Raw Deal for Medical Secretaries?

SIR,—I should like to comment on the anomalous situation which has arisen in hospitals following the implementation of the Salmon Report.

Secretarial assistance provided for high-ranking nursing officers is now on the higher clerical grade (maximum annual remuneration £1572). Except in rare cases secretarial assistance provided for hospital consultants is restricted to the personal secretary scale I grade, with a remuneration ceiling of £1,335. There is positively no machinery for upgrading a personal secretary working for a consultant, regardless of the number of years of loyal service she has completed with the same consultant. She can of course improve her position by changing her post and working for a senior nursing officer.—I am, etc.,

M. GILLESPIE
Medical Records Officer
Cane Hill Hospital

Coulsdon, Surrey

Reorganization of the B.M.A.

SIR,—We must be grateful to Dr. C. S. Attwood (19 May, p. 425) for epitomizing the pro-Chambers faction's attitude to the General Medical Services Committee. Admittedly, Sir Paul spent as much as half a morning actually watching the G.M.S.C. at work and Dr. Attwood claims to have read assiduously, but neither of them has realized the enormous volume of work transacted by the G.M.S.C. and its subcommittees. Having sat through dozens of such sessions, I can assure Dr. Attwood that far more business is transacted than is ever reported and that decisions are taken "in depth" by the committee. If ever Sir Paul's recommendation of a 24-man committee were carried through, its members would either have to give up practice to get through the work or else delegate large quantities to officials. In view of the need for those who do the committee work to have intimate day-to-day knowledge of the details of practice, neither course is desirable.

Since it reformed its procedure a few years ago the G.M.S.C. has become a surprisingly efficient and effective machine. This has become increasingly apparent year by year at the Conference of Representatives of Local Medical Committees as attacks on G.M.S.C. policy have become less frequent and less virulent. One cannot help wondering, too, if the G.M.S.C.'s effectiveness has engendered a jealousy which is a driving force for some of the attacks it has suffered in the past few months from other sources.

Dr. Attwood states that B.M.A. divisions should take over the functions of the L.M.C.s. In case he has not yet realized how absurd this idea is, it must be pointed out that L.M.C.s are recognized by statute as representing all N.H.S. general practitioners (and only the general practitioners) in each executive council's area, and that all the L.M.C.s' constitutions have to be approved by the Department of Health and Social Security. As Dr. James Cameron carefully explained at the Special Conference of L.M.C.s in February, Sir Philip Roger's letter (*Supplement*, 19 February 1972, p. 46) from the D.H.S.S. to Dr. Stevenson makes it clear that they would not recognize the Council or the main committees of a Cham-

bers-type B.M.A. as representing the whole profession for negotiating purposes. It therefore seems extremely unlikely that the D.H.S.S. would recognize a B.M.A. Area council—let alone a division—as representing all G.P.s in one of the new local authority areas.

Additionally, Dr. Attwood claims that the Special Conference voted against Chambers only in a spirit of self-preservation. An alternative interpretation is that the conference knew in November that the interests of the whole profession lay in the continuation of the L.M.C./Conference/G.M.S.C. structure within the ambit of the B.M.A., and after due and full reconsideration, it emphatically reiterated that opinion in February. Dr. Attwood also seems to think that such a structure could not exist independently. Contrariwise, while, as stated above the B.M.A. could not exist as the sole negotiating body without the support of the G.M.S.C. and Central Committee for Hospital Medical Services, both those bodies could independently negotiate with the Government on behalf of their separate sections of the profession.

The L.M.C./Conference/G.M.S.C. structure is based on the L.M.C.s, which exist as bodies recognized by statute. Through the trustees of the defence trusts, who are members of the G.M.S.C. for the time being, the L.M.C.s between them dispose of funds not far short of a million pounds. An L.M.C./Conference/G.M.S.C. structure outside the B.M.A. would be nothing like as effective as it is now, but with a structure, functions, and assets like those mentioned above, it seems much more likely to flourish than to wither away.

