Dyslexia

SIR,—Your leading article on dyslexia (27 December, p 724) will have interested many doctors who are being consulted more and more by anxious parents puzzled by the unexpected failure of their child to learn to read, write, and spell and worried because the term "dyslexia" may have been used to describe the child's difficulty.

We have seen a number of adults and children presenting with reading difficulties and no longer have any doubt that the syndrome of dyslexia exists and affects a small but significant number of otherwise normal children, often of above average intelligence, who require help from doctors, psychologists, and teachers to realise their full potential. The point Dr MacDonald Critchley makes in his letter (24 January, p 217) when he says "We are dealing with a syndrome which is something more than an isolated defect in reading" is very important and should be stressed. In our experience dyslexic children who have learnt to read to a level which might be considered normal all continue to have difficulty with spelling and in expressing themselves in writing, especially in situations of hurry or stress or when they are fatigued or below par physically.

It is most important for doctors to reassure parents that their dyslexic child is not suffering from some dreadful "disease of the brain" and that with patience and suitable management he can confidently be expected to learn to read. They should, however, know that he will continue to have a certain amount of difficulty and should be directed away from a career which requires difficult reading and fluent writing.

The school medical officer as well as the family doctor has an essential role in the early recognition of the child who is likely to have difficulty with a symbolic decoding task such as reading. At the first school medical examination a note of the stage the child has reached in speech development, motor co-ordination, and establishment of laterality would be helpful in recognising those "at risk" so that teachers' attention could be drawn to them. When reading failure becomes obvious an assessment by an educational psychologist is in our view essential and then the path is clear to suitable remedial teaching.

The diagnosis of dyslexia may be medical but the treatment is educational. Although more is being done for these children nowadays, the situation still leaves much to be desired and it could certainly be improved if doctors were fully aware of the condition.

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Medical manpower

SIR,—Further to the most interesting papers and panel discussions on medical manpower (3 January, p 25, 10 January, p 78, and 17 January, p 134) and the subsequent comments by Sir George Godber (31 January, p 277) I trust that I will be permitted to make some general comments on this important topic.

Firstly, there appears to be a fundamental contradiction in the first progress report of 1969[1] and its safeguards which were agreed upon in 1970. On the one hand we were told that virtually all specialist trainees had to become consultants, while at the same time banning a permanent subconsultant grade, while on the other hand we were assured that consultant work and standards would remain unchanged. Perhaps the experts on your panel could explain how we are to reconcile these two incompatible propositions.

Secondly, the controversial and highly emotive subject of the subconsultant grade requires careful study in the light of evidence available. (*a*) It appears quite illogical on the one hand to accept the presence of a part-time subconsultant grade in the guise of a clinical assistant while banning its presence in a full-time capacity as a medical assistant (see accompanying table). (*b*) Despite the three progress reports[1-3] and the presence of the various manpower committees it is clear that between 1968 and 1974 the number of doctors in the subconsultant grades increased more rapidly than that in the consultant grade, thus proving that if we continue our present staffing pattern we must inevitably accept the presence of the subconsultant grade in our hospitals (see accompanying table). (*c*) The Hospital Consultants and Specialists Association Staffing Report of June 1974 was based on the assumption that consultant work and standards would remain unchanged and the recommendations followed from this premise. The numbers of doctors required could of course be reduced by changing the pattern of existing staffing.

Last, but not least, no staffing exercise designed to improve the current chaos in our hospitals can ever hope to succeed if we do not first ensure satisfactory recruitment of British doctors into the existing posts in our hospitals and also ensure that they remain in this part of the service, which, after all, currently employs nearly 50% of doctors practising in this country.

Numbers of doctors in consultant and subconsultant grades between 1968 and 1974

Grades	1968	1974	Change
Consultants	9198	11164	+21·37%
Subconsultant			
SHMO	556	228	−58·99%
Medical assistant ..	754	1011	+34·08%
Clinical assistant ..	4718	6376	+35·14%
Ratio, consultant:subconsultant	1:0·66	1:0·68	

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[1] *British Medical Journal Supplement*, 1969, **4**, 53.
[2] *British Medical Journal Supplement*, 1971, **3**, 119.
[3] *British Medical Journal Supplement*, 1972, **3**, 143.

Consultants' ballot

SIR,—Mr D H Teasdale and his colleagues (21 February, p 462) are entitled to disagree with decisions taken in the Central Committee for Hospital Medical Services. However, this does not mean that the CCHMS is out of touch with the "grass roots". As an ex-member Mr Teasdale well knows that the voting power of the committee is held by elected representatives from the regions of England, Northern Ireland, Scotland, and Wales.

The regional committee for hospital medical services that I represent has representatives from 12 district hospitals on it, and in our recent discussions various members of the committee have expressed diametrically opposed views as to what action should be taken by consultants. My fellow-representative and I then had to attend the CCHMS and, having listened to various matters debated at length, had to decide which way to vote. Inevitably, whichever way we vote on these occasions there will be districts within our own region that will disagree with our decisions.

The consultants have not lacked "leadership to a clear course" as Mr Teasdale suggests, but I am afraid that as a group they will remain an ineffectual collection of individuals until such time as the majority of consultants are prepared to devote some time to participating in medicopolitical meetings, to elect people in whom they have confidence to represent them, and then to take the action that is asked of them by these representatives whether they agree with that action or not.

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Family planning in hospitals

SIR,—The letter over the signature of Professor Huntingford and others (14 February, p 400) is in line with previous letters on this subject and I would like to add my support. If sterilisation were an extra service there might be an argument in favour of payment, but most sterilisation operations (with a laparoscope or abdominally) are done by gynaecologists as part of patient care and there is no rhyme or reason for extra payment.

No gynaecologist has asked for the money yet many, like me, will be able to claim between £4000 and £5000 a year extra to our salary. This is far beyond the £6 limit and our juniors will be aggrieved if we do not give them at least half the cases to do. Consultants of other disciplines cannot hope to add to their salary in the same way apart from the general surgeon who does vasectomies. The cost to the NHS will be far greater than the authorities in the DHSS realise, and indeed there is already doubt in some areas that the money can be found, making for further discontent.

The decision to pay this item of service was not supported by one gynaecologist, nor was the Royal College of Obstetricians and Gynaecologists consulted at all, as far as I know. The offer of payment is totally crazy but, more seriously, most unwise when the NHS is so short of money. Have the DHSS the courage to reverse it, or could the gynaecologists be persuaded to direct the money to their hospitals, when it would not attract tax?

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**The Royal College of Obstetricians and Gynaecologists is precluded by its charitable status from taking part in negotiations on fees and terms of service.—ED, *BMJ*.

SIR,—I note the concern expressed by Professor P J Huntingford and his colleagues (14 February, p 400) that hospital doctors should