the whole-timer if we also bear in mind the additional 2/11ths factor to be paid for simply not seeing private patients. The present 18% differential between full and part time is for an extra work commitment if one takes into account the travel time factor allowed in the maximum part-time contract. It now seems that the Government are offering this extra money for no extra commitment, surely a most unusual example of distorted thinking. Whatever has become of the concept of equal pay for equal work done?

I would ask those who seem so keen to accept these proposals to consider how divisive they are when professional unity is so important. The proposals would certainly force large numbers of part-timers to go whole-time, albeit unwillingly, thus limiting the choice in the private sector in many geographical areas in Britain. If we fall, no doubt the general practitioners will be the next to be threatened by a salaried service. This would result in the medical profession being totally under State control, and we would therefore become civil servants with all that that could mean to our professional freedom.

One doubts if many young men and women would want to come into such a system and therefore I feel that our present stand is not, as many seem to think, a matter simply of private beds, but it is the future of our profession and with it the future of the National Health Service itself. —I am, etc.,

IAN K. MATHIE

North Tees General Hospital,
Stockton-on-Tees,
Cleveland

SIR,—As one of that large and relatively silent minority of doctors employed in the National Health Service who make up 45% of consultant staff, I would like to put forward some of my views as a full-time consultant.

To me the greatest advantage is the clinical freedom to provide the best available service to the patient without having to consider the financial relationship between myself and my patient. My clinical freedom is unrestricted by considerations as to whether it is more profitable to me to operate on the patient or to treat him conservatively such as would be liable to arise in an item-of-service system. I also appreciate the freedom of not being remunerated on an hourly basis. I am not placed in the position that if I should take a little longer over an operation I would receive additional payment or if I delay seeing an emergency for half an hour I am eligible for an out-of-hours payment.

There is always a possibility that dedication to clinical work may be exploited and most of us would wish for protection from this. I will never forget the additional work load and perpetual on-call responsibility which fell upon me when a colleague was taken ill. At least if we were substantially remunerated for such additional work load employing authorities would have an incentive to provide relief. I should like a system of off-duty entitlement basically similar to that negotiated on behalf of junior hospital staff and I would only wish to be paid extra when an agreed normal work load was exceeded.

The 1% of hospital patients in private beds generate a great deal of emotion. It seems to me wrong that the treatment of such a small proportion of the population should bring such disproportionately high rewards to a minority of consultants and that so many others should try to emulate their more successful colleagues in private practice. If the N.H.S. is to attract the best of the profession to devote the whole of their energies to the Service the Department of Health must pay them to do this. I cannot see why a total commitment payment should in this context be emotively termed a bribe unless it is done for the purpose of furthering a particular political ideology.

Merit awards, to most of our minds, seem acceptable only if we have one and unmeritorious if we do not have one. Surely payment for merit should be attached to posts which demand merit to fulfil them. The profession would be in a position to compete for such senior posts in an open market. Such posts would be available in every district and the definition of seniority would cover the additional clinical, research, and administrative responsibilities of such posts.

I would ask for a substantial basic salary which does not have to be made up by additional payments to any great extent. Politicians and the public are not deceived by a remuneration which is made up of many different items, they all know about "overtime" and "bonus." A factor which must act to the detriment of the consultant starting at the bottom of the salary scale is the public image of the consultant earning up to £16,000 a year. With this image in front of the public how can we expect the support of the country in an improvement of the remuneration of the majority? There must be a reduction in the differential between the lowest and the highest paid members of the profession if the lowest are to get anything worthwhile.—I am, etc.,

J. F. PATRICK

Rehabilitation Department,
Pinderfields General Hospital,
Wakefield, Yorks

SIR,—The following motion was passed at the last meeting of the Executive Committee of the Lewisham Division of the British Medical Association.

"The Executive Committee of the Lewisham Division of the B.M.A. express their full support for any sanctions that the consultants may use in their struggle for a just contract."—I am, etc.,

A. H. W. BAIN
Hon. Secretary

London S.E.6

SIR,—One of the causes of the long waiting lists for admission to N.H.S. hospitals in some areas has been the closure of wards owing to the lack of cleaning staff. Might I suggest that an urgent priority for our employers should be to prevent the diversion of our skilled manpower into private work outside the N.H.S.? To this end these admirable ladies and gentlemen should be asked to sign a contract of employment committing themselves to full-time N.H.S. work and undertaking not to work for any private employers in their spare time; and those who decline to sign such a contract should have their N.H.S. wages reduced.

