Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Present State of Medicine

SIR,—The fracas at Oxford over remuneration may yet produce some good if it causes the B.M.A. to re-examine its own constitution, function, and relations with outside medical bodies. It is naive to preach about the unity of the profession and the B.M.A.'s position as the only organization which can "speak for the whole profession" when the general public and one large and important part of the profession regard the Association as the G.P.'s trade union. Of course it is the G.P.'s trade union, but for this reason and because of the B.M.A.'s constitutional structure the ancient Royal Medical Colleges do not accept it as proper to be their instrument for negotiation with the Government or the Review Body on major pay matters, as you point out in your leader of August 24 (p. 453).

In 1948 the B.M.A. claimed with justification that it was the only organization with the necessary know-how in the field of pay negotiation to cover all the various branches of medical practice. Pointing to the fact that its membership was open to, and its policies therefore determinable by, all sections of the profession, and that doctors in all fields of practice were members, it claimed that it was the most suitable body to be entrusted with this work. Largely because of the stigma of the G.P.'s trade union this claim was rejected by senior hospital doctors embattled in their tradition-bolstered Colleges. The various compromises have on the whole worked fairly well, but their seams have creaked and have several times shown signs of coming apart. A sharp tug, like that of Dr. I. M. Jones at Oxford, might at any time tear the patchwork in pieces. This is the way of compromises which, mixing the metaphors a little, only paper over the cracks and are always vulnerable to sudden disruptive forces when restoration of an apparently sound structure can be achieved only by further compromise which leaves the same vulnerability. In 1948, or thereabouts, negotiations between the B.M.A. and the Royal Colleges produced the compromise of the Joint Consultants' Committee, which in top-level major negotiations on remuneration operates along with the B.M.A. as the G.P.'s trade union, thus maintaining an illusion of unity in the profession. The strains imposed by and upon this compromise are considerable, as are those in the public health field. If they are to be abolished the present state of medicine should be looked at closely with a view to drastic reform.

There is widespread ignorance and criticism of the degree of control exercised by the G.P.-trade-union side of the B.M.A., acting through the Representa-

tive Body and the Council, over the so-called autonomous Central Consultants and Specialists Committee and of the degree of subservience of that Committee to the Joint Consultants' Committee. The recent completion of representation of the Royal Colleges on the C.C. and S. Committee is a notable step forward, but I believe that the time is ripe for a conference of the B.M.A., the Royal Colleges, and the Society of Medical Officers of Health to explore the possibility of evolving a new joint (pay) negotiating committee representing all these parties, with power to discuss and prepare evidence for the Review Body or the central or local government authorities on major matters of remuneration and remuneration structure on behalf of all the relevant branches of the profession, and with powers to commit the constituent organizations.

The Council of the B.M.A., advised by the G.M.S., C.C. and S., and Public Health Committees, has for long appeared to many to be the appropriate body to fulfil this function. But so long as the B.M.A. Council is the executive of the R.B. (as it must remain), and so long as the G.M.S. Committee is in the anomalous position of being the executive of and responsible to the Conference of Local Medical Committees as well as to the Council and the R.B., and so long as the Council does not include representatives of the Colleges (with powers)—so long is the Council likely to be rejected by the other bodies as the sole negotiating committee.

Not only should the B.M.A. re-examine its own constitution with a view to improving its acceptability, but the other bodies should be invited to place their views frankly before a joint conference on streamlining and making more efficient the profession's machinery for major pay negotiations in an attempt to prevent recurrent crises of confidence.—I am, etc.,

J. G. M. HAMILTON.

Edinburgh.

SIR,—I was surprised and grieved to find that Dr. D. Craddock could summarize his article on general practice (September 14, p. 673) with the suggestion that an increase in the general level of payment for general practitioners is the prime factor in producing a contented body of family doctors.

I would have thought that any student of human nature would have realized that addition of luxury to affluence does not add to contentment, and one's salary is never "high enough." Also, the grass is always greener in the next field, and is made more so when one does not risk grazing there and finding that it is not greener.

The first essential towards better general practice is to have doctors with time to examine and treat their patients fully, and time to continue their medical education. This means a massive increase in the number of general practitioners. Might I suggest that we should be exerting all our energies towards increasing the intake of medical students? It will take a lot of pressure on the Government before this will take place.

I would agree entirely with the suggestions about financial help for equipment and ancillary help, but these are secondary matters. We are fortunate in having a system of payment that will not cause a loss of income as we increase in numbers; a thought to remember when the oversanguine suggest payment by item of service as a cure for all ills.—I am, etc.,

Stockport, Cheshire.

W. R. GRAY.

Migration of British Doctors to Australia

SIR,—Dr. John M. Last's figures (September 21, p. 744) confirm my view that emigration of doctors from the British Isles to Australia has recently been unusually high in relation to the output of our medical schools and in relation to pre-war medical emigration. His data in association with those which I was able to obtain (March 17, 1962, p. 782) give a more satisfactory indication of the extent of permanent emigration of British doctors to Australia since 1930 than did my data alone. My figures for Australia represented the number of graduates of medical schools of the British Isles who registered in five of the states of Australia each year between 1930 and 1961 and, as I pointed out in my paper, as an indication of emigration of doctors these figures were inflated to an unknown extent by double counting and by the subsequent return of some to Britain. Furthermore, I was unable to obtain information from Queensland and the Australian Territories.

