specialist bodies throughout the world including the EEC and North America. This additional specialist examination will be an optional one.

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Dental anaesthetic fees: all is now clear

SIR,—After legalistic rereading of the eighth report of the Review Body on Doctors' and Dentists' Remuneration (1978) it is now clear to me that the scale of fees at present payable under the general dental services statement of fees and allowances for the anaesthetic is intended to apply only to general dental practitioners working with their partners in the same practice, because no provision is made for the cost of milage or the provision of equipment.

It will be recalled that the scale of dental anaesthetic fees is as follows: for 1-3 teeth extracted—£2·00; for 4-11—£2·60; for 12-19—£3·50; for 20 or more—£4·60; for any anaesthetic given by a dentist operator—£0·60.

These fees are clearly too low to remunerate the general medical practitioner called in to give an anaesthetic, for whom the Review Body scales are increased as follows: administration of nitrous oxide or ethyl chloride—from £4·60 to £5·75; administration of any other general anaesthetic—from £7·65 to £9·55. (Presumably general dental practitioners called in from outside to anaesthetise should be paid on a similar basis.)

Still less does the present scale meet the case of the consultant (anaesthetic or dental) called to give a dental anaesthetic—in this instance a domiciliary scale fee is clearly earned, because the skill, work, and responsibility involved are higher than those in other instances of domiciliary consultation. Again, it will be recalled that a consultant can be called in for a domiciliary visit whenever the general practitioner considers the need is justified; the scale of fees advised by the Review Body is to be increased from £10·90 to £12·30 a visit. Additional fees are payable for milage and for the use of equipment.

When will the Secretary of State see fit to honour their obligations in the interest of the public seeking dental treatment?

CYRIL SCURR

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Use and abuse of medical women

SIR,—Scrutator reported my views (7 October, p 1031) as expressed at the recent meeting in Birmingham with accuracy. Dr Patricia Price, in her letter (21 October, p 1167), obviously disagrees with some of those views (as she is entitled to do), but since she has expressed herself at some length I must reply to her letter, as the initial report was naturally brief.

While there remain shortages, women doctors have indulged in certain demands. I stated that when we eventually get to a stage of overmanning women would have to maintain a realistic approach. This in no way denies part-time work, or children; but having made a decision to offer full-time or part-time work they must see that they fulfil that particular commitment. This has nothing to do with not seeking proper tax reliefs, but male and female colleagues will expect them to arrange their personal lives so that they offer a proper commitment at whatever level they have sought. They must therefore be good organisers and be willing, out of the joint incomes, to contribute financially to give adequate domestic support. The women must not expect her income to be as profitable as if she were without husband or children. Patricia Price is also wrong in her comparison of former costs of domestic help relative to salary. It is a question of attitudes. Women doctors will get just as much equality as they are willing to compete for, even allowing for special arrangements.

I stated that I have considered crèches were not really as helpful to doctors as they have been to nurses. The latter more often work as part of a team; a doctor is more likely to work on her own—and what happens when her child has measles and cannot go to the crèche, and she is committed to an operating list or an outpatient session? It also needs to be stated that during school age there are long school holidays which must be catered for, and that young teenagers may be, in different ways, as demanding as very young children. However, the trend of society towards a more sharing parental role should be noted.

In the early years women in medicine looked for opportunities to train and opportunities to work. My main theme is that because of a period of shortages, when it has been easier for women to work, let us by all means look for satisfactory arrangements for training and for work and tax reliefs; but let us not make unrealistic demands and complaints so that medical women of the future are denied a right to work—on equal terms if they wish. When there is overmanning, they will have to pay particular attention to making satisfactory back-up arrangements for whatever level of commitment is offered, as I would hope women do at present.

