doctor's discretion if it is thought the patient cannot meet the fees.

We believe that locally approximately one-third of patients fit into this category and that this proportion is rising. Moreover, some local authorities, including Teesside, Camberwell, and shortly the West Riding of Yorkshire, will pay the F.P.A. a fee for all patients seen, no charges being passed on to patients. This fee varies, and at present ranges up to £5 per year per patient. Several points arise from this:

(1) If we as general practitioners were to offer free a full contraceptive service to the needy third (or needy 100% depending on location) of our patients, would the same local authorities be prepared to continue the same terms of remuneration? Compared with this our other capitation fee of £1·45 per year for every aspect of medical care would be a mere pittance.

(2) If the utterances of politicians are to be believed it may soon be government policy to make free contraception available to all, with the contraceptive pill available on form E.C. 10 for social reasons. There has been mentioned an item of service fee as compensation for the general practitioners forfeiting their existing right to charge a fee for what is not a National Health Service responsibility. The precedent of up to £5 per year now thought to be appropriate by the same local authorities who remunerate us will probably be acceptable to most general practitioners who have given a full service for a much smaller fee for many years. One would hope that the profession's negotiators will not overlook this precedent.

(3) What attitude should one take towards patients vis à vis this problem? Is it ethical to offer a service for those who can afford it and refer the rest to the F.P.A.? Is it ethical to refer all to the F.P.A., knowing that it will cost them more than the profession has always thought reasonable for this service? Of the shrewd patients who have already started attending the F.P.A. in their "free" postpartum year, many will presumably return to their family doctor when this has elapsed and the financial demands are considered excessive. Indeed, many F.P.A. patients have always brought their problems back to their general practitioner, who is after all more available, able to prescribe, and more knowledgeable about their relevant past.

It may be suggested that a fee of £5 per year is appropriate for an organization which provides a specialist service but would not be appropriate for general practitioners. One of the signatories of this letter is very conscious of the fact that the contraceptive service he gives to his own patients is better than that given to those patients he sees in his capacity as an F.P.A. doctor.

We feel that an unbalanced situation has arisen whereby a disproportionate financial priority has been given to family planning compared with the whole of the rest of primary medical care.—We are, etc.,

JOHN C. FRANKLAND
FRED SMITH

Lancaster

## Paget's Disease in a Five-year-old

SIR,—The article by Dr. N. J. Y. Woodhouse and others (4 November, p. 267) should not pass without comment. In the final paragraph the authors explain their reasons for using the title "Paget's disease." Any attempt to simplify medical terminology commands praise. In this case, however, only confusion can result.

This particular disease of childhood is a high turnover bone disease, as is Paget's disease (osteitis deformans) of adults. Biochemical changes in both disorders reflect the high bone turnover. Radiographs of the childhood lesion resemble those of Paget's disease of adults in some respects but not in all. In the case reported the appearances in some radiographs resembled those of polyostotic fibrous dysplasia rather than those of Paget's disease. Some cases of the childhood condition have shown other features such as dwarfism and premature loss of teeth.

The authors could conceivably prove correct in suggesting that this condition is the childhood counterpart of adult Paget's disease. Nevertheless, it must be emphasized that some workers regard hyperostosis corticalis generalisata (van Buchem's disease) as an adult form of this childhood lesion. —I am, etc.,

PHILIP JACOBS

Severalls Hospital,
Colchester

## General Medical Council

SIR,—Like many others I have been vociferous in insisting that there should be a public inquiry into the functions, structure, and financing of the G.M.C. Now that the Secretary of State has agreed with these views, I hope that you will add your weight to the request that members of the public and of the profession will assist the inquiry. For, only if a wide spectrum of views are expressed and coolly considered, can we hope to achieve good reform, suitable to serving public and profession alike for the next 114 years.—I am, etc.,

D. BELL

Hexham General Hospital,
Northumberland

SIR,—Dr. M. Sim (25 November, p. 485) postulates a lack of spirit on the part of our representatives on the recent Joint Working Party on the subject of the General Medical Council. I believe that in doing so he is unfair, because he appears to base this opinion on one opinion expressed by one representative, Dr. J. H. Marks, on an entirely different subject.

Dr. Marks's realistic opinions on the subject of the Seebohm Report[1] seem hardly relevant to his views on the future of the G.M.C. or on his willingness to try to secure reform of that body. Indeed his declared reluctance to bang his head against a parliamentary brick wall suggests that, if anything, he would prefer to spend his time, in concert with his no less enthusiastic colleagues, in tackling the (perhaps) slightly less impenetrable brick wall presented by the G.M.C. Dr. Marks's record on the subject is well known to members of the Representative Body; he moved the motion that rejected the Council's policy on the G.M.C. and called for reform of the composition of that body.

It is perhaps also relevant to point out that on the Steering Committee that produced *Management Arrangements for the Reorganized N.H.S.*[2]—the grey book—Dr. Marks served as a private individual and not as a representative of the profession.

