to put it on record that they have the wholehearted support of this regional committee.—I am, etc.,

A. K. THOULD

Chairman, South western Regional Committee for Hospital Medical Services.

Truro, Cornwall

[1] Astley, C. E., *Daily Telegraph*, 5 January, p. 16. (see also *B.M.J. Supplement*, 13 January, p. 17.)

Community Physician: A Statutory Consultant

SIR,—Referring to Appendix IV of the Annual Report of Council, which comments on the report of the (Hunter) Working Party on Medical Administrators (*Supplement*, 10 March, p. 80), I note with approval the proposal that a community physician at both district and area level should be required statutorily to produce an annual report and have the responsibility for reporting at any time on matters affecting or likely to affect the public health with protection similar to that currently given to medical officers of health.

A question which now needs to be posed is: can a community physician—a nonstatutory officer—be charged with a statutory duty of this kind? If not, this is added reason why in the same way as the medical officer of health was firmly written into the statute and recently, and in no uncertain terms, the office of director of social services, so likewise should the office of community physician be spelt out in the National Health Service Reorganization Bill, where it does not yet appear.

It is, indeed, submitted that unless community physicians are created in more realistic numbers than is suggested in the Hunter Report, are provided with more adequate supportive staff than is yet apparent, and are given statutory protection there is grave danger of the best interests of preventive and promotive medicine being submerged by the insatiable demands of the curative services.

To which may be added a final question: need a consultant be any less a consultant by bearing statutory office?—I am, etc..

KENNETH VICKERY

Health Services Department, Eastbourne

Expansion of the Consultant Grade

SIR,—In his interesting article on "Expansion of the Consultant Grade" (*Supplement*, 10 March, p. 71) Mr. F. S. A. Doran has obviously given the subject his usual thorough investigation and has produced some typically provocative solutions.

Unfortunately, his suggestion of dividing the work of a general surgeon into three 11-year contracts is completely unacceptable. In most cases a surgeon does his best work between the ages of 35 and 55, and the proposal that he should confine his activities during this period to emergencies and "intermediate" operations is hopelessly impracticable. At the end of Mr. Doran's "second consultant contract" he would be quite incapable of any worthwhile major surgery.

In a previous letter[1] I proposed the restoration of the post of assistant surgeon. The most recently appointed surgeon would be so designated and be responsible mainly for emergencies, but would be of equal status in all other respects with his colleagues. On the retirement of the senior surgeon, usually after five or six years, the junior man would be replaced and would automatically be accepted as "full surgeon." I also suggested that the most senior surgeon would, at the age of 60 or earlier, relinquish half his beds and progressively diminish his share of major surgery. It would be interesting to hear Mr. Doran's comments on the arguments I then put forward for these possibly more acceptable proposals.—I am, etc.,

T. H. BERRILL

Gulson Hospital, Coventry

[1] Berrill, T. H., *British Medical Journal*, 1969, **1**, 250.

SIR,—While allowing that the article by Mr. F. S. A. Doran (*Supplement*, 10 March, p. 71) was headed "for debate," I find it hard to believe that he can really feel that a varied and satisfying career could result from his scheme to establish a three-tier consultant grade. One is tempted to suggest that Mr. Doran may perhaps have entered the third 11-year phase of his career welcoming the "professionally interesting" complaints which he now admittedly is probably best qualified by experience to handle. It seems also likely that he has the emergency admissions (first consultant contract) handled for the most part by competent senior house officers and the conditions from the waiting list—"dull, routine, and professionally unrewarding"—by higher trainees such as registrars or senior registrars, depending on the local staffing structure (this is the second consultant contract). In effect, he wishes to delay consultant status until the age of 54, admittedly not in terms of status or remuneration but certainly in terms of "job satisfaction."

In the past it has always been thought reasonable that there should be some element of competition to reach the consultant grade, and the myth of eventual great reward financially and professionally still lingers on to spur a diminishing proportion of medical graduates towards this goal. The two major factors in causing fancied runners to scratch from this race are firstly the obvious financial attractions of general practice, together with its improving conditions and work load, and secondly the increasing realization of the "drudgery and hard, servile, laborious toil" of the regional consultant by his junior staff. One can think of many solutions and few seem to me as unattractive as Mr. Doran's scheme.—I am, etc.,

CHRISTOPHER D. JEFFERISS

Exeter

B.M.A. and R.H.C.S.A.

SIR,—I am much disturbed at the apparently imminent creation of another breakaway negotiating body, the Regional Hospitals' Consultants and Specialists Association. I have been a member of this association for many years and I think it has a valuable role to play as a pressure group for consultants, but I do not see it as a completely separate negotiating body in competition with the B.M.A.

Is there really no way in which the breach between this association and the B.M.A. can be healed so that a further split in the profession is prevented? The present situation savours far too much of A.S.L.E.F. and the N.U.R. Is it not possible even at this late hour for the B.M.A. and the R.H.C.S.A. to come to terms with each other and present a united front?—I am, etc.,

R. E. IRVINE

St. Helen's Hospital, Hastings

Earnings of General Practitioners

SIR,—Despite his closing sentence, Dr. J. Winter (17 March, p. 682) can only have the intention of needling his G.P. colleagues. Again we have the canard of the £10,000-per-annum G.P. This specimen must be as much of a *rara avis* as the £20,000-per-annum consultant.

The argument about incomes quoted in the "Partnerships Available" column was dealt with by the 1972 Halsbury Report[1] in paragraphs 48 and 49. The advertisements neglect to mention that there will be "expenses incurred and paid personally" which on average will amount to £1,500.

One suspects that were the spokesman for the Regional Hospitals' Consultants and Specialists Association allowed to see a selection of practice balance sheets he would accuse G.P.s', accountants, and the Inland Revenue of concealment and collusion, as these balance sheets are the source of part of the information which led the Review Body to arrive at the figure of £5,500 per annum as the average net income of the G.P.—I am, etc.,

IAN A. MACRAE

Seaham, Co. Durham

[1] *Report of the Review Body on Doctors' and Dentists' Remuneration, 1972*, Cmnd. 5010. London, H.M.S.O., 1972.

SIR,—May I point out that it is reasonably easy to work out the projected basic earnings of a practice, which any executive council will provide on request?

For example, for an average list of 2,500 patients:

Basic practice allowance	£1,595
Basic capitation fee ... ... (increased by 55p for each elderly patient)	3,625
Supplementary practice allowance ...	310
Supplementary capitation fees ...	420
	£5,950

This sum represents total N.H.S. income before expenses. It can of course be increased by being a member of a group, being in a designated area, etc., but not all of us are so favoured or indeed wish to be. One can also earn more by doing extra work, as indeed can consultants, even full-time, but it is agreed that this is limited. There is also an income from rent for use by the N.H.S. of one's premises. Just as a consultant's income varies according to subject, eminence, merit award, etc., so can that of a G.P.

If Dr. J. Winter (17 March, p. 682) wishes to confirm that my income is close to the Review Body's calculations he is quite welcome to visit me and peruse my accountant's figures. Otherwise may we see an end to these internecine arguments and simply work towards achieving fair incomes for all doctors?—I am, etc.,

W. E. GREAVES

Sheffield

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