Patients and Tablets

SIR,—Dr. A. R. K. Mitchell (11 June, p. 1482) questions the factual basis for my tentative conclusion (21 May, p. 1301) that general practice may be the most appropriate setting for conducting clinical trials.

Two types of defaulting in respect of adherence to treatment schedules must be distinguished, and perhaps should have been distinguished in my original letter. The first group are the "overt defaulters," and the second the "occult defaulters." The former fail to complete the trial for reasons which are obvious to the doctor—for example, volunteering that they have stopped the tablets, leaving the district, failing to reattend, etc. Being readily identifiable, their presence can be allowed for in the final assessment. It is the "occult defaulters" who may, and probably usually do, invalidate a trial. This group, having persevered, may appear to the unwary to have been entirely consonant to the treatment schedule, but in fact they have been dissonant.

If my figures are examined, bearing in mind this distinction, then it can be seen that out of 29 "completers" 22 (76%) were available for assessment, and that only three of these patients were suspected as being definite defaulters. Can these figures be matched by any hospital outpatient trial?—I am, etc.,

Camberley,
Surrey.

A. M. W. PORTER.

Parameters

SIR,—Your leading article (30 April, p. 1063) and the subsequent correspondence have shown considerable variation of meaning ascribed to the word "parameter." Definition is clearly needed. Yet in whatever way this semantic tangle is unravelled we shall still need a word with a meaning close to one of the present usages of "parameter," taken, as Dr. N. J. Legg said (14 May, p. 1235), as "measurement alongside," or perhaps "measurement in parallel."

The pulse rate and the blood-pressure measure directly nothing beyond themselves. Nevertheless, taken in conjunction with other observations, precise or imprecise, and a few informed guesses, they do provide indirect evidence about vital indices such as cardiac output, heart work load, arteriolar tension, and tissue-perfusion rates. The pulse rate and the blood-pressure are parameters of the circulatory state of a patient, easily measured but related only indirectly to what we need to know. There is a world of difference between the statement that performance in an intelligence test is a parameter of intelligence and the statement that performance in an intelligence test is a measurement or even an index of intelligence.—I am, etc.,

R. G. MILLER.

Bedford General Hospital,
Bedford.

SIR,—Certainly the use of the word "parameter" needs to be tidied up—but it will not be helped by the attempted definition by Mr. L. N. Reece (4 June, p. 1421), which could hardly be more exotic.

A parameter is not variable. It is a fixed boundary which limits and defines a variable and against which this and only this variable can be measured.—I am, etc.,

Littleover,
Derby.

H. R. W. LUNT.

Institute of Neurology

SIR,—Your article on the Institute of Neurology (4 June, p. 1413) prompts me to refer to a proposal made by the late Dr. Roy Mackenzie Stewart. In a letter to me of 5 April 1964 he suggested that, "I would pull down the National and erect in its place a 20-storey building which could take all the hospitals round about, not limited to Maida Vale, but including Moorfields, the Skin Hospital, etc. The sites they occupy are so valuable that if they were sold there would probably be enough money to pay for the structure I have in mind. Something, I imagine, like the Mayo Foundation in U.S.A." A 20-storey building may be ambitious, but the principle of one tall building in Queen Square housing the various types of specialist hospital, including of course the Hospital for Sick Children, would lead to less isolation of the specialties.—I am, etc.,

G. DE M. RUDOLF.

Clevedon,
Somerset.

Cheadle Royal's Bicentenary

SIR,—Your special correspondent's interesting historical sketch of Cheadle Royal Hospital opens with a statement made by the then trustees of Manchester Infirmary that at the time of Cheadle Royal's foundation in 1766 there were only three public foundations for "poor lunatics" in the kingdom—"to wit, the Hospital of Bedlam and that of St. Luke, both in our great Metropolis, together with one at Newcastle upon Tyne."

Though perhaps not strictly a public foundation, it is curious that St. Patrick's Hospital in Dublin was overlooked. St. Patrick's was founded under the provisions of the will of Jonathan Swift. As far back as 1731, when the celebrated Dean wrote his brilliantly cynical "Verses on the Death of Dr. Swift," the foundation had been planned. One of the final quatrains reads:

"He gave what little wealth he had
To build a house for fools and mad:
And showed by one satiric touch
No nation wanted it so much."

Incidentally, when it became known that the Dean intended to settle his whole fortune to erect and endow a hospital for "the support of idiots and lunatics" the *Gentlemen's Monthly Intelligencer* commented:

"The Dean must die! Our idiots to maintain!
Perish ye idiots! And long live the Dean!"

He died in 1745. Work on the original building was started in 1748 and the first patients were admitted in 1757. They paid no fees, but a charge of sixpence per week was made for washing and a lodgement of 20s. had to be made to defray possible burial expenses.

