SIR,—I have just read your leading article "Pay Methods and the Future" (22 February, p. 447). In all the controversy about "differentials" I feel there is one point that has been completely missed. This is that hospital practice needs to ensure a steady flow of recruits just as badly as does general practice.

I am at present working as a registrar, with the hope of one day reaching a consultant post. I see many of my contemporaries who have elected to go into general practice already earning twice my salary and settling down to organize their homes on a long-term basis. By contrast I have to struggle financially with the knowledge that I will have to move to different parts of the country three or four times in the next six years. For my wife this means another six or more years before she can start a permanent home, and before she can enter into any sort of permanent social contacts.

In face of these facts, were it not for the "carrot" of high financial gains at the end of, and only if I make, the grade, I would feel compelled to give up my chosen specialty. Certainly if I had the temperament for general practice the present financial terms would not deter me from joining my many friends already in practice.—I am, etc.,

City Hospital, Nottingham. C. J. CARR.

. . . May one who is neither a general practitioner nor a consultant be allowed to comment on some of the wilder statements appearing in your correspondence columns comparing earnings and conditions in general practice with those in the hospital service? What is the true picture?

(1) *Better Prospects.*—The chance of anyone entering the hospital service attaining consultant status is less than 1 in 4; there are over 3,000 registrars in this country; recruitment to the consultant ranks is at present under 300 per annum. The average age of senior registrars at the time of the Platt review was 35½ years; 997 registrars had spent six or more years in that grade. The average age on attaining consultant status is 38–40. Prior to this, the salary scale ranges from £1,000 to £2,400. Even a cursory study of these figures shows that the aspiring consultant, with absolutely no guarantee of ever becoming one, has to spend some 10 to 15 years in training, paying his examination fees, raising his family, receiving virtually no expenses, and at a salary which is about £1,000 a year less than his contemporary who plumps for general practice.

(2) *Career Earnings.*—Do the figures commonly produced, showing about £1,000 per annum in favour of the consultant, bear close examination. I doubt it. First, consultants in the hospital service number less than 50% of the total hospital medical staff. Secondly, the figure commonly attributed to the consultant assumes that he has a "C" merit award and includes earnings (estimated) in private practice; the general-practitioner total excludes private earnings (said to be negligible).

(3) *Better Conditions of Service.*—Many correspondents have made play of the hospital staff's car allowances, telephone allowances, paid locums, and so on. But there is no "car allowance"; mileage and telephone rental are paid only for well-defined reasons, and that by no means invariably. When colleagues go on leave their work is done by the remaining staff, which helps to rub the shine off one's own leave.

(4) *Recruitment.*—There is a shortage of recruits to the medical profession as a whole, but where is this shortage to be found? Are general practitioners unaware that it is impossible to fill hundreds of junior hospital posts, and that but for the wholesale influx of Commonwealth doctors, mainly from Pakistan and India, many hospitals in this country would have no junior staff at all? At the time of the Platt Report, no less than about 3,500 of the 9,500 junior hospital posts were filled by overseas graduates. Does a similar situation exist in general practice?

The basic cause of the shortage is, of course, a failure of the Government to foresee the expansion of our populace and the corresponding increase in the demands on the Health Service in all its spheres. Nevertheless there is little doubt that the poor promotion prospects, in terms of both length of training, fierceness of competition, insecurity in junior posts, and low salary compared with general practitioners have all served to discourage all but the keenest graduates from specializing, and these latter, I submit, choose their career for its own sake, not for the pots of gold they might earn some day.

For these reasons, Sir, I feel it is highly desirable that questions of "differential" and so on remain outwith the Memorandum to be placed before the Review Body, not for the sake of the consultants, but for the general practitioners themselves. Let the whole profession pull together for a change, for it is surely entering the most critical stage in its career since 1948 in terms of overall manpower shortage. . . .

Bearsden, Dunbartonshire. A. G. GRAHAM.

The Norwegian System

SIR,—As another of the new generation of general practitioners and an aspirant to Lady Summerskill's list, may I support the suggestion of Pertinax that we modify our National Health Service on the lines of the Norwegian system?

Surely we have something to learn from a country which is more welfare-minded than our own and which operates a Health Service which leaves all concerned well satisfied. It is accepted without question that the direct contribution by the patient to the cost of his medical care prevents the abuse with trivialities which is rife in our scheme. The waiving of this payment (as with our prescription charge) in cases of need, ensures there is no real "financial barrier."

Norwegians are amazed at our topsy-turvy Health Service in which all comers may have "free" treatment for their hangovers while we remain desperately short of maternity beds.—I am, etc.,

Oxford. GODFREY FOWLER.

Fixed Capitation Fee?

SIR,—Lord Taylor (8 February, p. 366) is wrong when he advises us to abandon the proposed enlarged Pool before we have had a chance to try it. We should not be tempted by his offer of more money in the short term from fixed capitation fees. Who could prophesy what will be the purchasing power of a capitation fee in five years' time, or what will be the scope and size of the G.M.S.C. of the future?

