—I am, etc.,

Martley Rectory, J. S. LEATHERBARROW,
Worcester.