regarded the decision as "indefensible" and that the patient should not have been discharged no matter how overcrowded the hospital might have been.

(5) The complaint is primarily against the authority and not against the individual doctor.

Of course the Select Committee said it would have been "appropriate" for the commissioner to have contacted the doctor and that the authority should have done so initially, and they "note" that the authority did not contact the doctor when the draft report was submitted for comment. But they confirmed the decision and they confirmed it without contacting the doctor themselves.

Meanwhile, in America, the senior house officer comes off best. He now lives in a country where all men can defend themselves if complaints are made against them. But we don't.

DAVID L WILLIAMS

Holywell, Clwyd

Distribution of registrars

SIR,—Professor L P Le Quesne (2 September, p 697) has suggested that calculations involving the redistribution of senior registrars should take account of work done by university staff holding honorary contracts with the NHS. However, not all clinical university staff hold honorary contracts with the NHS. The Sheffield Area Health Authority (Teaching) issues honorary senior registrar contracts to doctors employed by the Medical Research Council, to research fellows financed from outside sources, and to members of the armed forces on secondment, but not to lecturers employed by the University of Sheffield. As the Sheffield AHA (T) is part of the Trent Regional Health Authority, Mr V M Demmery (23 September, p 898) has continued to overestimate the "deficiency" of general surgical senior registrars in the Trent Region.

H CONNOR

Department of Therapeutics,
Hallamshire Hospital, Sheffield

Medical care in inner cities

SIR,—The volume of correspondence on the problems of medical care in inner cities is a measure of the concern of our profession.

What is needed is to attract highly motivated, vocationally trained doctors to accept the challenge of a changing and disadvantaged population. The special medical and social problems must be seen as worthwhile tasks. However, it must be accepted that the pattern of the classic family doctor who lives on the premises may have vanished in these areas. Incentives will be needed, both in the form of enhanced remuneration and by the provision of high-standard premises, equipment, and back-up staff. New attitudes will be required of hospital colleagues, not least those in the teaching hospitals, to accept the burden of back-up and encouragement to the troops in the field.

So far there have been few attempts to plan a realistic programme to meet the difficulties of these areas. It is therefore a pleasure to report that the North-east Thames Regional Health Authority, which is acknowledged to have the worst problems in the country, has recently produced a comprehensive discussion document¹ on practical measures which could be taken to reverse the crisis situation in its

inner city boroughs. This will cost money. Stated DHSS policy since 1976 has been directed towards (a) achieving an equitable distribution of health care resources throughout the country²; and (b) securing a shift of emphasis from secondary/institutional to primary/community care.^{3,4} The RAWP exercise has ensured that hospital resources are being shifted from these already disadvantaged areas. Under these circumstances inner London general practitioners are unwilling to erode further the hard-pressed hospital services. They do not want to rob Peter to pay Paul. The only alternative is to inject additional capital into primary health care in these special areas and this should become the declared policy of our Government.

ARNOLD ELLIOTT

Ilford, Essex

¹ North-east Thames Regional Health Authority: *Planning for Primary Care, A Discussion Document*. London, NE Thames RHA, 1978.

² Department of Health and Social Security, *Shaping Resources for Health in England. Report of the Resource Allocation Working Party*. London, HMSO, 1976.

³ Department of Health and Social Security, *Priorities in the Health and Personal Social Services*. London, HMSO, 1976.

⁴ Department of Health and Social Security, *The Way Forward*. London, HMSO, 1977.

Emergency allowances in the community health services

SIR,—I wish to draw attention to the anomaly now existing in the community health services.

It has been the custom to date in some districts, including this one, for senior medical officers (a number of whom have a higher qualification in public health) to take part in the duty rota for emergency calls for infectious diseases. More recently the newly appointed senior registrars in community medicine have joined the rota. Under the new pay awards for community doctors the latter, who are doctors in training, will now receive considerably more remuneration for this duty than the former, who are doctors in established grades.

Presumably all doctors on the rota are equal, but some are more equal than others.

MARGARET EWART

Guy's Health District,
Community Health Officer,
London SE1

*.*The Secretary writes: "The Negotiating Subcommittee of the Central Committee for Community Medicine has always considered the emergency rota allowances to be derisory and is pressing for them to be increased."—Ed, *BMJ*.

Fair play for pensioners

SIR,—The recent Review Body recommendations, for all that they are not to be implemented in full (as usual), were not unrealistic. They do, however, especially in the way in which they are to be actioned, make bitter reading for doctors compelled to retire because of ill-health, as I was myself, before April 1978. Doctors working up to April 1979 will suffer a considerable loss compared with what they should have earned, but it is a once-for-all sacrifice and dynamising factors by that date will make pensions look a lot healthier. But the Review Body figures were intended to take account of what doctors should have been paid during the two years up to April 1978

and to make good the loss by a 28% increase at that point. Greatly to oversimplify figures, this implies that every £100 a doctor earned in December 1977 should have been about £120, and this "rise" should have been reflected in his pension.

I accept that it is never possible completely to correct all pay anomalies that arise, but I suggest that it is simple justice that doctors forced to retire before they could benefit by the new dynamising factors should at least receive pensions reflecting the implied intentions of the Review Body and the virtual admission of Government that the recommended increases were absolutely justified.

We haven't got much muscle as a group, but by heaven we have endured the "burden and heat of the day" since 1948 and we should surely be able to look to the General Medical Services Committee and the BMA to press for a fair deal.

DENIS CASHMAN

North Shields, Tyne and Wear

*.*The Secretary writes: Attention is drawn to the statement by Dr B L Alexander, chairman of the Superannuation Committee, to the Annual Representative Meeting (5 August, p 444). His committee has already made representations to the Department of Health and Social Security on this matter."—Ed, *BMJ*.

War service and NHS pensions

SIR,—It is now two years since the announcement (27 November 1976, p 1337) that HM Government was prepared to recognise war service as additional years of service for NHS pension purposes. It is nearly a year since the Department of Health and Social Security agreed to deal first with the oldest pensioners "as they are likely to be in the greatest need" (24-31 December 1977, p 1680). It would be interesting to know how many (if any) retired doctors have yet received any addition to their pensions in respect of their war service.

I retired 14 years ago and I am informed that I still have to wait for a further two years (should I live so long) before I shall receive any addition to my pension in respect of my four years of war service. This information was conveyed to me by the Department in a mimeographed letter, obviously prepared for wide circulation to retired doctors.

Several factors contribute to the delay. Principal among these is the fact that contributions by the doctor to the superannuation scheme were not paid during his war service and are being treated as a debt in arrears. Compound interest at 3½% from 1950 to 1975 is added, multiplying this "debt" by a factor of 2.37, and the additional "lump sum" payable to the pensioner is insufficient to pay this "debt." The balance of the "debt" is paid by withholding the increase in pension until the debt is satisfied. The increase dates only from July 1975 for doctors who retired before that date.

A debt paid in arrears with compound interest is a debt fully paid, and a debtor who pays his debt in full is surely entitled to the full benefits for which he pays in full—that is, the relevant pension from the date of his retirement. Doctors not yet retired will in fact receive the additional pension from the date of their retirement. If the Government did not intend that doctors already retired should