This would solve the problems facing the N.H.S. at a stroke.—I am, etc.,

M. J. LOCKWOOD

Andover, Hants

Common Approach

SIR,—The junior doctors committee of this hospital feels that too much energy is wasted in rivalry between the Hospital Junior Staffs Group Council and the Junior Hospital Doctors Association when trying to overcome a common problem. Could these two bodies follow the consultants, who have persuaded the B.M.A. and the Hospital Consultants and Specialists Association to work together?

We also consider that in the present crisis the junior doctors and consultants would benefit from a common approach.—We are, etc.,

A. R. GAYMER (Chairman)
A. B. KASBY
J. KENT
V. GRAHAM
N. A. OLBOURNE
S. MITCHELL
J. WOLFE
J. P. CALVERT
R. T. JOHN
J. A. CEMBALA
C. J. S. NYE
M. TRAUB
A. N. EMERY
E. M. J. A. FOSSION

Salisbury General Hospital,
Salisbury

Sanctions

SIR,—Like other consultants I may soon be asked to take industrial action in support of the profession's claim for more remuneration. It is my intention not to take such action for the following reasons.

(1) Working to contract (that is, $11 \times 3\frac{1}{2}$ hours per week) will limit my freedom to work to a variable time-table according to patient needs and my own convenience. This freedom I consider a valuable and necessary privilege earned by "continuous responsibility." We already fear demands to "clock in," and working to contract will support those who wish to see us regimented.

(2) Working to contract may increase surgical waiting lists but only for benign conditions. I presume cancer will still be called urgent as it was during the ancillary workers' strike. How sensitive is the Government to large waiting lists for hernias or varicose veins, or even painful hips? If I, as a physician, see fewer outpatients there will be no epidemics of death or disability such as may follow interruption of water and sewage services. Remember how few people need consultant care but remember also that in certain cases our work is too important to be interrupted by strikes. Some patients do die or get near to death while awaiting consultant care which could prevent it. Moreover, much of our work is directed to preventing illness—for example, by treating hypertension or diabetes. Our opponents will not be influenced by an increased incidence of vascular disease in 10 years' time.

(3) We already regret the decreasing continuity of patient care. This tendency will be aggravated if consultants adopt a clock-watching attitude or even appear to do so.

(4) The B.M.A. Secretary has written "It is sad that sanctions are bound to cause inconvenience to patients."[1] This remark

reminds me of the leaders of other service unions who have apologized before strikes which have left people in the cold and sometimes in danger. It is indeed sad that our patients are inconvenienced by their illnesses, be they organic or hysterical, as well as by the inadequacies of the Health Service. Will the public sympathize with doctors who increase that inconvenience in order to increase incomes which are already twice the national average (albeit less than many groups with less training and responsibility)? If we use the strike weapon to which so many people now turn eagerly the strike habit will spread. Who other than the I.R.A. wants a police strike in 1974 or water supply 12 hours a day?

In summary, I will not take industrial action because in this instance I think it wrong and ineffective. In 1974 I doubt if such action is right for any group in our country. Resignation may be.—I am, etc.,

R. F. GUNSTONE

Hospital of St. Cross,
Rugby

1 *B.M.A. News*, October/November 1974, p. 57.

SIR,—I find the B.M.A. battle plan (9 November, p. 357) inadequate and lacking in inspiration and a sense of urgency. It can lead only to arguments between general practitioners and patients and an increase in the work burden which results from prolonged hospital waiting lists and therefore ill feeling between G.P.s and consultants.

Withdrawal from the N.H.S. is likely to prove impracticable as in the past because of lack of unified support. The most effective policy would be to increase our cost of prescribing by 50% or more until the Government grants an interim pay rise, and to my mind the figure of 15% is already outdated by inflation.

The advantages of this plan are as follows. (1) It is aimed directly at the Government. (2) It causes no hardship to patients. (3) It involves no argument or ill feeling between patient and doctor. (4) It can be implemented immediately; therefore it should gain universal acceptance within the profession and full implementation, something which no previous plan has ever achieved. (5) Any prevarication and delaying tactics which the Government usually employs at our expense will result only in a loss to the Exchequer and not to us. (6) Provided that we all act in unison, and since the charge of overprescribing can be brought against any individual doctor only if his prescribing costs are considerably higher than the local and natonal average, there is no way in which the Government can retaliate.