Dr. Attwood may be like Henry Ford and believe that history is bunk, but the L.M.C./Conference/G.M.S.C. structure has 60 years of hard-headed experience and expertise behind it. To destroy this machine would be an act of crass stupidity.—I am, etc.,

B. D. MORGAN WILLIAMS
Claverdon, Warwick

SIR,—I think I have been misquoted in your report of the Junior Members Forum (*Supplement*, 19 May, p. 57).

In discussing the Chambers Report the Medical Teachers Committee had suggested that an age-based division of academics or research workers was inappropriate. I stated that the committee favoured established status as being a suitable criterion for junior: senior division—namely, lecturer versus senior lecturer and other established grades (or equivalent grade for research workers).

My personal view was that if age was to be used, then years from qualification make more sense than years from birth. This is especially true considering the rising proportion of "mature students" enrolling in medical schools.—I am, etc.,

M. C. HAYES-ALLEN
Sheffield

Salary Structure for Specialists in Community Medicine

SIR,—I refer to the letter by Dr. E. B. Lewis on the salary structure for specialists in community medicine (12 May, p. 370).

If any proposition is put forward that

specialists in community medicine should be equated in all respects with consultants in the hospital service, then presumably juniors in that specialty will have to rank with sub-consultant grades in the existing hospital service. It would be interesting to know what proposals would be made to bring about parity in salary scales. An example of this difficulty at the present time would be the £500 difference between the top of the scales for medical assistants and assistant senior administrative medical officers. Another example would be the difference between the top of the S.A.M.O. scale and the top of the consultant scale, unless perhaps an ex officio merit award to S.A.M.O.s, or their new equivalent, is to be permitted in the reorganization of the N.H.S.

These anomalies can hardly have been overlooked, presumably in negotiations with the Department of Health and Social Security. It would be interesting to hear a little about this aspect of the unification of the service, even if precise scales are still not settled.—I am, etc.,

T. GIBSON
Harston, Cambridge

Work Fit for a Consultant?

SIR,—Mr. F. S. A. Doran (5 May, p. 309) asks for a debate on what tasks a consultant should undertake. I agree that it is impossible to define what constitutes a consultant's work. Established consultants even in the same specialty undertake differing work loads and responsibilities. The administrators and the nurses have their beloved job descriptions, but these are characterized by uninformative verbosity.

I have had no difficulty in the past in coming to a tacit understanding with my registrar as to what is within his clinical scope. Indeed, its content varies with his experience, and at the end of three years his cold work is virtually indistinguishable from mine. We have standing orders but these relate only to administrative matters. I would anticipate the same easy relationship with a specialist with whom I was working.

It is no good for Mr. Doran to dismiss my suggestion because he says the sub-consultant grade has failed. In my letter (24 March, p. 745) I asked specifically for the appointment of specialists to be paid on the consultant scale. The main difference between a specialist and consultant would be that, contractually, the former would have a clear commitment for emergency work and, in times of junior staff shortage, would, as Sir George Godber euphemistically says, "carry out more items of care for any individual patient."¹

As to responsibility in law, every doctor, irrespective of his juniority, is liable to be called to court to explain his clinical conduct.—I am, etc.,

J. P. TURNEY
Whitehaven, Cumberland

¹ Department of Health and Social Security, *Responsibilities of the Consultant Grade*, p. 1, para. 4. London, H.M.S.O., 1969.

National Insurance Certification

SIR,—It is disturbing to hear of the Conference of Representatives of Local Medical Committees voting with such little dissension

for the abolition of sickness certification by the G.P. Such a move to remove this long-established duty from the hands of the family doctor is surely one more blow at the doctor-patient relationship.

