patients, and with patients demanding more and more, it is going to be essential that some form of discipline for patients is needed. Further, summonses to medical services committees on the whim of a patient or relative are quite unrealistic. If a patient is neglected he has recourse to the courts, though he will find there less toleration of litigation-mindedness.

These are two examples of many that must be righted before the discontent is removed. Of course as our case was in the hands of a committee with a majority of specialists we could expect nothing better than is proposed. The majority of specialists have no idea how we live.—I am, etc.,

Long Eaton, Notts. C. H. HIGHFIELD.

SIR,—Dr. Leila Sutherland, of Crocketford, Dumfries (*Supplement*, 25 January, p. 28), puts most of the demands from the periphery clearly so that our diffident negotiators can no longer say with honesty that they don't know what the periphery wants. For the first time she has underlined that our so-called average income of just under £2,800 per anum is for a 168-hour week:

168 hours = 4 × 42 hours
= 4 × 1 trade-union working week.

£2,800 per annum based on a 168-hour week is equivalent to £700 based on a 42-hour trade-union week. No wonder that, coupled with our appalling terms of service, we consider that £700 is inadequate remuneration.

Come on, negotiators! Dr. Sutherland has told you what is only a good doctor's due; there is now no room for excuses or reliance on the betrayals which marred the early history of the N.H.S. and from which it has never even started to recover.

Let us have something done and no more talk of 14%.—I am, etc.,

London S.E.6. G. C. SMITH.

SIR,—I feel the unity of the profession would have been more convincingly demonstrated if the Joint Consultants Committee had seen fit to approve the original Memorandum of Evidence (whatever this document contained) without amendment.

There is nothing in the Memorandum suggesting that the pool, one of the principal grievances, should be abolished; and nothing about our terms of service—namely, the fact that we have to provide deputies at our own expense for holiday and illness.

I am sure an evidence committee should be appointed composed solely of general practitioners, and the present Memorandum referred back, as I am very doubtful if it represents the feelings of the majority of general-practitioner opinion.—I am, etc.,

Gloucester. P. G. CRONK.

SIR,—I was shocked and horrified to read Dr. W. R. E. Harrison's letter (*Supplement*, 1 February, p. 34). One wonders why such men go into the medical profession. If all they want is to gain a livelihood surely there are many professions in which they could gain a better livelihood. I have recently retired after over 40 years in general practice, during which I always regarded my work as a service and—when one thought about it—hoped to get enough to live on. One went into the profession with one's eyes open to all it involved. Perhaps such a view as that held by Dr. Harrison is responsible for a good deal of the discontent and frustration that one hears so much of these days.

No doubt my remarks will be classified as "sentimental rubbish . . ." from "the pre-N.H.S. days" mentioned by Dr. J. Miller Aitken in his letter (1 February, p. 306).—I am, etc.,

Farnham, Surrey. G. HUMPHRY WARD.

SIR,—I am sure Lord Taylor's diagnosis (House of Lords Debate, *B.M.J.*, 1 February, p. 315) for a reconstruction of our pay structure is the correct one from all points of view. It reconciles payment per item of service with eventually a salaried structure in our grandchildren's time.

For a whole-time salaried service 26,000 doctors would be a minimum requirement for 2,000 patients per doctor, not including the extra number required to cover night duties, week-ends, maternity, and all the other extra items of service, and a 48-hour week, perhaps eventually reduced to 40 or even 33 hours. In the same debate Lord Cohen estimated 10 years for the recruitment of an extra 1,000 doctors, and I wonder what the waiting period for a sore throat would be in general practice? No doubt a salaried service is a definite future possibility when the 30,000 or extra 8,000 doctors become available.

The present pool comprises a gross payment of 6s. per item of service at an estimate of 4.5 items of service per patient per annum for pure general medical services and exclusive of prior charges.

The remedy comprises a gross payment of 7s. 2d. per item of service, and still at 4.5 items of service per patient per annum, and this estimate includes a readjustment of the expense factor. The seniority factor works out at an extra 9d. after the first 15 years and 1s. 4d. per item of service after 25 years for an average list.

I have calculated for my own practice an average of 5.1 items of service per patient per annum for pure general services over the last four years—that is, 4.6, 5.0, 5.0, 5.7—and the corresponding gross figures would be 5s. 2d. for the present level of remuneration and the remedy 6s. 4d. gross per item of service. The index of 5.1 comprises definitely booked visits and appointments and does not include all the extra incidentals met with, which conservatively would add a further 20% to the index.

At a bare 10 minutes per item of service a list of 3,000 averages 60 hours per week, with a minimum variation from 45 hours to 87 hours for slack to peak periods over the four years. The corresponding figures for a list of 2,000 patients works out at 40 hours per week, with a variation from 30 to 58 hours per week. These estimates include the maximum ancillary help.

We must therefore reduce our negotiations to fundamentals—that is: (1) A suitable net payment per item of service, geared to incomes relative to other professions. (2) An equitable estimate of the items of service per annum per patient notwithstanding that these could vary from 2.5 to 1 owing to differences in morbidity. (3) A revised expense factor, which the profession is now negotiating with the Ministry. (4) A capital factor to deal with the costs of premises. (5) A seniority factor to compare favourably with other professions.

Thus for an average list of 2,345 patients at 6s. net per item of service at 5 items of service per patient per annum the revised figure would be £3,517 net for pure general services and exclusive of "prior" charges, before proceeding with the other recommendations. This would entail an extra of £25m. and not £13m., which the B.M.A. are proposing. The B.M.A. £2,765 net figure works out at 5s. 2d. net per item of service at 4.5 items per patient per annum. Negotiations would be more factual, and every three years adjustments with the aid of the Review Body could be made and be applied retrospectively to compare with our "final settlement" of yesteryear.

It can be seen, therefore, that even if the present B.M.A. proposals proved acceptable to the Government there would soon be renewed dissatisfaction. If we are to try to fulfil the recommendations of the Gillie Report lists must be reduced initially to 3,000 per doctor and every effort made to reduce them eventually to 2,000 per doctor.

Please do not allow any other intrusions or particularly red-herrings like consultant differentials in an otherwise straightforward and fundamental pay structure.—I am, etc.,

Rhyl, Flintshire. HENRY BRISK.

SIR,—The evidence which our negotiators intend to offer to the Review Body includes a quote from the Gillie Report concerning the lack of payment for experience and seniority under the present pool system. The memorandum then suggests that these factors should attract special rewards, which of course will come out of the pool. The answer of the Review Body might well be that the general practitioner is unique in our profession in that the value of his services tends to decline rather than increase over the years.

Like many young practitioners who are in no position to make terms when entering a partnership I signed an agreement approved both by the B.M.A. and the local executive council which gave me a small initial share rising to parity over seven years. I find that the two younger partners each provide double the services provided by the senior partner, whilst last year the income of the latter was the sum of that of his two juniors. The patients come freely to us younger men because our more recent contact with hospital practice enables us to tender advice of a higher quality.

I believe that such agreements, which are common in this country to-day, enable many senior practitioners to receive more than their just share from the pool solely by virtue of age and without necessarily any corresponding merit.

The proposed payments are, I feel, wrong and would be only treatment of a symptom. We need opportunity to grow in the art and science of medicine with a related growth of income as one gets older. I submit that such will not be possible until all doctors, whether specialists or general practitioners, are paid on a graduated item-of-service basis for all services from open-heart surgery in hospital to the simplest psychotherapy for minor emotional disturbances dealt with in the consulting-room. This reform combined with a system of hospital privileges based on experience would also do much to remove the present grievances over the differential.