In the event, the Joint Working Party failed to secure agreement on proposed reforms of the G.M.C. rapidly enough. Could it possibly be that failure to do so was due not to any lack of spirit or drive on the part of our representatives but to the obduracy of the people with whom they were negotiating?—I am, etc.,

B. D. MORGAN WILLIAMS

Claverdon,
Warwick

1 Local Authority and Allied Personal Social Services, Report. Cmnd., 3703. London, H.M.S.O., 1968.
2 *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

## Scene on T.V.

SIR,—Can you do anything to discourage the kind of scene one witnessed last week (on T.V.) of junior medical doctors parading in white coats, prominent stethoscopes, and a general behavioural pattern which I for one felt brought not discredit on the G.M.C. but an excellent demonstration for its retention?

I wondered where they all came from. I belong to a generation where doctors—once they had become doctors—knew how to behave, and if they didn't would certainly have been told so. Exhibitionism would have been a serious cause for admonition. To see this lot made one sick.

If they have a reason for objection to G.M.C., then for heaven's sake teach them not to behave in this matter. I felt ashamed when friends of mine commented, as they did, on that procession.

I am retired. I still pay my G.M.C. fee, not because I enjoy paying a £5 fee, especially no longer in practice, but because I respect the need for such a body. Indeed, since this episode I respect that need more. If there is need of some review of its administration by all means advocate that, but please remember ours was once also a gentleman's profession, not just a career for apparently anyone to behave in that sort of fashion.—I am, etc.,

D. FITZGERALD MOORE

Poole, Dorset

## C.C.H.M.S. and Consultant Contract

SIR,—The chairman of the Medical Committee of the West Middlesex Hospital complains that no opportunity was given for open discussion on the proposals for a new consultant contract and that several members of his committee were surprised at the claim of the C.C.H.M.S. to represent them as no direct communication exists between the members of the C.C.H.M.S. and themselves (2 December, p. 533).

The backbone of the C.C.H.M.S. consists of three representatives from each of the 16 regional committees for hospital medical services (and five from Scotland). The regional committees themselves are composed mainly of representatives appointed by the group medical staff committees in the region. The South West Middlesex Hospital Group Medical Staff Committee appoints a representative to the North West Metropolitan Regional Committee for Hospital Medical

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Services and that representative is a consultant at the West Middlesex Hospital.

On 7 February the regional committee received Hospital Circular No. 34 from the C.C.H.M.S. which referred to the decision taken by the National Hospital Staffs Conference in 1971 that the C.C.H.M.S. should carry out a complete review of hospital contracts and which stated that the C.C.H.M.S. had appointed a working party to produce a completely new consultant contract. On 27 March the regional committee met again and received Hospital Circular No. 36 which included the draft proposals of the working party and set out a proposed timetable. The circular emphasized the need for widespread discussion by hospital doctors and it included an offer to send further copies for circulation among constituents. The offer was taken up to the extent that 16,000 copies of the proposals were sent out from B.M.A. House.

On 22 May the regional committee met again and decided to accept the principal proposals. It also decided not to submit any motions to the National Conference of Hospital Medical Staffs on the contract proposals. Later, the proposals were published in full in the *B.M.J.* (15 July, *Supplement*, p. 39).

The representative of the South West Middlesex Medical Staff Committee was sent all the above communications and he attended all the meetings of the regional committee with the exception of the meeting held on 22 May. That meeting was preceded by a notice which was sent to members on 26 April drawing attention to the fact that the new consultant contract would be discussed at the meeting.

I am sorry that the chairman should also complain that there was no discussion on the proposals at the A.R.M. as I have already dealt with this complaint at length in a previous letter to the *B.M.J.* (21 October, p. 179). In that letter I explained that before the new contract is introduced the results of negotiations with the Department will be sent to the regions for comment, and I again urge all consultants to take that opportunity to join in the discussions and to ensure that their representatives on regional committees are aware of their views.

The chairman also complains that there is no direct communication between members of his committee and members of the C.C.H.M.S. It is difficult to see how we can improve this communication as by a fortunate chance one of his own consultants happens to serve on the C.C.H.M.S. as a representative of his regional committee.—I am, etc.,

C. E. ASTLEY
Chairman,
Central Committee for Hospital Medical Services
Middlesbrough,
Teesside

**Joint B.M.A.-C.M.A. Meeting in Vancouver**

SIR,—May I send a personal invitation to your readers to consider attending the Joint Annual Meeting of the British and Canadian Medical Associations to be held in Vancouver next June. The provisional programme is published in this week's *Supplement* (see p. 83).

My Canadian colleagues and I are planning what we hope will be a stimulating and enjoyable programme, both scientifically and socially, and our wives have arranged a full ladies' programme. Thanks to the proposed changes in the transatlantic charter fares next year M.I.A. Travel Limited is able to offer reduced "package" rates for travel and hotel accommodation for periods of two or three weeks covering the Vancouver meeting (see p. 83). Some private hospitality will also be available in the homes of Vancouver doctors for those who prefer this to hotel accommodation.

