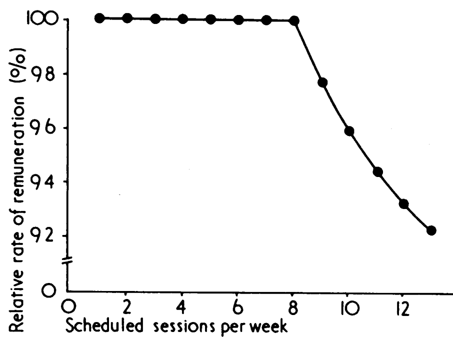

Rate of remuneration according to number of sessions worked.

tion for each session worked will be only 92·3% of that for the eight scheduled sessions of the standard contract.

The CCHMS Negotiating Committee made the following comments on the new contract[1]: "Those individuals who are presently whole time and work all the normal working hours from Monday to Friday are likely to need to maintain this pattern and will, as a result, be paid for 12 NHDs each week. The part-time consultant with significant private practice will be able to accept the standard contract and discharge it fully while retaining sufficient free time to carry on his private practice successfully." Thus consultants working a 5-day week will be remunerated at an overall rate which is 96% of that of the basic 4-day contract and those working a 5½-day week will receive less than 95% of the standard rate.

Only if the Review Body recognises this anomaly and prices timetabled NHDs in excess of eight at a rate 25% higher than those forming the "standard" contract will all consultants receive equal pay for equal periods of scheduled work.

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[1] *British Medical Journal*, 1978, **1**, 1300.

***The Secretary writes: "The authors have made the mistake of regarding the two unscheduled NHDs as involving no work. These NHDs are in recognition of the very heavy administrative load undertaken by consultants at unpredictable hours and of their obligation in accepting continuous responsibility for patients or departments under their care. The implication that there is no work involved in the unscheduled NHDs and consequently any NHDs above the basic 10 is quite fallacious."—ED, *BMJ*.

Reduction of pay-beds in the NHS

SIR,—Your issue (13 January, p 146) carries information that the Health Services Board proposes to reduce the 35 private beds in the Bury, Oldham, Rochdale, and North Manchester Health Districts to nil on the grounds that there are alternative facilities at Highfield Nursing Home. The Health Services Board, in its letter to our health authority, suggests that it requires 75% occupancy at Highfield Nursing Home as being a satisfactory index of full occupancy and suggests that there is still spare occupancy at Highfield. We are reliably informed by the managers of Highfield Nursing Home that the occupancy rate for the four full weeks in October was 80% and for the 21 weeks ending November was 67%.

We are most concerned that the Health Services Board is proposing to take action—and the board itself by its own admission never revokes its action—on the basis of inaccurate statements concerning the capacity of Highfield Nursing Home to replace the 35 remaining private beds in these four health districts as, in fact, there are only 36 beds altogether at Highfield Nursing Home.

Furthermore, while not deprecating the high standard of nursing care and the modern theatre facilities at Highfield Nursing Home, it should be noted that there are no *x*-ray department and no resident medical staff at Highfield. On clinical grounds, therefore, the board's statement that the beds at Highfield Nursing Home constitute alternative facilities to the private beds in the hospitals in the four health districts is incorrect as it would seem to us to be medically unsafe to manage patients with certain clinical disorders in Highfield Nursing Home with its present facilities.

O BAUEROVA
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J P FRASER
M J GOODMAN
A E GREEN
K S HAWORTH
K KAUSHAL
O P LAKHANPAUL
S LAL
M M P LEAHY
J C LOWRY
J MCLENACHAN
D K MUKERJI
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BUPA and private practice anaesthesia

SIR,—At the beginning of last year, when I heard that British United Provident Association (BUPA) was soliciting comments in preparation for a new edition of *A Guide to Private Consultant Practice*, I felt constrained to write to them about the lack of attention paid to the anaesthetist in private practice in the first edition. It seems to me that private practice is something of an abyss to the newly appointed consultant anaesthetist; he is unlikely to have been involved in assisting as a junior (in contrast to his surgical colleagues) and what he does learn about private practice is probably distorted and unfavourable. I wrote to BUPA suggesting that there should be a section devoted to private practice anaesthesia in the new booklet. I also suggested that 20% of surgeons' fees was a niggardly amount for the anaesthetist and that they should quote anaesthetists' fees separately in their patients' booklets.

I had no reply to this letter and six months later I wrote again enclosing a copy of my original letter. This time I was favoured with a reply which was slightly encouraging. Judge my disappointment in October when I was sent a copy of the new booklet and found that there was no section or even sentence about the problems of private practice anaesthesia, which are of interest to perhaps 1000 members of the medical profession, and that fees were still quoted inclusively with 20-25% as the usual ratio to the surgeon's fees. BUPA now has certain schemes in which the anaesthetist's fees are shown separately, and makes the curious comment in the booklet that "it is accepted that anaesthesia should thus be seen to be recognised as a specialty in its own right." This is a very conservative statement 120 years after the death of John Snow, or even 30 years after the establishment of the NHS and appointment of consultant anaesthetists, but perhaps crystallises BUPA's attitude to the specialty.

ADRIAN PADFIELD

Department of Anaesthetics, Hallamshire Hospital, Sheffield

Trade unionism in medicine

SIR,—My thanks to Dr Richard Dreaper (24 February, p 558) for his support of my plea at the recent Honorary Secretaries' Conference for a more cautious approach to trade unionism by the BMA.

At a time when there are severe political pressures on the BMA to adopt trade union status and principles and yet tremendous apathy about the whole concept, it would appear to me (certainly in our division), I feel very uneasy about what the future holds for us all as a professional body. Do our leaders really feel convinced that this move will improve our status in society, our financial position, or, even more important, the service we are able to offer our patients? If the BMA is to have power as a trade union, does it not seem logical that it eventually adopts the closed-shop principle and, ultimately, the right to "withdraw its labour"?

If this is what is envisaged I suggest we place the facts fairly and squarely before our membership and invite them to express their views by postal ballot.

EGRYN M JONES

Wilmslow, Cheshire

SIR,—The nursing profession has shown us a splendid example in refusing, by a big majority, to contemplate strike action, as they would thereby "be betraying a trust." May we also stand firmly by our principles and refuse ever to consider industrial action or, as Dr Jean O Williams (17 February, p 494) warns, "be betrayed into such industrial action again." I heartily agree with Dr Richard Dreaper (24 February, p 558) that if we seek short-term advantage by such means we shall eventually cease to be regarded as a profession. Let us, as Dr D L McNeill (24 February, p 559) emphasises, keep our professional status and independence and give the TUC a wide berth.

MARGARET WILKINSON

Cardiff

College of Anaesthetists?

SIR,—The letter from Dr R S Atkinson and his colleagues (3 March, p 624) lists reasons why they believe anaesthesia should remain as a faculty within the Royal College of Surgeons, and questions how much support there is nationally for a college of anaesthetists.

While support nationally cannot be assessed without investigation, it is worth recording that at the annual general meeting of the Junior Anaesthetists Group held at Exeter in March 1978 there was overwhelming support for the establishment of a college (nobody voted against the formation and two voted as

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