Dr. Last has been able to remove these sources of error by showing the number of graduates of medical schools of the British Isles who were both registered and resident in Australia at the end of 1962, and by indicating the year of their first registration there. He noted a "very large discrepancy" between his totals of the number resident in Australia to-day and my totals of the number of registrations.

Fig. 1 shows his and my annual totals and Fig. 2 shows the former expressed as a percentage of the latter. Whereas the percentage averaged 27 in the ten years 1930-9, it averaged 51 in 1946-56, and 73 in the most recent five years 1957-61. One would expect the percentage to be lower in the earlier years because with the passage of time the proportion of those who registered in Australia who subsequently died, retired, or left Australia would tend to rise.

From Dr. Last's study in combination with my own a more accurate picture of

the volume and trend in long-term medical emigration from the British Isles to Australia since 1930 can now be deduced. Fifty-one per cent. of the figures I gave for doctors registering in five Australian states in 1946-56 represented doctors with British degrees who first registered in Australia in those years and were still there in 1962. The duration of stay of these doctors has been between six and 16 years and they might reasonably be considered long-term emigrants and a "permanent" addition to the medical manpower of Australia.

Dr. Last's figures relating to the decade before the second world war are 27% of mine. Doctors in Australia who registered there in 1930-9 have now been there for 24-33 years, and death and retirement must have affected some of those who arrived in the 1930's.

I would suggest that a reasonable estimate of the number of British doctors emigrating permanently to Australia each year would be obtained by reducing my figures by 50%. A rather smaller reduction (40%) was suggested by Mr. Enoch

Powell after a detailed analysis of my registration figures for Australia in 1957 in a paper in which he concluded that large-scale medical emigration from Britain was an "exploded myth" (June 16, 1962, *Supplement*, p. 267).

A 50% reduction would indicate an annual average rate of permanent emigration from the British Isles to Australia of 14 doctors per year in the 1930's, 43 in 1947-51, 55 in 1952-6, and 113 per year in 1957-61. The rate of medical emigration to Australia since 1957 has, therefore, been at eight times the rate prevailing in the 1930's, and, whereas it was equivalent to only 0.8% of the output of the medical schools of the British Isles in the 1930's, it rose to 1.9% in 1947-51, and to 5.7% since 1957. Dr. Last has demonstrated that there are today in Australia 1,400 graduates of British medical schools who have arrived since 1950 (over 1,000 of them since 1956), and it is unlikely that many more than 300 of them will return to Britain.

Dr. Last would probably agree that, despite the "very large discrepancy" be-

tween his figures and mine, an emigration of 113 doctors per year from Britain to Australia (equivalent to the combined production of the medical schools of St. George's Hospital and the London Hospital) will represent a useful contribution to the medical manpower of Australia if it continues. Conversely, it already represents a significant loss of our medical manpower which has not been counterbalanced by a comparable permanent migration of Australian doctors to Britain. The reasons for the recent heavy one-way traffic may be disputed but it is surely unrealistic to suggest that it does not exist.—I am, etc.,

Richmond, Surrey.

JOHN R. SEALE.

The Gillie Report

SIR,—The report of Dr. Annis Gillie's advisory committee (October 5, p. 861) contains a few forecasts and recommendations as unpredictable as may have been imagined. Once again, both within its context and in comparison with the Porritt Report and Hospital Plan, it highlights the contrast and at times contradictions of current medical opinion.

In the first instance this document advises that "the total and continuing responsibility for his patients contributes to the essential concept of the family doctor," and implies that such will be best attained by "group practice," with improvement in their premises, and with the acquisition of ancillary help by means of nurses, midwives, and health visitors; it thinks it improbable that health centres will develop as was once envisaged. If the aim of this scheme is the preservation of personal relationship, I would like to know why and how, with the clinical responsibility to the patient admittedly split between various partners, is this likely to be more so than if the same "groups" did work in properly equipped health centres which did incorporate ancillary help, appointments, and emergency systems? Some will argue that the "group practice" represents no more than the chrysalis stage in the metamorphosis towards such a system and that the merits of this plan will be more than offset by its impracticability, inefficiency, not to mention the greater expense incurred in touching up a multitude of group premises. As an alternative the possible conversion of some redundant hospitals, a relatively simple task, would be less of a financial burden. Its one outstanding virtue is, of course, that it is likely to offend fewer people, but will it in the long run satisfy the demands of modern medicine? Again if "research has proved a particular pattern of practice to be theoretically most efficient," then surely such a plan deserves at least a practical trial?

There is no field in which the fluctuations in the wind of change shows greater variation than in that on the future relations between the G.P. and the Hospital Service. When the Hospital Plan emerged in 1962 it did not provide for G.P. beds, merely claiming "that it did

FIG. 1.—Graduates of medical schools of the British Isles registering in five Australian States, 1930-61 (A) and graduates resident in Australia in 1962 by year of first registration 1930-62 (B).

FIG. 2.—B expressed as a percentage of A (see Fig. 1). Two-yearly averages.