ing. A family history of depressive illness should increase awareness of the possibility that a particular child's behaviour, which is causing concern, may be based on a primary disturbance of mood. Suicidal threats, gestures, and, occasionally, successful attempts are not unknown in the young, and suicidal threats and gestures should always be taken seriously as being distress signals.

The fact that emotionally disturbed children may be referred to paediatricians, physicians, surgeons, child-guidance clinics, and school medical officers, initially makes diagnosis difficult. It is customary in many child-guidance clinics outside the hospital service for a psychiatric social worker to become involved in case work with one or both parents and for a psychiatrist to be responsible for the therapy of the child.

Parents bringing a child to a psychiatric clinic, especially within the hospital service, should always be seen and interviewed by the psychiatrist in charge of the case. This is a medical matter and the training, skill, and experience of the psychiatrist are needed in order to elicit accurate details concerning the medical aspects of the child's problems. Application of diagnostic criteria used for adult patients suffering from depressive illness, to children and adolescents, increases the difficulties.—I am, etc.,

Child Psychiatric Unit, St. James's Hospital, Leeds 9. MARSHALL FRIEZE.

Work Load in Group Practices

SIR,—Your article by a special correspondent on "Impressions of Group Practices" (27 November, p. 1300) must be of special interest to many general practitioners throughout the country, and for this reason I am wondering whether this report is intended to apply to practices other than near Edinburgh. It appears that seven doctors look after 20,000 patients: and each partner has five weeks' annual holiday; so it would seem that for 35 weeks of the year the six remaining doctors are responsible for 3,300 patients each. As it also reports that "the number of items of service per patient is high, roughly double that in the south of England," I feel I should be capable of looking after more than 6,000 patients and still have time to do haemoglobins, erythrocyte sedimentation rates, and stool cultures, and take an active interest in practice research and possibly also be a regional or industrial M.O.

Can someone please tell me why I think I should find this work load impossible while my friends in Edinburgh take it in their stride?—I am, etc.,

Bognor Regis, Sussex. DAVID HAY.

Independent Medical Services Ltd.

SIR,—Whatever may be the result of the continuing negotiations on the doctors' charter and the decisions reached by the Review Body, and whether or not there is a mass resignation by family doctors, I sincerely hope that all medical men, including consultants who believe in freedom of choice and the upholding of private practice, will support the Independent Medical Services Limited by subscribing £10 to the capital fund needed to launch this all-important service effectively on a nation-wide basis. It will be of value to the patient and to the doctor because it will increase and widen freedom of choice for all. If there is not mass resignation it will run in competition with the N.H.S.—it will be excellent for the N.H.S.—and if there is mass resignation it will give patients an immediate and effective service.

I do not believe such a chance will occur again for a generation, so I hope there will be overwhelming support, and £10 is not too much to pay for such an opportunity now to enhance medical services. The Private Practice Committee, under the inspiring leadership of Dr. I. M. Jones, has sponsored several excellent schemes that have been of great benefit and assistance to all doctors. This is another one—which has the support of Council and of the Representative Body.

Let us have the courage to believe in ourselves and make Independent Medical Services the success it deserves to be. I hope consultants will join in support as well—we are one profession and should demonstrate the fact.—I am, etc.,

Reading, Berks. S. F. LOGAN DAHNE.

Proposals for Salaried Service

SIR,—The publication of the Sheffield Medical Committee's proposals for salaried service (*Supplement*, 20 November, p. 212) should not be allowed to pass without examination of some of its assumptions and consideration of related factors to which it makes no reference. The first assumption which I challenge is the statement that the system of remunerating consultants is one which has aroused no complaint from the doctors concerned. On the contrary, there has been complaint from the doctors ever since its inception. The sessional system of payment includes no relationship between work load and remuneration. The conscientious can work themselves into the ground without recompense. The difference in work load as between different specialties and different posts is not recognized; part-time contract-holders are expected to provide the same service as whole-timers, and essentially the consultant's responsibility for his patients is the same as that of a general practitioner—namely, 24 hours a day seven days a week.

We come now to factors not mentioned. First, it must be realized that in 1948 the consultants were compelled to accept a salaried service because, by reason of the N.H.S. taking over ownership of the hospitals, they had no option but to accept the terms offered by the new owners of the only premises in which they could work. Hospital staff could not then, and cannot now, withhold their services from the N.H.S. without also withholding those services from all but a tiny fraction of the population. In other words, the consultant, being salaried, and having nowhere to work but State-owned hospitals, cannot bring pressure to bear on the Ministry by offering an alternative service to the public, as can the general practitioner who owns his own premises. The salaried officer's only recourse is to strike, thereby withholding his services from the public, a course of action many consider, and I think rightly, to be unethical.

Out of this arises my second point. The two great steps forward in remuneration which have rescued the N.H.S. from imminent collapse in the past were the Danckwerts Award and the Royal Commission. In both instances the impelling force which activated the Governments of those times to seek arbitration in one case, and to form a commission in the other, was the threat of mass withdrawal by general practitioners. At the present time we are in the midst of negotiations to recast remuneration for the general-practitioner side of the N.H.S., and no one can refute the argument that once again the threat of withdrawal by general practitioners is the lever by which the profession has again forced the Government to take action.

Because hospital staff are salaried and have no lever which they can ethically use, they cannot make their own terms with their employer. The concluding lines of these proposals, "The Minister cannot afford to forfeit the good will and trust of the profession," etc., make no sense in the light of recent history, and suggests a disregard of facts by the authors.

The only strength the profession has in its relationship with the Minister is the ability of the general practitioner to withhold his services from the N.H.S. while at the same time offering those services outside the N.H.S. Once he becomes salaried, or does not own his place of work, then all the doctors in the N.H.S. are rendered helpless and completely in the power of their monopoly employer—unless they emigrate.—I am, etc.,

H. LESLIE LEAMING.
Middlesbrough, Yorks.

SIR,—As a proponent of a salaried service I write to support Dr. J. C. MacLarnon (27 November, p. 1312), and I am much impressed by Dr. J. W. Wigg (20 November, p. 1248) and by the Sheffield paper (*Supplement*, 20 November, p. 212). It is surely time for us to consider and to be seen to consider the quality of the service as an end in itself and not just a chance by-product of better conditions and higher pay for doctors.

Dr. MacLarnon's medico-social crisis must be resolved, for it is unthinkable that in a civilized country with a social conscience anyone in need of them should want medical advice and care. There is little chance of increasing the doctor/patient ratio in the near or even the foreseeable future, so we must increase our productivity by redeployment of personnel and by integration and rationalization of the whole N.H.S. A salaried service would make this possible and indeed would be a *sine qua non*. We should take the initiative, and by campaigning for it demonstrate that we think of more than our own pay and conditions, and make certain of having a big say in the planning and control of it.

Of course it would take a ten-year plan to assemble such a service and perhaps another five years to have it running at full steam, but by taking the initiative we could have all that is good in the hospital service without what is bad, and at the same time have a family doctor service which was the envy of the civilized world.

Let us now, before we go any further in considering the fatuous and ultra-complex Second Report, have a plebiscite for the family doctors under 50 years of age. "Assuming that the terms and conditions of service would be similar to those now enjoyed