Part of the doctor's duty is to caution the over-enthusiastic on the one hand and to stimulate the work-shy on the other. It will be an impoverishment of the doctor's role if his function becomes limited to purely medical matters. Though he has no desire

to be a "task-master for the employer," yet he shirks his duty to the community if he does not embody the concept that work is both beneficial in itself and the return to it after illness the aim and object of his therapeutic effort. Moreover, long-term certification gives him an invaluable excuse to supervise the condition of chronic patients.

One is entitled to ask—"what is general practice coming to?" No more vaccination of infants, certification soon to be abolished

from his surgery, self-medication becoming the norm for a multitude of complaints, and a general acceptance of generous deputizing arrangements to save him from ever getting out of bed at night—will even the Royal College of General Practitioners be able to save general practice from the jibe that it is rapidly becoming "money for jam"?—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield

Points from Letters

Nutrition of the Pregnant Woman

Mr. H. A. HAMILTON (Gloucester) writes: I cannot let you get away with out-dated advice on pregnancy nutrition in your leading article (5 May, p. 255). If a woman in my department were to put on 40 lb (18 kg), let alone the 50 lb (23 kg) you recommend, she would be admitted for dieting as a certain candidate for toxæmia. The correct weight gain is 21 lb (9.5 kg), 7 lb (3.2 kg) in the middle trimester and 14 lb (6.3 kg) in the third. Each pound above this will still be present when the baby is six weeks old. Specific instruction should be given about protein. It should not just be left that a high weight gain will automatically result in adequate protein intake as suggested in your last paragraph.

Metal Foreign Bodies in the Bronchus

Dr. K. D. JONES (Nevill Hall Hospital, Abergavenny, Mon.) writes: Recently a child was admitted to this hospital for removal of a steel screw lodged point down in the right main bronchus. Considerable difficulty was experienced in grasping the head of the screw with the conventional bronchoscopic forceps. What is required to deal with problems such as this, may well be magnetic instruments. An adequate magnetic field could be obtained at the end of a soft steel probe with a single-turn coil winding connected to a 6- or 12-volt supply. I think this would be particularly useful for removing ball-bearings.

Tar and Nicotine

Dr. D. D. HILTON (Portsmouth) writes: There appears to be an omission from the recently published tables of tar and nicotine yields of cigarettes. I can see no reference to the cigarettes which are still supplied duty-free for the exclusive use of officers and men of the Royal Navy.

Distinction Awards

Dr. G. M. GREIG (Edinburgh) writes: The B.B.C. has recently shown a film on medical affairs which included a review of merit awards to consultants. I was shocked to learn that £9m. was paid in secret awards to consultants last year. What would the British public think if Cabinet ministers were paid secret awards and civil servants and service ministers drew secret salaries? . . .

Cubital Tunnel External Compression Syndrome

Mr. T. G. WADSWORTH (London W.1) writes: Dr. John Williams and I were interested in Dr. W. H. Jopling's letter (21 April, p. 179). We feel that he is quite right to emphasize that the ulnar nerve is frequently implicated in leprosy. . . . We have to disagree with Dr. Jopling that only orthopaedic surgeons should be considering the cubital tunnel

external compression syndrome. This syndrome can affect all types of patients and we feel that all members of the medical profession should be aware of it and of its consequences.

Ophthalmic Self-medication

Mr. J. S. PHILLPOTTS (Guildford) writes: There is another simple way of administering eye drops to oneself. The patient should lie flat on his back and put the dropper horizontally on the bridge of his nose until he can see the tip is above his eye. Then he squeezes the nozzle and the drop falls into his eye without contaminating the dropper. A similar procedure can be used for instilling drops into small children's eyes. The child is laid flat on his back, told to shut his eye, the drop is instilled into the inner corner, and usually the child opens his eyes the moment later to see what is going on and the drop runs in. . . .

Work Fit for a Consultant?

