rewarding all round could be domiciliary surgery. With the high infection rate for hospital surgery, domiciliary minor surgery might well be safer for the patients with the use of aerosol hard-surface disinfectants, and skin preparation together with prepacked sterile dressings. The introduction of this pattern of practice would cut the transport costs of the ambulance service and relieve expensive and costly operating theatres of a work load of minor surgery, enabling more major surgery to be carried out in them and potentially reducing waiting lists. To reduce the risks of misdiagnosis such procedures would naturally fall to the hospital-based specialist, not only making him eligible for a domiciliary consultation fee but also giving him a glimpse of the world outside hospitals.

Were a trial to be carried out in this field the results would be easily measurable and comparisons easily made. For I am sure that very few of us would ever wish to see wholesale change made again without pilot studies.

PAUL R J VICKERS

Gosforth,
Newcastle upon Tyne

Closure of cottage hospitals

SIR,—It has been said that a camel is a horse designed by committees. Looking around the British scene at the moment one is impressed by the number of decisions being taken by committees in various positions of responsibility which seem to contain no grain of common sense, no feeling of sound economics, and no thought for the future. Decisions are made because of expediency and apparent short-term benefit or economy.

A perfect example of this is the decision by the Hillingdon Area Health Authority to close Uxbridge Cottage Hospital, accompanied by the suggestion that it is likely that Northwood, Pinner and District Hospital and Hayes and Harlington Hospital will follow suit. All three hospitals have served the community in which they are placed for many, many years. Each has built up a fund of good will and respect in those who support and use it and each has attracted a superfluity of voluntary aid and support in its activities. Whenever possible, when ill, people prefer to go to their own hospital.

Speaking for Northwood, Pinner and District Hospital, which is known to me personally, I can say that it is a highly efficient unit where many cases of selected surgery are dealt with annually, where severe and uncomplicated medical conditions can be economically cared for, and where the cost per bed is very much less than that of the large district hospitals. In it over 800 operations are performed annually.

If the decision to close these hospitals is made and carried out they will never be reopened. The happy staff relationship which has been built up through the years and which falls as a benison upon the patients within their walls will be forgotten. In a small unit it is possible to use one's beds most efficiently, and the turnover is rapid indeed. If the small hospitals are closed it means that the district hospital will have to cope with all the patients suffering from ordinary uncomplicated complaints and needing comparatively simple operations. The district hospital is geared to deal with the most complicated type of case. It has sophisticated diagnostic and therapeutic equipment which may be totally unnecessary and wasted upon such patients. The cost per bed in the district hospital is vastly greater than that in the cottage hospital. There will be no economy. Indeed, this is a most expensive way of saving money. The bed occupancy of the district hospital is in fact very much lower than that pertaining in the cottage hospital. Surely the rational and common-sense thing would be to close temporarily a number of wards of the district hospital and leave the cottage hospital to continue its good work but with increased pressure upon its bed occupancy. In this way there could be a concentration of medical, nursing, and ancillary staff, the occupancy of the district hospital in the wards remaining open would be far more economic and efficient, and there would be no destruction of valuable units. It would be a comparatively simple thing to reopen wards when the need and the economic situation make it necessary and possible. It is a very different thing to reopen a small hospital.

These are the simple facts and surely the long and wise view can be taken rather than the short, irrevocable, and destructive one.

DUDLEY BAKER
Chairman of Medical Committee,
Northwood, Pinner, and District Hospital

Northwood, Middx

Unpopular specialties

SIR,—Further to my previous letter (9 October, p 883), I was most interested to read Dr S B Datta's letter in the same issue (p 883) and compare the situation in venereology with that in geriatrics. As in that specialty, venereology has a large number of consultants who are overseas born. On examination of the paper by Professor J Parkhouse and Mr C McLaughlin on career preferences (11 September, p 630) I could not find any reference to venereology and therefore can assume, as did Dr Datta, that no one was prepared to take up either venereology or geriatrics as a career.

I would agree that the only solution, as Dr Datta says, is that there be "a cash incentive in the form of a higher differential salary scale for anyone concerned" with either specialty (and some of the other minor specialties such as radiotherapy), but it should be remembered that venereology, unlike geriatric medicine, is without domiciliary visits.

I was interested to see in your review (9 October, p 886) of the Chief Medical Officer's Annual Report for 1975 that there was a reduction in the cases of syphilis and gonorrhoea, but on comparing the annual analysis for the year 1975 with the totals for 1974 there would, in fact, be an increase in cases of gonorrhoea, while there was a very small decrease in cases of syphilis.

F M LANIGAN-O'KEEFFE

Coventry and Warwickshire Hospital,
Coventry

JHDA and HJSC

SIR,—Dr Elinor Kapp (30 October, p 1076) alleges that inaccurate statements about the Junior Hospital Doctors Association had apparently been made at a meeting of the Hospital Junior Staff Committee. As three who have been among those most closely concerned with the HJSC during the past few years, we feel that Dr Kapp may have forgotten a little of what has happened during those years.

The new contract for hospital junior staff was conceived by junior doctors working through the BMA and published in November 1973. The JHDA's reaction publicly was to express doubts about this contract. By the end of last year the large majority of junior doctors, together with the JHDA, were undoubtedly in favour of this contract, but by August 1976 it was revealed that the JHDA still did not understand it. This was clear from (*a*) its mistake in treating UMTs like extra duty allowances which were not payable during leave, whereas we had negotiated a contract based on a prospective assessment of the doctor's normal working week and payable throughout the year, including leave periods, and (*b*) statements circulated to junior doctors that the contract is between a junior doctor and his consultant. As everyone else realises, the contract is between the individual doctor and his employing authority.

During the final phase of the dispute with the DHSS, which was resolved in September this year, the HJSC worked hard to inform junior doctors and to ascertain their views. Nobody at the HJSC meeting about which Dr Kapp complains had heard of any JHDA regional meetings during that period. There were, however, many public pronouncements of the views of the JHDA.

On the documentary evidence, which was available to Dr Kapp as well as ourselves, it was counsel's opinion at about the time we negotiated a settlement that there was sufficient evidence to say that there had been an agreement to pay full salary throughout 52 weeks of the year. This is indeed what was restored to the contract. Even more important was that the Government was prevented from imposing unilaterally a new term of service which had not been agreed with the profession (the contentious paragraph 204). This principle was of great importance to the whole profession and was recognised as such by the Annual Representative Meeting of the BMA. It seems to us that the JHDA was prepared to accept the content of the imposed term of service on the grounds that not to do so would have broken the pay code. The Government regards its pay code as still being intact, yet paragraph 204 has been withdrawn.

We have no doubt that many find the lack of accord between the HJSC and the JHDA a cause for regret. There is a fundamental difference in attitude. There have been many doctors over the years who have been unhappy about the structure and functioning of the BMA. The question for hospital junior staff has been whether to stay with the BMA and help to improve the organisation, not least in the area of representing junior staff, or to join the JHDA, which has consistently criticised the BMA from outside, as a competitor. There have been many improvements for junior staff within the BMA brought about by those working in the HJSC together with others throughout the Association. The HJSC is now one of the four principal standing committees and in its negotiating work has equal status with the Central Committee for Hospital Medical Services in a reorganised Joint Negotiating Committee.

The JHDA has said that it "will not flinch from defending the rights of junior hospital doctors even if it is forced to take certain