notice. This would accommodate changes in personal or professional circumstances. Family health services authorities could match skills to jobs. Job sharing and mobility would be facilitated. The whole exercise may be construed as a global job share. "Ghettoisation" for either sex would become voluntary rather than imposed by consumers.

Family health services authorities' skill banks would offer a wider distribution of services and facilitate planning. Benefits would accrue to consumers and practitioners through a wider choice of service and variety of experience, respectively. Referral to secondary care would probably fall.

Modular contracting would allow specialisation within the primary health care team. Specialisation by general practitioners could be extended into "primary consultant" posts: obstetrics, minor surgery, dermatology, psychiatry, rheumatology, diabetes, audit, and geriatrics are obvious candidates. Hospital, Department of Social Security, and industrial appointments could also attract recognition.

Modular contracts would offer improved provision of services, easy planning, flexibility, rewards for effort and skill, accreditation, some independence, career planning, and equality of opportunity.

STEVEN FORD

Haydon Bridge,
Northumberland NE47 1HJ

Goya's living skeleton

SIR,—I am grateful to Richard and Maureen Park for providing contemporary descriptions of the feet and hands of Claude Seurat, the "living skeleton."^{1,2} They do not exclude a diagnosis of fibrodysplasia ossificans progressiva as valgus deformities of the great toes and clinodactyly are common features of the condition.³ Ossification within the paraspinal and cervical muscles, so well seen in the drawings of Seurat, is invariable but does not always cause scoliosis or torticollis. About 70% of patients have involvement of the jaw muscles, which would explain why Seurat could eat only small fragments of food.

As his bones cannot be examined the diagnosis of Seurat's illness must be speculative, but fibrodysplasia ossificans progressiva remains a strong possibility.

GEOFFREY HOOPER

Princess Margaret Rose Orthopaedic Hospital,
Edinburgh EH10 7ED

1 Park R, Park M. Goya's living skeleton. *BMJ* 1992;304:844. (28 March.)

2 Park RHR, Park MP. Goya's living skeleton. *BMJ* 1991;303:1594-6. (21-28 December.)

3 Connor JM, Evans DAP. Fibrodysplasia ossificans progressiva. *J Bone Joint Surg [Br]* 1982;64:76-83.

BUPA and consultants over 70

SIR,—British United Provident Association (BUPA) has announced that by the end of this year it proposes to make no further payments to insured patients in respect of consultants' fees if the consultant is aged 70 or over. I believe this to be a mean cost cutting exercise dressed up in a mantle of spurious righteousness. I speak as a doctor who has subscribed to BUPA since the day it was born.

At the moment none of the other private medical contributory schemes are wielding the axe to consultants aged over 70. I suggest that medical practitioners who are under 70 and are currently insured with BUPA should start shopping around and switch their personal insurance to whichever company offers the best deal.

I have two specific complaints, one general and

one personal in so far as it concerns my practice. I have patients who have been under my care for 30 years. I think it a bit much to have to say to them that, because of my age, if they belong to BUPA, from the end of this year they will not be refunded what they pay me. They don't wish to go to a younger man; if they did they would have gone long ago.

In the United Kingdom I am the only person who corrects severe myopia by inserting an implant into the anterior chamber of the eye without disturbing the crystalline lens, which has a high minus optic. I have done 40 such operations over the past two and a half years; I think I have a duty to keep doing them to benefit patients and so that I can accumulate experience to lay before my colleagues to help them take an informed decision on whether they should start doing this operation themselves. Consultants' potential contributions to the welfare of their patients and their specialty should be considered individually.

D P CHOYCE

London W1M 7DG

*We sent Mr Choyce's letter to BUPA, whose reply is given below.

SIR,—In declining to pay benefits to members for fees from specialists over the age of 70 BUPA is bringing itself into line with private hospitals and the NHS. Most private hospitals withdraw admitting privileges at the age of 70. Consultants over 70 are permitted to undertake locum posts in the NHS only with the specific permission of the Department of Health. Since the NHS requires specialists to retire at 65 it could be argued that BUPA should have followed suit. The motive for introducing this change has nothing to do with cost containment but is to promote the highest possible quality and most up to date medical advice to BUPA's members.