St. Patrick's celebrated its bicentenary in 1948.—I am, etc.,

FRANCIS PILKINGTON.

Moorhaven Hospital,
Ivybridge, S. Devon.

Salaries and Cardiographers

SIR,—Dr. D. C. Deuchar in his letter of 21 May (p. 1302) writes, "Cardiological technicians, of course, require considerably greater training and skill," and here he means, than technicians engaged in electroencephalography. Any physician with experience of both techniques knows that this is not so. Further, P.T.B. 174 recognizes that it is not so when it lays down that a student cardiographer is eligible for promotion to cardiographer after six months' training (i.e., capable of working without supervision) and can qualify for appointment as a cardiological technician after another year's experience. A student E.E.G. technician cannot be considered for promotion to E.E.G. technician until after two years' service in the student grade, during twelve months of which an organized course of training and study has been completed.

The complexity of the basic E.E.G. recorder is considerably greater than the basic E.C.G. recorder. It is 1,000 times more sensitive, may have as many as 16 times the number of channels, a much greater number of controls, and costs approximately 17 times that of the E.C.G. machine. Also, the E.E.G. technician must learn to understand something of the clinical problems presented by the patient in order to take the best record.

E.E.G. technicians do not wish to enter into any conflict with their colleagues in electrocardiography. It might be more fair, however, to all concerned to place students of all the medical auxiliary services on a common salary scale until they merit upgrading according to their age and qualifications, irrespective of the service to which they belong.—I am, etc.,

S. NEVIN,

President of the Electrophysiological
Technologists Association.

Maida Vale Hospital,
London W.9.

Award to Junior Staff

SIR,—A just criticism of central negotiating committees is that the average doctor without contact with these committees never knows what is happening until it has occurred. I should like, therefore, through your columns to let junior medical staff know what is going on over the implementation of the recent Review Body award.

On Tuesday, 14 June, the Joint Consultants Committee formally accepted the award. This was done with comment (*Supplement*, 18 June, p. 281). There now follows the phase of negotiations between the representatives of the Ministry of Health and those of the J.C.C. on the details of implementation, these discussions being necessary because the Review Body lays down only guiding principles on certain matters and leaves the details for the profession and the Ministry to negotiate.

The major issues of direct importance to junior staff concern: assimilation on the new

salary scales, and coupled with this is the extent to which a doctor's pattern of career experience prior to 1 April 1966 shall count towards his new assimilation point; how much compulsory residents shall be charged for meals; and how much will be charged for rooms, flats, and houses to those who are voluntary residents.

The views of the Hospital Junior Staffs Group of the B.M.A. on these matters have been made known to the J.C.C. through its representative on that committee, and the broad principles of these views are set out below for information:

(1) *Assimilation.* As a result of the overlapping nature of the scales and so that the Review Body's recommendations shall apply equally and therefore fairly to experience before as well as after 1 April 1966:

(a) On assimilation to the new registrar scale one additional increment shall be given for any year, or part of a year, in excess of two spent previously in the S.H.O. grade.

(b) On assimilation to the new senior registrar scale increments to a maximum of two shall be given for each year, or part of a year, in excess of three which have been spent previously in the registrar grade.

(c) Just as past experience in respect of the number of years in junior grades shall be taken into consideration in determining assimilation, so shall the fact that a drop in grade occurred for training purposes, whether this happened before or after 1 April 1966, so that those who have suffered financially in the past will cease to do so.

(2) *Board and Lodging Charges.*—With the Review Body's recommendation that all lodging charges shall be abolished for all doctors who are compulsory residents and its other recommendation that all meals shall be charged for:

(a) That it will be ensured that the abolition of the lodging charge shall apply to all who are compulsory residents, whether this be in hospital rooms, flats, or houses.

(b) That as soon as possible doctors will pay for what they actually eat, and that until such times as this can be brought in, a doctor may elect either to pay a reasonable charge on a *pro rata* meal basis, or on an inclusive charge basis, which should take full cognizance of the facts that resident doctors take a considerable proportion of their meals outside hospital, and that such a basis would be less expensive to run.

We have every reason to believe our views and those of the J.C.C. coincide on these matters, and since the tangible effects of the award will not be seen until these matters are settled, we hope the Ministry will find that they can speedily accept our interpretation of the Review Body's recommendations.—I am, etc.,

E. A. HARVEY-SMITH,
Chairman,
Hospital Junior Staffs Group,
British Medical Association.

Beckenham, Kent.

Future of the Health Service

SIR,—The Review Body's report has been published; it is the mixture as before with a bit more money and a shift of emphasis. The Minister's Hospital Plan has been published; also the mixture as before with the bottle merely shaken. The Government has rattled on the one, and will probably follow the example of its predecessors by rattling on the other. Meanwhile the public wrongly believe that they have the world's

best health services and that all doctors are well paid. The doctors are still emigrating.