MARY WHITE

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The Glanvill case

SIR,—"Scrutator" (30 September, p 969) quotes remarks I made to the General Medical Services Committee about the Glanvill case (in which Dr Glanvill successfully challenged the exclusion of his wife from the ancillary staff payments scheme for general practitioners). I wish to clarify certain matters. I referred to the introduction at a late hour of a new claim which challenged the integrity of the Secretary of State. The Secretary of State's power to exclude wives had been challenged from the start of the action in 1976. During the trial Dr Glanvill's counsel submitted that from the original statement of claim it was open to him to argue that the Secretary of State had not only exceeded his powers but also acted unreasonably. DHSS counsel considered that the argument about what was reasonable should be specifically pleaded and so the statement of claim was amended during the course of the trial. I have been informed that it was not part of the Glanvill's case to challenge the Secretary of State's personal integrity; what was in issue was the way in which he had exercised his statutory discretion. This I readily accept and I apologise if my necessarily summarised report to the GMSC was misleading. The BMA received from the Medical Protection Society in July 1976 a copy of the writ and statement of claim, but it is now clear that the BMA could not have been told of the amendment to the statement of claim before the trial began.

Four weeks before the trial a letter was received from the MPS seeking a great deal of detailed information, which was readily supplied. The letter also inquired whether, if necessary, a representative of the GMSC would be willing to give evidence in court. In reply it was made clear that, while we would be happy to give evidence in this case, the hearing unfortunately clashed with the Annual Meeting of the BMA in Cardiff. A telephone call was received about five days before the trial saying that it would be of help if someone from the GMSC could appear in court to verify one particular point. The MPS was informed that, although it would not be possible to appear, the chairman or secretary would be prepared to sign an affidavit covering the particular item.

I would like to reiterate that the GMSC will give every support to the Glanvills in their continuing legal actions on this issue, and I hope that any misunderstanding we have had in the past can be put behind us.

TONY KEABLE-ELLIOTT
Chairman,
General Medical Services Committee

British Medical Association,
London WC1

Withdrawal by HJSC from the Review Body

SIR,—We write as representatives of the junior doctors at the Whittington Hospital who met recently to discuss the Hospital Junior Staff Committee's decision to withdraw from the Review Body.

While not in a position to judge the rightness or wrongness of the HJSC's decision, we are concerned that it was not better communicated to the junior staff whom the committee represents. It appears that at present the links between junior hospital doctors and their representatives are inadequate: we feel it is important that these links should be developed and a proper negotiating structure set up.

We wish to record our provisional support for the HJSC as our representative body for the present but with the proviso that under no circumstances would we be prepared to take strike action in view of the harm to patients that would result. We would be interested to know the opinions of other junior doctors on these points.

MARK DENYER
Chairman,
Whittington Hospital Junior Doctors' Executive

SIMON O FRADD
Local representative of the JHDA

Whittington Hospital,
London N19

Clinical medical officers

SIR,—I note that Dr Shelagh Tyrrell's relentless publicity drive for members of her organisation has now been extended to your columns (28 October, p 1233). It is indeed sad that members of the British Medical Association seem to prefer not to attend local meetings where these issues can be discussed and negotiators briefed, but instead prefer to establish splinter organisations which try to establish their national credibility by criticising

the supposed inadequacies of the Association's concern for their future.

The Central Committee for Community Medicine is very well aware that the considerable voting strength of community health doctors in the regions seems not to have been reflected in the final composition of the committee itself, and one can only speculate on the reasons for this strange irony. The committee has therefore taken steps through its regional machinery to secure the election of a nationally representative group of community health doctors, who first produced a response to the Court Report and who are now formulating principles for the career future of *all* doctors in the community health services. There is by no means unanimity of view among community health doctors nationally, and some regions report considerable opposition to the child health specialist concept advocated by Dr Tyrrell. Since some employing authorities circulated her questionnaire only to doctors exclusively involved in the child health services, the statistics quoted in her letter must be interpreted with some caution. The facts are as follows.

(1) A substantial majority of clinical medical officers do some work in the child health services, but a high proportion of senior medical officers in particular work in other fields.

(2) The Central Committee is determined that any career structure which it negotiates shall be acceptable to the doctors whose future it represents, and it intends to consult widely through its national machinery, which is not exclusive to BMA members, before any agreement is concluded.

(3) At the time of the conference the CCCM was led to believe that the DHSS hoped to finalise agreement in the current year, and that the proposals which the conference was seeking were indeed on offer from the Government. The DHSS has since circulated its own questionnaire and the CCCM now considers the original timetable to be unrealistic.

(4) We have repeatedly urged those with views on career structure to come forward either as individuals or groups to help us in this important task. Very few constructive comments have been received in response to these requests.