Those Canadian doctors and their families who invaded Edinburgh in July 1959 for the last Joint Meeting will never forget the welcome they received then from their Scottish colleagues and I for one look forward to making "Vancouver 1973" an equally memorable occasion.—I am, etc.,

PETER J. BANKS
President-elect,
British and Canadian Medical Associations
Victoria,
British Columbia

# Points from Letters

**New Consultant Contract**

DR. J. A. BLACK (Children's Hospital, Sheffield) writes: I was astonished to read (*B.M.A. News*, September 1972) that the draft document had received the support of the Representative Body in July. . . . The points made in the report (*Supplement*, 15 July, p. 40) on "on-call" and "stand-by" are extremely vague. Consultants are paid to be consulted and I had always assumed that they were available to give advice or to visit their patients, whether N.H.S. or private, at any time. If we think that we are not being adequately paid for this commitment, then we should say so. This availability of the consultant to his own patients should not be confused with the situation where a consultant is "on-call" every day of the week and every weekend, without any relief (and continually without a registrar), for emergency admissions. This is an intolerable situation which exists in many areas where there is only one consultant in that particular specialty. Quite rightly, some of these posts are unfilled because it is the post which is unsuitable. To pay people extra to stay on, or to go to, such posts is not going to solve the problem nor will it give the holder of the post a reasonable family and social life. A consultant post which remains unfilled for more than six months should be looked at by an outside assessor, and if the working conditions are found to be unsatisfactory, they should be altered or the post should be abolished.

DR. WILFRED FINE (Liverpool) writes: The correspondence about allowing whole-time consultants to engage in private practice ignores the most relevant fact—the economy of Britain in terms of inflation. The freedom to engage in private practice is a safety mechanism for the economic survival of whole-time consultants. It is, however, unfortunately true that some whole-time consultants are engaged in specialties where there is no opportunity for private practice, or are attached to hospitals, or work in areas where there is no opportunity for private practice. It is therefore essential that our negotiating committee should link its present demands with special payments for appropriate specialties and appropriate areas.

**Oil of Spanish Fly**

DR. C. C. M. WATSON (Penrhyndeudraeth, Merioneth) writes: I was much amused by the Personal View article by Dr. A. P. Radford (21 October, p. 171) in which he makes a humorous comparison between the activities of insects and humans . . . However, I was rather surprised when Dr. Radford said he had never known cantharidin to be used therapeutically. It is still used extensively as the tincture in lotions for the treatment of alopecia. Whether it is any good for this purpose I am not sure, but as many dermatologists still recommend it one assumes that it must be of some use in this awkward complaint. It is true the old cantharides plaster is never used now, but it had a great vogue at one time . . .

**Outpatient Delays**

DR. V. E. COLEMAN (Inkpen, Berks) writes: Mr. Keith Norcross (18 November, p. 421) believes that "we have no reason to apologize to a patient who attends casualty with a minor lesion if he does not complete his visit in two and a half to three hours." I hope Mr. Norcross never complains when he has to sit waiting for a train, an aeroplane, or a garage mechanic.

**Hazards of Travel**

DR. G. W. CSONKA (Central Middlesex Hospital, London N.W.10) writes: In October I saw a patient with nonspecific urethritis and gave him a course of tetracycline. Ten days later he attended again, no better, telling me that while travelling to East Germany the East German frontier guard confiscated his clearly labelled tablets in spite of his strenuous remonstrations that he needed them for treatment. This is, in my experience, a novel therapeutic hazard, and I wonder whether a similar situation might arise in patients with angina on trinitrates, cardiac patients on digitalis, or epileptics on anticonvulsants, with much more serious consequences.

**Phoenix from Physical Medicine**

DR. D. C. SHIELDS (London S.W.3) writes: I read that what was once called the Department of Physical Medicine is now to be described as that of "Rheumatology and Rehabilitation." How can this description embrace, for example, patients referred for ante-natal exercises, for treatment of allergic conditions of the nose, for chronic sinusitis, for specialized treatment of spastics? Teaching a thalidomide child to make the best use of what limbs it has is certainly not rheumatology; can it properly be described as *re*-habilitation? Someone has suggested that such a department should be under the direction of an "orthopaedic physician." Would such a person be familiar with the conditions I have mentioned above, with electromyography, and with the correct use and application of electrotherapy? . . .

**Tedious Chore**

DR. TIMOTHY C. WOOD (Watford) writes: Writing names and addresses on the headings of prescriptions, pathology and *x*-ray forms, etc., is a tedious and unrewarding chore, and annoyance is reflected in increasing illegibility. The format of notes in general practice is at present under review, and it seems likely that a new folder will soon be produced. Might it not be a good idea to include in such a folder an embossed card similar to the account and credit cards produced by so many undertakings now, which could be used to print out the name and address and if necessary the date of birth of each patient on all the many forms which we have to fill in? I feel that this would be a simple and comparatively inexpensive way of increasing our efficiency.

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