Concurrently, the B.M.A. should inform the public by every method available of the plan and the need for it, reducing it to the most simple terms of relating the cost of various items of service to the cost of household items or a maintenance visit for the television set, and not in terms of annual income.—I am, etc.,

W. R. BLATCHLEY

Gloucester

Government and Profession

SIR,—I entirely agree with what Dr. S. O'Tierney says (23 November, p. 470) concerning negotiations by the B.M.A. on doctors' pay. Doctors in Britain need an association to represent their views on the effect of financial constraints on patient care. If, however, the same association negotiates on pay, then the two are likely to become confused in the mind of the public, and doctors may be thought to be offering a better service in return for higher wages. If, for instance, the B.M.A. were to claim that more money was necessary to attract doctors into geriatrics, the Government might conclude that this was merely a claim by geriatricians to be considered as a "special case."

I would much prefer the B.M.A. to limit its political role to providing evidence on the effects of financial restrictions and leave the public to decide whether more money should be spent to maintain standards. If, on the other hand, doctors want more money for doing the same work as they do now, then they need an efficient trade union, and Clive Jenkins would appear to be the answer. Trade unions can recommend their members to withdraw their services, but a medical association should concentrate on providing the best possible service for the money available.—I am, etc.,

R. D. TURNER

Department of Social Medicine,
The Medical School,
Birmingham

Points from Letters

B.M.A. and Review Body

Dr. W. D. BOX (Wellingborough, Northants) writes: I was astounded to read (30 November, p. 544) that Dr. R. A. Keable-Elliott is a party to letting yet another month go by before taking action to obtain for the profession, at least in part, the sort of salary which they deserve and which they are sadly in need of. . . . I am disappointed that Dr. Keable-Elliott should be portrayed in your journal as a tough negotiator when he in fact, in my opinion, like many negotiators before him, is a perfect gentleman. . . .

Private Patients in N.H.S. Hospitals

Dr. A. G. WATKINS (Cardiff) writes: In Cardiff we have virtually no private beds in N.H.S. hospitals. The private bed demand is met by a nursing home able to deal with uncomplicated cases, and patients outside their scope are admitted to N.H.S. beds as non-paying patients like everyone else. I do not approve of private patients in an N.H.S. hospital but I am strongly in favour of retaining private practice for this allows and encourages direct contact between general practitioners and consultants. . . . Queue jumping is not as common as imagined, emergencies accepted and excepted. The need for it would be reduced by having a larger number of single rooms in N.H.S. hospitals, such as we have at the new University Hospital of Wales, where a quarter of the beds are in single rooms. One suspects that the more likely the patient is to be a public figure the more likely is the queue to be jumped, but with adequate single rooms available this creates no problem. Our experience in Cardiff with no private beds in N.H.S. hospitals is surely not unique; there must be many such throughout the country. Politicians tend to relate their problems in terms of London, which is not typical of the country as a whole. . . .

Consultant Contract

Dr. G. D. OFFICER (Dudley Road Hospital, Birmingham) writes: I wish to put on record that I support the stand by the B.M.A. and the Hospital Consultants and Specialists Association against the Government at this time wholeheartedly, but I never fail to be amazed by the naive letters consultants write bemoaning their financial lot, particularly full-time consultants, and I speak as one of them. . . . Specialists on the Continent and in Canada working in health services as comprehensive as the National Health Service would never accept any other status than that of independent contractor, but it is their item-of-service contract which guarantees them this independent status. All consultants should realize this and the B.M.A. and other organizations should negotiate such contracts for consultants who would wish it so. Such a contract should not be imposed on those who would prefer a closed contract such as the proposed 10-session contract; nor would one wish any consultant satisfied with his present contractual arrangements to accept any other. For my part the 10-session contract, unless it bestows the proper professional status of an independent contractor, is not worth the candle in these days of escalating prices and taxes. . . .

B.M.A. Subscription

Dr. HELEN L. KIRKPATRICK (Edinburgh) writes: I have just received notification of the new rates of subscription for the Association. As a "Wife of Member," I was astonished to see that my subscription had increased from £3 to £10 per annum. I am only too well aware of the problems imposed by the current wave of inflation, but surely the B.M.A. cannot justify an increase of over 300% for the Cinderellas of British medicine, the working married women doctors. . . .

Dr. J. B. MONRO (Horsham, Sussex) writes: Since the end of 1972 until April this year I have seen my income from general practice increase by about £300. This has been virtually wiped out by increased motoring costs during this time. Further increases in motoring costs will have to be paid out of income, which will be further decreased by about £250 next year by increased National Insurance charges. I relate all this to explain why I am unable to meet the increased B.M.A. subscription.