have admitted that it actually gives them a "buzz" (addict jargon; positive pleasure response to some drugs, particularly morphine derivatives). This preference for methaqualone over barbiturates and other hypnotics shown by the young heroin addict could be ominous.

It may be wise, therefore, for practitioners to prescribe this powerful hypnotic less routinely and to keep a closer watch on those patients in whom they considered its use is indicated.—I am, etc.,

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Death Certificates

SIR,—The time is over-ripe for altering the medical certificate of the cause of death in England and Wales to bring it into line with other countries. The minimal requirements, it is thought, are as follows: surname (maiden name), forename(s), date of birth, place of birth, main occupation, and other details, as mentioned by Acheson.¹ It is indeed strange that this country is behind Holland, the U.S.A., Canada, Scotland, New Zealand, and Australia in providing sufficient details for the purposes of critical investigations and in obtaining more accurate mortality statistics.

Making the death certificate a secret document, as in Holland, would enable practitioners to give information which would not upset relatives. For example, recently a

patient objected to the words "due to cigarette smoking" being put on the death certificate when the husband died of lung cancer, this particular patient having been a heavy smoker most of his life. To obviate this, a counterfoil could be modified to indicate the main cause of death, and the medical certificate itself, which should be posted to the registrar, would contain all the relevant details as to the mode of death.

The present certificate seems to be medically orientated, and does not help research workers. For example, I feel that there is about 20% under-reporting of lung cancer patients in this country—that is to say, patients may be stated to have died of pneumonia or bronchopneumonia when they may have died of lung cancer, perhaps to avoid upsetting relatives. In this practice deaths due to lung cancer greatly outnumber those dying from pneumonia or bronchopneumonia. It must of course be emphasized that these figures are applicable only to this practice.

It is also felt that by making the certificate of cause of death up to date the disparity between clinical and pathological cause of death would diminish. As is well known, there is agreement only to the extent of something like 45–51% shown in previous investigations on post-mortem examinations of in-patients in several hospitals.²—I am, etc.,

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REFERENCES

- ¹ Acheson, E. D., *Medical Record Linkage*, 1967, pp. 84 and 85, London.
- ² *Brit. med. J.*, 1966, 2, 1465.

Consultant Contracts

SIR,—At the request of the Ministry of Health the Negotiating Committee of the Central Committee for Hospital Medical Staff considered proposals for revising the contracts of consultants. At the last meeting of the C.C.H.M.S. (*Supplement*, 21 December, p. 73), we were asked to approve the proposed draft contracts, which included the requirement for consultants to live within a certain distance of their main hospital appointment. During the discussion it was pointed out that under the present regulation whole-time consultants who wished to change to maximum part-time were permitted to do so only provided that they did the same amount of work and held the same responsibility for patients as when they were whole-time.

This arrangement is obviously unfair. During the 16 years that I have had a maximum part-time contract I have had to do a work-load in excess of 11 sessions. As a result the regional board has had work done without having to pay for it, and the total amount involved is over £10,000. In addition, my pension will be £300 less than that for which the work-load should have entitled me. Any alteration in these regulations cannot affect me now, and by drawing attention to this anomaly I am only trying to help the large number of my colleagues who are or may be in a similar situation. Many of the newly appointed consultants have had their nine sessions defined so that they do no more work than that for which

they are paid, but this situation could be altered by the Ministry. In one case in Wales a nine-session consultant was told by his regional board that he must take on two additional sessions without additional payment. When many years ago the Ministry were asked by the Joint Consultants committee to permit whole-time consultants to change to maximum part-time their request was refused until an offer to do the same amount of work was put forward. The Ministry were not slow in getting something for nothing and accepted this solution and also agreed that unless there was some special local reason all contracts should be advertised as whole or maximum part-time. The C.C.H.M.S. at their last meeting by the narrowest possible majority refused to refer this matter back to the Ministry, largely on the ground that to do so would give the Ministry an opportunity of withdrawing the part-time option.

It would be interesting to know the opinions of other consultants on this matter. Do they agree that the present requirement is a travesty of justice, and which, if our profession were to be represented by a union, would not be permitted to continue?—I am, etc.,

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H. A. KIDD.

* * The motion was as follows: "That the discussion of draft model contracts with the Ministry be deferred and the principles underlying them be debated in the committee."—Ed., *B.M.J.*

Specialist Adviser or Controller?

SIR,—Your leader on the administrative structure of the National Health Service (28 December, p. 783) claims that "there is complete agreement within the profession that the Health Service should be run by doctors and not by laymen." If this is true, I don't think it ought to be. Situations in which it is necessary or desirable for the doctor to have control are much more limited than you apparently recognize, and the running of a comprehensive Health Service is not one of them. His professional expertise in this regard fits him to be an adviser rather than a controller. It is important to distinguish the two functions.

On the one hand, a doctor is trained to employ special techniques (many of which would be harmful in unskilled hands) for the diagnosis and treatment of disease. For the proper exercise of this function it is essential that his clients accept a passive role (i.e., become patients) and allow themselves to be under his control. When he is acting in this way nurses or relatives or other "ancillary" workers have to accept a role as his technical assistants, and are also therefore controlled by him.

On the other hand, the doctor's specialized knowledge enables him to advise clients (individually or corporately) as to how they may avoid illness, or recover or increase their health. The recipients of advice are not adequately defined as patients, since they are required to be active rather than passive in following the advice given. For example, the doctor may advise his individual client to take a special diet, or he may advise the relatives or nurses to give a patient a special diet; or he may advise a community agency to make special diets available for particular groups of people at risk. In each case, control remains with the person advised, not with the doctor.

It would appear from the current discussion of administrative reorganization in the fields of health and social service that many of us confuse these two functions and claim rights of control in situations where our function should properly be advisory only. One hopes that those who control the health services will listen to medical advice, but perhaps not always take it; for, if they do, there is little doubt that an excessive proportion of resources will be devoted to curative medicine, and far too little on preventive measures and on the care of those for whom medical science has no cure to offer. It is doubtful how much curative medicine, as contrasted with general social betterment, contributes to the health of the community at large.^{1 2}

I must confess to feelings of considerable discomfort in reading the "cogwheel" report on the organization of medical work in hospitals³—where the absence of any consideration of the role of the nursing staff in determining how medical work will be carried out makes the document seem hopelessly irrelevant to my experience: for it is the ward nurses who control a great deal of medical work, not the doctors, who only advise (even if they call their advice instruction). I feel embarrassment when I hear my colleagues so vehemently opposed to the suggestion in the Seebohm Report⁴ that social workers should be under the control of someone other than a doctor: I am happy to be a