Mr. J. J. SHIPMAN (Letchworth, Herts) writes: Mr. F. S. A. Doran (5 May, p. 309) would like to define what consultants and other doctors do in medicine and would hope to assess them mathematically. It is frankly impossible. Individual consultants vary widely in their activities. Some consultants spend all day coping with a vascular problem, others enjoy outpatient surgery. Regarding staffing, it would be better if we accepted realistically its constant changes and allowed natural adjustments to occur. These are rapidly taking place and inevitably do modify the problems. No one forces a doctor to specialize; on the other hand the new controls will restrict doctors from specializing and will dictate in which area of the country he should practise. Examination of trends of figures in the past is no golden key to unlock the secrets of the future. Fixing future staff numbers "in bureau" may be found impracticable "in vivo." We must not risk the future by accepting rigid plans for the solution of a rapidly changing problem.

Thyroxine "Addicts"

Dr. V. C. MEDVEI (London S.W.1) writes: With reference to the paper by Dr. R. F. Harvey (7 April, p. 35) thyroid addiction was first described in Britain in 1934 by Dr. S. W. Patterson, who reported three cases¹. . . . I myself observed several patients towards the end of the 1940s, two of them young hospital nurses. One of those took 18 grains (1.2 g) of thyroid extract surreptitiously daily in order to reduce weight, causing—for a time—considerable diagnostic problems.

¹ Patterson, S. W., *British Medical Journal*, 1934, 2, 6.

Vehicles for the Disabled

Miss MARGARET E. BIBBY (London E.7) writes: While I endorse entirely Dr. J. Sherliker's efforts

for disabled drivers (21 April, p. 176), the needs of those who are too handicapped to drive themselves and need a car to get farther than wheelchair-pushing distance from home are even more urgent as they get no financial help with their transport. Help may be given in the form of road tax fund exemption if the vehicle used is specially adapted, but this in itself is expensive and in many cases not needed. . . . To find £25 per year for the road fund tax is a hardship for those living on an invalidity benefit which the politicians have so far ignored.

Bone Marrow in Infectious Mononucleosis

Dr. S. VARADI (Staines, Middlesex) writes: The letter of Drs. J. F. Boyd and D. Reid (21 April, p. 176) referring to your leading article (31 March, p. 757) prompts me to make the following comments. In 1937 Dr. F. Nemecek and I¹ noted a considerable decrease in the segmented neutrophils in the bone marrow ("maturation arrest"?) in infectious mononucleosis, explaining the marked "shift to the left" described by us as one of the cardinal signs found in the peripheral blood; this can precede the emergence of the typical lymphocyte morphology. Further, we pointed out the presence of abnormal lymphocytes similar to those seen in the blood films (and in smears of lymph node aspiration material). . . .

¹ Varadi, S., and Nemecek, F., *Casopis Lékarů Ceskych*, 1937, 76, 200 and 242.

Infantile Mumps

Dr. J. M. WARD (Que Que, Rhodesia) writes: I don't claim to beat Dr. B. S. Milner's record (24 February, p. 491) but my household was hit somewhat explosively by mumps some years ago. One son came home from boarding school with the disease and passed it on to his two brothers and to my wife, who was 6½ months pregnant; hers was complicated by oophoritis and encephalitis. Lastly our 7-month-old fox terrier became sick, developed severe bilateral orchitis and died, presumably also of mumps.

Bruising after Venepuncture

Dr. S. L. FRANK (Preston, Lancs) writes: Dr. P. B. Schofield (21 April, p. 182) will find that extravasation of blood occurs even more rarely if the patient's arm is raised vertically (to collapse the vein) before removal of the needle.

Pre-admission Investigations

Dr. S. R. BRENNAN (Royal Hospital, Sheffield) writes: I think Dr. B. Taylor's suggestion (7 April, p. 54) of inclusion of more pre-admission information into hospital case summaries could be a good one. However, it would require the provision of this material in the doctor's referral letter. In my very small experience in a localized area doctor's referral letters contain very little in the way of accurate details about the patient's illness or treatment, with a few notable exceptions.