and includes an effective date of 1 April 1975. —ED, *BMJ*.

SIR,—Could I comment on the letter by Dr R Wann (18 March, p 722) and the further letter from Dr J S Gilmore (15 April, p 991) regarding payment to clinical members of district management teams? Surely, both these gentlemen are very mistaken in putting forward the view that additional payments should be made to doctors who serve on these teams. I would have thought that what the profession should be campaigning for is extra payments for those who have to carry the clinical load of their colleagues who are members of district management teams or perhaps extra payments for those who have to put into practice ill-considered district management team decisions, or extra payments for those who have to spend their time persuading the district management team to reverse daft decisions.

Surely, as a profession, we should be campaigning for an end to this consensual management and the consequent administration by the lowest common denominator. We need a return to local leadership and with it we could have district health authorities (call them boards of governors or hospital management committees if you will) and a sensible medical advisory structure. There would then be no necessity for the bureaucracy of the area health authority and the savings made by its abolition could be translated into more adequate clinical care, which would be then available in every district.

H BRENDAN DEVLIN

North Tees General Hospital,
Stockton-on-Tees

## Hospital practitioner grade

SIR,—The Secretary's third paragraph in reply to Dr A B Shrank's letter (15 April, p 992) astonishes me. If it is unrealistic to expect a general practitioner to do hospital sessions for less than is received in general practice, how much more unrealistic is it to expect the consultant to carry responsibility for the hospital practitioner for less than the rate received by that practitioner? The "needs" of the service and the pay policy are irrelevant.

If the service really needs this grade it is the responsibility of the DHSS to find a way round the pay policy to correct the extraordinary anomalies of the consultant pay scale. Until this has been done the BMA must hold back. To promote the introduction of the grade, as the Secretary suggests, will merely confirm the impression that in hospital matters the BMA puts the interests of the consultants way behind those of other doctors and even, here, of the DHSS.

ROGER HOLE

Department of Urology,
North Ormesby Hospital,
Middlesbrough, Cleveland

**The Secretary writes: Mr Hole's argument is based on a comparison of the remuneration for a notional half day (NHD) in the hospital practitioner (HP) and consultant grades, respectively. For reasons explained in the note to which he refers, the number of NHDs which can be contracted in the HP grade is limited to five. In practice the great majority of GPs in the grade do no more than one or two. The number of consultants contracting for such a low number of NHDs is extremely small, and the number of those consultants who incur responsibility for a doctor in the HP grade will be even smaller. Furthermore, it will be clear from the figures given below that a consultant in this position would have to be recently appointed and the doctor in the HP grade near the top of his incremental scale. Even if such a situation existed it would be rapidly remedied, as the consultant's remuneration would overtake his colleague's by incremental progression.

The level of remuneration of the HP grade is the subject of recommendations by the Review Body, which takes into account both the average net remuneration of GPs and relativities within the hospital staffing structure. It was priced for the first time by the Review Body in 1974, and as far as I know no objection was voiced at that time, although the grade could not be introduced because of the prevailing economic policies of the Government. Subsequently, as we all know, consultants have suffered the most grievous and oppressive anomalies as a result of the entirely unfair and discriminatory effects of the Government's pay restraints. The Review Body has stated that it regards the correction of anomalies as being of the utmost priority, and its report was received by the Prime Minister on 4 April. It has been BMA policy for the past 10 years to accord the highest priority to the issue of consultant remuneration. Meanwhile, it is difficult to see how obstructing the introduction of the HP grade can advance the overwhelming case of the consultants for large increases in remuneration.

It may be helpful to set out the figures on which the comparison which Mr Holes seeks to rely is based. But in interpreting them it is important to take into account the practical points which I have made in this note:

| | 1974 £ | 1977 £ |
|---|---|---|
| Consultants: | 494 · 25 (9) to 722 | 685 × 71 (4) to 971 |
| Hospital practitioners: | 460 × 23 (6) to 598 | 610 × 36 (6) to 826 |

Figures have been rounded off to the nearest pound and the supplements paid in 1976 and 1977 have not been included.—ED, *BMJ*.

SIR,—With reference to the Secretary's comments (15 April, p 992), the BMA must recognise and be seen to recognise the grave difficulties that are going to result if the hospital practitioner grade is widely implemented. The Secretary states that it is unrealistic to expect the general practitioner to carry out hospital sessions for less than they receive in general practice. How much more is it then unrealistic to expect registrars to do the same work for far less than the general practitioner will receive, and unrealistic to expect the consultant to carry out the hospital sessions for the same amount as the general practitioner receives when the consultant is taking far more responsibility and has had far more training and experience in that particular branch of medical practice? I fully agree with Mr Alan Shrank that until the salaries of senior hospital medical staff are regularised then the profession should remain opposed to any appointments in the hospital practitioner grade. If the grade is needed by the hospital service, as the Secretary claims, then it is quite unfair to expect the consultants altruistically to acquiesce in it merely for the public good. If this grade is to be introduced then the salary scales of the profession must first be regularised.

A L HOVENDEN

Newcastle General Hospital,
Newcastle upon Tyne

## Abuse of Form Med 3

SIR,—As I understand it this form is intended for social security purposes only and indeed bears this heading. It is clear, however, that the doctor's statement which is part of the form is increasingly used as medical evidence of incapacity by many organisations, both large like the National Coal Board and small like the Amateur Sports Association, St Leonards on Sea, which issues a claim form stating that a photocopy of the National Insurance medical certificate will be acceptable. Attempting to restrict the use of Form Med 3 to social security purposes can only sour relationships with patients, and I believe that this could be obviated by redesigning the form so that the doctor's statement could be detached from the claim form which is issued to the patient. At the end of the day the doctor's statements could be sent to the local office of the DHSS in a suitable Government envelope.

My suggestion has not found favour at my own local medical committee and I would be interested to know whether others would support my view.

A S URQUHART

Blyth, Northumberland

## Joint announcement by BMA and Secretaries of State

SIR,—As long ago as 1964 I had had some five years of "growing anxiety about rising patient expectation and consumption of NHS facilities." The BMA and health departments have been slow to act, and when they do it seems that, yet again, the burden must fall on the practising doctor. Surely it is the responsibility of those who opened the cornucopian Pandora's box of socialised everything to disenchant the recipients of their bounteous socialism by saying firmly that it cannot any longer be afforded and by taking appropriate action to that end.

As an individual I did try to reduce the consumption by my patients of unnecessary, dangerous medication; I did try to refuse medical certificates for those who were workshy, and I hoped that by my doing so those in real need would benefit from more of my professional time. The net results of those attempts at social and professional responsibility were that 10% of my practice went elsewhere in order to satisfy their "rights" as promised by the NHS and pathology gained a GP.

It is truly disgraceful that the Secretary of State and the Chairman of the Council should find it necessary to draw the doctor's attention so that he may draw the patient's attention, etc. Does not the use of the other "box" provide a means for Government to tell people what they may expect of and what they may not (and never should have been able to) demand from the profession?

J R DONALDSON

Camberley, Surrey