If as he says there will be a new financial crisis every three years under the present system we will as of right take our case again to the Review Body. In the long run we will always have the money, and what is more important we will retain the right to use it as we think fit. Anomalies and injustices arising from a fixed capitation system could not be dealt with. The flexibility of the Pool allows for changing needs in general practice.

Whereas the Pool could be enlarged at any time to any agreed figure, the fixed capitation fee could not go up more than the percentage rise in the population—i.e., 8% in 10 years according to Lord Taylor. We have fared better than 8% in 10 years using the Pool system.

The Pool system is neither perfect nor permanent. It is the method which successive R.B.s and L.M.C. conferences have chosen. When a better method is accepted for trial by the R.B. and conference it can be presented to the Review Body. Let us all agree that the major purpose of this memorandum is to get a proper basic income for general practitioners and the major purpose of the Review Body is to review the situation at least every three years. The method of payment of the basic income should not be made the root cause of a great dissension, such as Lord Taylor advocates. Our case has been sympathetically presented elsewhere by Lord Taylor, and it amounts to this: we need more money not only because we are doing an exacting job on the cheap but to repay the ever-increasing cost of supplying and staffing premises for the use of N.H.S. patients.

The proposed revised Pool of 1964–5 should solve many of our most urgent problems without involving the upheaval which would be caused by rejection of the Pool system. I hope the special conference will not support the case for a fixed capitation fee.—I am, etc.,

Hornchurch, Essex. I. H. J. BOURNE.

Negotiation and Disloyalty

SIR,—As one who has been a representative and attended all the meetings leading to the introduction of the Health Service and many subsequent meetings I observed with sorrow that reluctance to fight mentioned by Dr. F. E. Graham-Bonnalie in his letter (15 February, p. 433).

Negotiation is an excellent method of resolving disputes, but when one side is armed with a "big stick," which it will not hesitate to use in the event of deadlock, as the Government was and did in the past, it is up to the other side to be at least equally well armed. Our negotiators have not been so armed.

I am at an age when my interest in this problem is for the benefit of those who will come after me. Since the Health Service started I have been distressed by the large numbers in our profession who fail to provide a weapon for our negotiators and then complain when the results achieved do not come up to their expectations. They rarely attend meetings, and when they do usually voice their discontent with the Service or the efforts made on their behalf by their professional brothers.

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I would ask all those who up till now have merely complained, and done nothing, to read Dr. Graham-Bonnalie's letter, especially the last paragraph. Let them say to their negotiators that they will provide the weapon for use if reasonable persuasion fails. Unless and until doctors do this we must always accept what we are offered. Talking never won a battle.—I am, etc.,

Southall, Middx. J. A. MACDONNELL.

The G.P.s' Case

SIR,—I write to support most strongly the views expressed by Dr. M. P. Lewis in his letter (22 February, p. 499) when he said that we G.P.s alone should negotiate our case on its own merits without making concessions to the consultants which would result in a weakened case. We need the consultants for clinical consultation only—not for consultation on how to run our practices or to achieve less oppressive terms of service.

I am stimulated to write this letter to-day, 24 February, by the Minister's announcement of his proposal to set up a working party to investigate ways of securing the best possible standards of general medical practice. In his preamble he recognizes that there is discontent, although this is not referred to in the actual terms of reference. I think that there are three important facts to be understood by those who appoint or elect the G.P.s' representatives to the working party.

First, it is of vital importance that the representatives should include young, clinically active general practitioners who will still be practising in 10 or 20 years' time, and who have their major financial and family commitments now and in the near future. The majority of our representatives hitherto have been men, though albeit of great worth, who have completed their families' education and provision and who now have time to relax and give up clinical medicine to become committee men and negotiators until and after their retirement.

Secondly, the minority groups must have a voice to give vent to their opinions throughout the life of the working party, and the profession should only accept the findings of a party with one representative each from the G.P.A., the M.P.U., and the B.M.A., in addition to the Chairman of Council and a representative of the G.M.S.C. In point of fact the G.P.A. and M.P.U. representatives could, if in the right age-groups, look after the interests of those in my preceding paragraph.

Thirdly, I am sure that the overwhelming majority of the profession would agree that the G.M.S.C. representative should be Dr. Ivor Jones, who is the only member about whom we have read reports as being the fearlessly outspoken champion of a G.P. cause for G.P.s From B.M.A. and L.M.C. meetings which I have attended, heard about, and read about I assess S.C.7 as a fiasco which will be returned whence it came, with Ivor Jones as the only creditable name to come out of it.

