doctor with 3,000 patients *has not* been subsidizing the doctor with 1,500 patients—rather the reverse.

If a direct payment for ancillary help is given to the doctor with 3,000 patients (that is the doctor with ancillary help) it would result in the small-list doctor without ancillary help subsidizing still more the large-list doctor. For this reason, the present proposed scheme should definitely be abandoned as being inequitable, and perhaps a scheme fairer to all could be evolved.

If not, I should leave well alone, as the large-list doctor is already receiving higher practice expenses, with which he can pay for his ancillary help.—I am, etc.,

Glasgow S.1. M. LINKS.

SIR,—If I did not know my good friend Dr. A. Gildersleeve so well I might suspect from his letter (21 November, p. 1333) that he was complacent about the present state of general practice. Far from being "arrogant" myself, I am depressingly aware of the short-comings of my own practice of medicine.

I blame lack of time, at least in part, for these short-comings. I find that I have not half the time I really need for the careful diagnosis, treatment, and advice needed by my patients, despite receptionist help and the other "trimmings" with which I surround myself. I think it is careful diagnosis, treatment, and advice that are the items which should measure a doctor's worth to society. These need time; a receptionist makes more time available and therefore helps the doctor to fulfil his role. I am not suggesting that a doctor who has a receptionist is a better doctor, but it is my sincere opinion that most doctors would benefit from the help of a receptionist. I fail to see how this argument could be described as arrogant.—I am, etc.,

Montgomery House Medical Centre, Sheffield 6. D. G. BARROWCLIFFE.

SIR,—It seems to me there are still one or two aspects of this problem that have not been fully expressed. The practice of good medicine is independent of the use of ancillary services, and, in fact, occasionally the use of ancillary staff can impair the personal relationship between the general practitioner and his patient.

The employment of ancillary staff relieves the practitioner of many non-medical chores; the extra time so produced could be utilized to spend longer with each patient, but more probably would be used to be able to deal with more patients.

A practitioner not employing ancillary help, for whatever reason, has to perform all the extra work that would be done by ancillary staff, and thus is unable to cope with as large a list as a person employing ancillary help. Thus, without even considering the payment of expenses, he is worse off than his other colleague. If direct payment is to be made only to those employing ancillary help, those doctors not employing ancillary help will be subsidizing their colleagues who are already in a better position. It seems, therefore, that reimbursement from the Pool for the employment of ancillary help would cause hardship to those not employing help.—I am, etc.,

Rochester, Kent. W. A. PRITCHARD.

SIR,—I read the report of the G.M.S. Committee (*Supplement*, 7 November, p. 171) on the question of direct payment of practice expenses with a growing sense of bewilderment. Here was the cream of our profession helplessly lost in a maze of incredible intricacy.

Dr. J. C. Cameron spoke of "tempering the wind to the shorn lamb" and of "making the introduction of the scheme less painful." He said the Ministry might "prime the pump" but then admitted "this possibility would not be easily realized." Dr. W. Hedgcock dashed about in all directions, turned back from many culs-de-sac, and concluded it was "a very complex situation," whereupon Dr. H. N. Rose solemnly congratulated Drs. Cameron and Hedgcock on their "masterly reviews of the situation."

Predictably Dr. Bruce Cardew thought most doctors welcomed the scheme and (incredibly) that the solution lay not in the provision of money! One doctor suggested the Group Practice Loan Fund might be raided, but another described this "bright and ingenious idea" as unworkable. Dr. J. C. Knox aptly summed up by suggesting that members were getting very befogged on this issue.

And yet, shining like beacons amid this foggy verbiage, were three short speeches which clearly pointed the way. Dr. J. C. Arthur asserted that if the capitation fee had been increased by 20% this scheme would never have been heard of. Dr. Joan Chappell agreed, as did Dr. A. Reeve, who demanded a net average remuneration of £4,000 a year (I would say £4,500) and a threat of a withdrawal of service if the demands were not met.

Clearly the various proposals for a direct payment of practice expenses are a cause of bitterness and disunity, and should be thrown out. They needlessly complicate an already complex pay structure and were only introduced because we cannot make ends meet. Because of them the Ministry's negotiators can happily contemplate a profession's disarray. On the other hand, a drive for £4,500 a year (and no raiding the Pool to pay for other services) would unite the profession. All the pages of printed matter devoted to futile argument about expenses would become irrelevant. There would be enough money to pay for ancillary help, but it would be a doctor's right to do without it if he so wished. (For the record I have always employed ancillary help.) As independent professional men we should be left to run our practices in our own way.

The Government are in desperate need of doctors. We are in a sellers' market. United behind a justifiable pay claim and able to threaten withdrawal of service we should be in an invincible position.—I am, etc.,

Sleaford, Lincs. ALAN A. HALL.

Expert Advice

SIR,—At a well-represented meeting of this Division on 18 November we discussed, among other things, the present problems of general practice. There was agreement that general practitioners were incapable of fully understanding the real economics and complicated politics of medicine, and there was unanimous support for the following resolution: "That a financial expert should investigate, compare, and put before the profession alternative methods of remuneration and service and advise the profession on the comparative merits of each alternative."

The money for such a project could be raised by a levy on general practitioners.—I am, etc.,

C. C. LUTTON,
Honorary Secretary,
East and Midlothian Division.
Musselburgh, Midlothian.

Hospital Medical Staffing

SIR,—We, as a profession, should be indebted to the recent publications of Mr. Holmes Sellors (26 September, p. 816) and Professor K. R. Hill[1] concerning the shortage of doctors. On 31 December 1963 some 4,175 Commonwealth doctors were in active employment in the hospital service. This probably represents a labour force of nearer 5,000 as some are probably engaged on courses and examinations, etc. There is now irrefutable evidence that the number of Dominion graduates coming to this country is falling rapidly—from 1,735 registering in 1961 to 944 in 1963 and a further decline is apparent this year, and will almost certainly continue. Hence four or five thousand doctors will be required in the immediate future to replace these visitors—certainly long before 1981.

In anticipation of the Platt Report some two years ago hospitals were asked to review their future requirements. An additional number, including all grades, of approximately 6,000 was considered necessary by 1967. How accurate were the forecasts on which these requirements were based? Some guide may be deduced, by consideration of the facts concerning the staffing of accident units.

The acceptance of the principles recommended in the interim report of the Review Committee on the Accident Services of Great Britain and Ireland by the Ministry of Health led us to believe that there should be 300 accident units staffed by three consultants, an equivalent number of intermediate grades, and a suitable number of junior posts. This indicates that theoretically the staff for these 300 accident units should be:

Consultants	900
Registrars	900
House Officers and Senior House Officers	1,200
Total	3,000

The Platt report recommended an additional 115 consultants in the specialty, raising the present total to approximately 500. Hence, judged by this specialty, the requests for additional staff were a small proportion of what had been recommended and accepted by the Ministry. This may apply to other specialties as well. Probably the hospital service requires a minimum of 6,000 extra doctors during the next three years, in addition to the 5,000 necessary to replace Commonwealth graduates, making a total of 11,000.

General practice is probably some 5,000 doctors short, and this shortage exists now and takes no account of population increases in the future. Moreover, traditionally doctors from Britain have contributed to the medical services of our Dominions and Colonies overseas. To-day there are many unfilled posts in the Colonies. To fill these posts and satisfy the needs of the armed Services, industry, and