doing the same amount of NHS work, will only wish to take 10 NHDs—that is, work a four-day week—who is going to do the work involved in the two clinical sessions that will be dropped? Or are you implicitly confirming that the average maximum part-timer works only eight sessions for the NHS at present?

SAM BAXTER
Honorary Secretary,
National Health Service
Consultants' Association

London SW13

**The Secretary writes: "Dr Baxter ignores the fact that, in addition to the increased differential in favour of those consultants without significant private practice, which will rise from two-elevenths to one-fifth or even three-tenths, they will be particularly favoured in the allocation of further excess NHDs. If this is so whole-timers pondering the recruitment implications for specialties and areas with little private practice must conclude that they are greatly improved.

"The proposed new contract will not influence the development of private practice, which depends on other factors, notably deterioration in the NHS, as Dr Baxter admits. The additional work needing to be done if a consultant accepts only a strict 10-session contract will, of course, be identified and carried out by any colleague with time to spare who wishes to increase his NHS earnings"—ED, *BMJ*.

SIR,—The "disquiet among some whole-time consultants" regarding the proposed new contractual arrangements for consultants is not likely to be dissipated by the BMA background brief quoted in your leading article (10 December, p 1502). To state, as this document does, that "the present two-elevenths differential between those with and without a commiement to private practice will have been increased slightly to one-fifth" displays either total arithmetical incompetence or blatant chicanery. It does not require a knowledge of higher mathematics to comprehend that the ratio between 12 and 10 is less than the ratio between 11 and 9, so that whole-time consultants will be that much *worse* off under the proposed revision of contracts.

The statement in the BMA brief, repeated by the Scottish Secretary in a recent letter to the *Scotsman*, is demonstrably false and surely has to be withdrawn if whole-time consultants are to retain confidence that those who negotiate on their behalf know what they are doing.

PHILIP R MYERSCOUGH

Gynaecological Pavilion,
Royal Infirmary,
Edinburgh

Consultants and pay policy

SIR,—I refer to my letter (17 September, p 775), and to David Ennals's talk to the Colchester Medical Society (17 December, p 1615), in which he says that the pay policy refers to consultants as much as anyone else. So it does, but so does justice. Consultants and doctors have not been treated like anyone else. Our independent Review Body has been "nobbled" by the Government four times during the past seven reports. It says ". . . the fall in living standards for doctors has been more severe than for many salary earners at comparable income levels because of the timing of the restraint measures . . . the whole situation is made worse by the anomalies with which the pay structure is now riddled. . . . We also see there are real difficulties in the way of continuing to function as an independent Review Body unless it again becomes possible for us to have full regard to the principles behind the aims so clearly expressed by the Royal Commission on Doctors' and Dentists' remuneration (page 2)."[1]

The police have won a review and the firemen may have a review. The Government agrees to abide by their reports and also has a plan of intent to restore justice to them. The Secretary of State for Social Services should now declare the Government's intent, with a timetable of how it will restore the profession's pay structure, not perhaps all that we have lost, but at least to the previous position vis-à-vis other professional groups. As to the new contract, consultants are now not paid the going rate for the job they do. "Many full-time consultants now receive less than their senior registrars or even their registrars."[1] The new contract should enable the Government to pay a just payment for the job that is done. When this happens in industry, a new contract does not break the pay policy and neither should it with the profession, but if the Government pays proper rates and ceases to exploit the profession, it will inevitably cost more money, just as it cost the mill owners more money when they ceased to exploit their workers. As David Ennals says, consultants have total commitment to the interests of patients. And if politicians had as much commitment to the aims of justice there would be no problem.

B O SCOTT

Department of Rheumatology
and Rehabilitation,
The Radcliffe Infirmary,
Oxford

[1] Review Body on Doctors' and Dentists' Remuneration, *Seventh Report 1977*. London, HMSO, 1977.

Decline of visiting

SIR,—Dr B Whitaker (10 December, p 1545), referring to my James Mackenzie lecture, wonders if the reporting has been accurate, and I am afraid on the point to which he refers I was seriously misquoted. The statements I made about home visits by general practitioners included the following:

"In the late 1960s, however, a succession of reports appeared confirming a steady and progressive downward trend in the number of home visits to patients. Marsh[1] in 1968 showed this clearly, and indeed by 1972 Fry,[2] my distinguished predecessor last year, reported only 0·1 home visits per patient per year. For a doctor with an average sized list this is equivalent to four or five visits per week—less than one home visit a day. Similarly the home visiting rate on my own personal list (which has fluctuated between 2700 and 3000 patients during the last four years) has fallen from 0·50 visits per patient per year in 1974 to 0·43 in 1975, and to 0·35 visits per patient per year in 1976.

". . . I do not know, because there is no evidence, what proportion of our work ought to be in the home. There is much that our colleagues in the health visiting and nursing professions can do and are already doing very well. I am not suggesting that the number of home visits should necessarily be increased, but that there is a problem and we should not evade it. The message from Mackenzie is that it may take much hard work and many articles published over many years to clarify a problem. Those of us who care about home visiting should discuss and document our work while there is still time."

The full version of the 1977 James Mackenzie lecture is being published in the January issue of the *Journal of the Royal College of General Practitioners* and includes a detailed list of sources.

D J PEREIRA GRAY

Exeter

[1] Marsh, G N, *British Medical Journal*, 1968, **2**, 633.
[2] Fry, J, *Journal of the Royal College of General Practitioners*, 1972, **22**, 521.

Assessment for invalidity pensions

SIR,—Dr I G Mowat wrote (3 December, p 1483) about the possibility of the doctor-patient relationship being adversely affected when patients' claims to the housewives' non-contributory invalidity pension are turned down as a result of their general practitioners' reports. I share his concern. However, there is no reason why a doctor, if he does not wish to provide a report, should not return the papers to the local office of the Department of Health and Social Security. If he does so, then, as explained in the letter sent to every GP when his help is first sought, arrangements will be made for obtaining a report from another doctor.

The Department is most appreciative of the co-operation it has received from doctors in the launching of this new scheme. We are anxious that they should be inconvenienced as little as possible.

F J DARBY
Principal Medical Officer,
Department of Health and
Social Security

London SE1

Closing down family planning clinics

SIR,—I know you will agree that the transferring of expenditure from one account to another does not constitute an economy. As reported in *The Times* (15 December, p 4) this is just what the Brighton Health District Management Team is proposing to do in spite of a draft scheme being turned down at area level two weeks ago.

Their proposal to close down or drastically curtail the family planning clinic service in order to encourage patients to get their contraceptive advice from general practitioners would shift the funding from the district to the area, but at the same time it would cost the NHS more money. Statistics show that the GP contraceptive service is much more expensive and so the net result of this decision would be to decrease NHS funds available for other essential services.[1] Thousands of patients would be deprived of personal choice and there would be a stupid waste of taxpayers' money.

PAT THOMPSON

Lewes, Sussex

[1] *FPA Evidence to the Royal Commission on the National Health Service, Autumn, 1977*. London, Family Planning Association, 1977.