Finally, let us all remember that the Minister is going to have to listen to our views—and act on them, unpalatable though they may be. The population is rising fast and the G.P.-replacement rate dwindling (vide Lord Taylor's letter, *B.M.J.*, 8 February, p. 366). This working party is not being set up through altruism on the Minister's part—he knows that he must listen. Let us slowly and quietly tell him everything, not just the tentative little which the platform would wish to put forward.—I am, etc.,

Kimbolton, Huntingdon. J. V. KILBY.

Present State of Medicine

. . . As a simple summary of the present controversy, in a nutshell, pre-war my income was £2,500 a year, which should now be £7,500. At the present rate of remuneration it is obvious that this figure is unobtainable.

Similarly to add to my woes my compensation is, at the most, worth only two-thirds of the figure at which my practice was valued in 1949, already depreciated from its value in July 1948. As for the 2¾% interest, just think even of building societies, National Savings Certificates, and even Premium Bonds. . . .

Cross Hills, Nr. Keighley, Yorkshire. J. RENWICK.

Dental Anaesthetics

SIR,—An unfortunate editorial error has made it appear that I have offered as my own opinion one which is in reality that of the Editor of the *British Dental Journal*. I refer to the statement in my last letter (22 February, p. 504) that the majority of the increase in hospital admissions of dental cases is in fact due to dental causes which could be treated in the dental surgery, but for the problems of current anaesthetic practice therein.[1]—I am, etc.,

Manchester. ARNOLD M. DANZIGER.

REFERENCE

[1] *Brit. dent. J.*, 1961, **110**, 248.

Doctors' Widows

SIR,—Doctors are not noted for longevity, and amid all the talk on salaries thought should be given to widows and children.

Three practical measures could be applied locally: (1) a register kept of all widows and their qualifications and employment found for them, where possible by former colleagues; (2) fees for refresher course paid on application to the Royal Medical Benevolent Fund; (3) campaign waged to ensure that when serving members receive a pay rise something in proportion is done for pensions.

The first thing a widow needs is work which she can do without depriving her children of both parents at one blow. In my experience part-time medical work is like a desirable flat—it never appears in the press. The local B.M.A. could be of great help to qualified widows by keeping a register of them and making known its existence to those who have sessional work to offer.—I am, etc.,

QUALIFIED WIDOW.

Chronic Medical Students

SIR,—One evening recently the discussion at our multiracial table turned to what one of us (Noel Keane, of Dublin, 1957) described as "the chronic medical student." He knew well a medical student who had spent 21 years at university before graduating. Paul van den Broek (Utrecht, 1958) told of a student who was accidentally killed during his eighteenth year at university. I (Adelaide, 1954) knew of another who had taken 12 years to get his medical degree.

After much talk we agreed that the day of the chronic student was gone. Nostalgically we wondered if, granted the favour of your publication of this letter, some of those same students might communicate with the *B.M.J.* in chronological detail. Thus we could establish the record and write the epitaph.—I am, etc.,

New York. CYRIL T. M. CAMERON.

Points from Letters

Old People in the Cold

Dr. L. ZAMMIT (Twickenham, Middx.) writes: Dr. J. W. Paulley and his colleagues (*B.M.J.*, 15 February, p. 428) are to be congratulated for recording a 59% survival rate in their series of 22 patients who had a temperature "below 90° F. (32.2° C.) and most had temperatures below 85° F. (29.4° C.)." They took great pains to mention that in other series the survival rates were considerably lower.

In view of these differences in survival percentages and the different methods of treatment used, one feels that future series should be published in greater detail. It would have been very interesting, for example, to know the details of the temperatures recorded in all the 22 patients Dr. Paulley and his colleagues mentioned in their letter, especially the temperatures of the 13 patients who survived. One cannot help feeling that a patient with a temperature as low as 75° F. (23.8° C.) stands a very remote chance of survival than one with a temperature of 89.9° F. (32.2° C.)—still within the criterion of diagnosis—irrespective of the methods of treatment used. By knowing these temperatures one can see whether the "better-than-usual" survival rate in a particular series is significant or fortuitous.

Sterile Syringe Service

Dr. P. G. CRONK (Gloucester) writes: I too have had the same experience that Dr. Mervyn Goodman has had (*Supplement*, 1 February, p. 34), as I wrote to the secretary of our local hospital on 6 December asking what arrangements were made for the supply of syringes to practitioners and have heard no more. Apparently the subject is still being thrashed out behind the scenes between regional hospital board and the Ministry of Health. Comment is unnecessary.

Conception Despite the Pill

Mr. BRUCE EATON (St. Leonards-on-Sea, Sussex) writes: May I publicize as widely as possible the fact that the contraceptive pills now in common usage do not provide full protection against conception during the first menstrual cycle? Manufacturers usually point out this fact in the literature supplied to the medical and lay public, but patients cannot be relied upon to note this point and as a result a number of unwanted pregnancies have occurred.

Doctors who prescribe these drugs should emphasize to their patients that they must not rely on the contraceptive pill during the first week of the first course of tablets.

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