It would be invidious for BUPA to make individual assessments of the practice of consultants over 70. It would take only one untoward incident in which the advice given to a member could not be supported by current medical opinion for the whole system of specialist medical advice to be called into question.

Much of the clinical work that individual consultants over 70 have described in correspondence with BUPA seems to be long term follow up and surveillance of patients whose conditions have long since ceased to be "acute episodes of illness or injury." Treatment falling outside this definition is ineligible for reimbursement under the terms of the contract between BUPA and its subscribers.

I am unable to comment on the specific procedure that D P Choyce describes other than to note that it seems to be experimental; as such, neither Choyce's services nor the hospital costs are eligible for reimbursement under BUPA's rules.

HUGH THELWALL-JONES

Group medical director, BUPA,
London WC2R 3AX

Predictors of general practitioners' workload

SIR,—We agree with R Balarajan and colleagues that a scheme for compensating general practitioners for the effects of social deprivation should be based on an objective measure of workload such as consultation rates.¹ The use of the general household survey for this purpose, however, has serious limitations. The data on workload are based only on consultations over two weeks, so that even with a large sample there are wide confidence intervals around the odds ratios for the associations of socioeconomic variables with consultation. No distinction is made between consultations for illness and consultations for preventive pro-

cedures, which are likely to be used by the least deprived groups and for which general practitioners are usually remunerated separately. All consultations are counted equally, the workload generated by a telephone consultation being equated with that generated by a home visit, which people in households without access to a car are especially likely to require. For these reasons the analysis is likely to underestimate the effects of deprivation on workload.

We have also examined the effects of deprivation on workload by using consultations from the third national morbidity survey.² This dataset, linking general practice consultations with the census records of 140 050 subjects aged over 1 year, overcomes the limitations above. Our results, like those of Balarajan and colleagues, emphasise the importance of housing tenure and car ownership as predictors of workload. These two studies provide a basis for a more rational system for compensating general practitioners for the effects of deprivation than the Jarman underprivileged area index.

YOAV BEN-SHLOMO
IAN WHITE

Department of Epidemiology and Public Health,
University College and Middlesex School of Medicine,
London WC1E 6EA

PAUL MCKEIGUE

Department of Epidemiology and Population Sciences,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

1 Balarajan R, Yuen P, Machin D. Deprivation and general practitioner workload. *BMJ* 1992;304:529-34. (29 February.)

2 Ben-Shlomo Y, White I, McKeigue PM. Prediction of general practice workload from census-based social deprivation scores. *J Epidemiol Community Health* (in press).

Doctors and control of major releases of chemicals

SIR,—Though they are rare, major disasters leading to the release of poisonous gases have occurred. That health authorities should plan for disasters has been stated several times in the recent past.^{1,3} Chemical disasters, however, pose additional problems to those posed by other disasters in that poisonous gases can drift, causing morbidity and death over several kilometres.⁴ Prompt control of a release of toxic gas and the protection of the surrounding population demand the coordinated work of several authorities and emergency services. Recently we have participated, as medical officers, in a planning exercise to control a hypothetical major release of chemicals.

The incident medical officer has a dual role in such exercises. He or she will communicate with the local health authority and also be the source of medical advice to the incident control team. He or she will be the person best able to assess the possible health care needs of victims involved in the incident and then communicate this to the relevant health authority, hospitals, and general practitioners.

In addition, the medical officer will be the only site based source of medical skill for the incident control team. Whether or not to evacuate populations depends ultimately on the health gain or loss resulting from evacuation compared with no evacuation. This decision tends to be taken by the senior police officer or senior executive of the district local authority, neither of whom is likely to have the training or skill to make such judgments on his or her own. Deciding when to evacuate a population is not easy and requires a strong medical input.

That public health doctors should have a central role in planning for, and managing, disasters has been emphasised.^{4,5} Assessment of the health risks to the general population in releases of chemicals requires the skills of public health doctors. We suggest that in the United Kingdom the most appropriate public health doctor is the consultant