The last sentence of your leading article (Report under Examination, 18 June, p. 1496) points a way for us all. There is now less than two years before the next review of N.H.S. remuneration. Are we going to suffer again—the last-minute hurried collection of incomplete information, the sectional submission of uncoordinated claims, the subsequent sectional bleatings of the disappointed and corporate bleatings that as a profession we are misunderstood? This is what will happen if we do not act in the next six months.

We are all doctors, we all work for the community of our patients and we are all paid by the community of the State. We all know some of the things that are wrong about the N.H.S., but few have considered the services as a whole. Is it not time that we all got together, all sorts and kinds of doctors working in State-organized health services, and started to plan a structure for these services which would subserve and encourage that function which is now lacking—increasing quality of care for the patient at all his levels of need?

Functions change while we remain unaware, hidebound in our own little ruts of tradition (be we single-handed general practitioner or head of a special unit), but structure remains unaltered. A joint effort to restructure State health services for the improvement of care-quality would be accepted by the patient-public in a manner no Government could ignore.

Such an effort needs a basis of factual knowledge, both of the present state in the U.K. and of present states and trends in other countries. Much of this knowledge exists, published or unpublished, but much does not exist in factual form. A small well-supported unit could easily correlate that which is known from reports of organizations, committees, holders of fellowships, etc. It would then be within the wit of the research organizations of the B.M.A. and the College of General Practitioners (acting jointly) to identify gaps and plan how these can be filled with fact.

The patient's needs must be defined; the functions of a service to meet those needs must be devised; a structure to enable those functions must be invented—not by piecemeal growth out of tradition, but by clear thinking out of knowledge. The public must be given a plan, and this time one that can be seen to be workable.

We need a new health service to suit both patients and doctors. Only doctors can plan a service that will work. The Review Body has set the time for the job. You, Sir, have pointed the need, and I have tried to show how to start. Who is ready to begin the job? —I am, etc.,

Callington,
Cornwall.

F. H. STAINES.

Medical Witnesses' Fees

SIR,—May I point out a further anomaly in medical witness fees (18 June, p. 1542) as mentioned by Dr. J. E. Duffield.

Should a general practitioner spend a half-day at court, the fee is four guineas and he

can in addition claim four guineas more towards a locum—total, eight guineas. But if he spends a full day at court and requires a locum for this period, he can still only claim eight guineas, which he will probably have to hand straight over to his locum and get nothing himself for his day at court.

This to my mind is a ridiculous state of affairs which should be remedied at the earliest possible opportunity.—I am, etc.,

London S.W.4.

G. J. GRAINGER.

SIR,—Dr. J. E. Duffield (18 June, p. 1542) comments on the scale of fees paid to medical witnesses and by inference the fees paid by coroners to doctors. He refers to a brochure published by the Medical Defence Union in 1963 but has apparently overlooked the paragraphs headed "Fees for Medical Witnesses" and "Fees Paid by Coroners" in the Private Practice section of the Annual Report of Council (14 May, *Supplement*, p. 151). Study of these paragraphs will show that the Council has considered the problems to which Dr. Duffield directs attention and that representations are being made to the Home Office.—I am, etc.,

IVOR M. JONES,
Chairman,
Private Practice Committee,
British Medical Association.

London W.C.1.

Dispensing Doctors

SIR,—There are grave doubts about the proposals on dispensing causing concern to rural doctors.

(a) Section 59 of the third report on the family doctor service suggests removal of the present one-mile rule whereby doctors may dispense drugs for patients in rural areas living more than one mile from a chemist, and substituting the sole criterion, "Whether patients would otherwise have serious difficulty in obtaining any necessary drugs or appliances from a chemist by reason of distance or the inadequacy of communication."

Does this mean that where a doctor already dispenses for patients more than one mile away he may now dispense for any of his patients, even though they live within one mile of a chemist? Or does it mean that in future he must apply for approval of his dispensing to individual patients, old or new, and must he supply proof that they would have difficulty or inconvenience in reaching a chemist?

In the first case, small chemists might be hit; in the second, the dispensing doctor may well find that dispensing becomes increasingly uneconomical. Either state would lead to bad relations between the two professions.

(b) Does the figure of 49s. for the comprehensive dispensing fee include the cost of dispensing appliances? Dispensing doctors in Norfolk have been unanimous in declaring that the fee only marginally covers the cost of drugs and dispensing, and could not possibly cover appliances as well.

May we have an early authoritative declaration?—I am, etc.,

Dereham, Norfolk.

K. A. MOURIN,
Honorary Secretary,
East Norfolk Division,
British Medical Association.