Your report of the conference proceedings (29 July, p 376) states, "We seek co-operation, not competition; help, not hindrance; support, not sniping; in the interests of our members." This remains the most certain way to a secure future.

J STUART HORNER
Chairman, Central Committee for Community Medicine

British Medical Association, London WC1

An Irish look at the present consultant contract

SIR,—One wet summer's night in '78 two Irishmen meet casually in a seaside pub. Several pints later they discover common ground. The elder, a rather worn-out anaesthetist, has recently retired from the NHS under the age limit. The younger, a sparkling psychiatrist, intends to do likewise in the spring of '79 but in his case at the remarkably early age of 55. Comparison can be instructive and it is proposed to examine more fully our two friends (respectively Mug and Snug for easy identification see table).

Only part (one-third) of this seemingly absurd result is due to the devastating effects of pay policy. The comparison effectively destroys the widely held belief that the 1948 consultant contract treated all specialties alike from the point of view of opportunities and rewards, a belief expressed yet again by Dr F Hampson (19 August, p 573) in his defence of our present contract. Over and above the variables outlined in the given example there are four categories of merit award and sizable fees also for surgical procedures carried out under the family planning agreement. It must be agreed, however, that the Mark II model before us now, as yet unpriced, from the point of view of the service specialties is altogether a more sinister-looking beast. With precisely the same quantum of circulating cash its engine has been modified to trigger even more of the stuff in the direction of those very practitioners always favoured in the past.

In the footnote to Dr Hampson's letter the Association's secretary refers to special arrangements being sought for the shortage specialties *after* implementation of the proposed contract, and in saying this he thus turns the clock back to the magnificent con job of 1948. What special arrangements? Can they be listed? And if so why are they not set out in black and white in the rules of the new game?

K W BEETHAM

Radiotherapy Centre, Hull Royal Infirmary (Sutton), Hull, Humberside

Pay claims

SIR,—I feel I must write to voice my concern at the developing situation in the sphere of pay policy and pay claims in recent weeks.

It is clear that the unions as a whole totally reject the Government's 5% pay limit and will not be bound by it. I personally would be happy to agree to such a limit but only if other groups of workers do likewise. Since this is unlikely we must press for a settlement (over and above the phased 30% rise of last year, which was only a "reinstatement of differentials") in the region of the current settlements achieved by other groups. It is evident that the use of "productivity deals" in achieving above-average rises is a blatant deceit and trade union leaders have admitted as much. The nursing organisations have tackled this one neatly by claiming special provision for the inability to make such deals! We should do likewise or, alternatively, show

Details of Dr Mug and Dr Snug

	Dr Mug	Dr Snug
Date of birth	1 April 1913 (Londonderry)	1 April 1924 (Dublin)
Qualified	1936	1947
Pre-war and war-time activities	General practice and RAMC (6 years)	Grammar and medical schools (Dublin)
Post-war practice (Pre-NHS)	Trainee anaesthetist (non-superannuable post created for ex-RAMC medical officer	Locums in general practice and mental hospitals in Eire (two years)
Entered NHS	5 July 1948	5 July 1949
Specialty	Anaesthesia	Psychiatry
Peak status	Whole-time consultant anaesthetist	Whole-time consultant psychiatrist
Merit award	None	None
Domiciliary consultations	None	Maximum
Date of retirement	31 March 1978 (compulsory)	31 March 1979 (selected)
Age at retirement	65	55
Purchase of unreduced lump sum (special offer)	Full (by instalments and cash payment)	Full (by instalments and cash payment)
Purchase of added years	None (no funds for cash payment)	None (unnecessary)
War service: purchase of added years (half)	3	
Total service in medical practice before retirement	42 years	32 years
Service in NHS (nearest whole year)	30	30
Total superannuable service (years)	33 (30 + 3)	30
Superannuable service for calculation of NHS pension	33	40 (all years over 20 count double)
Superannuable pay in final (best) year for calculation of pension	£10 897 (basic)	£18 756 (£14 361 basic plus £4395 domiciliary consultations at notional up-to-date rates with effect from 1 April 1978)
Pension (index linked)	$\frac{33}{80} \times$ £10 897 = £4495*	$\frac{40}{80} \times$ £18 756 = £9378
Lump sum payment on retirement	£13 485	£28 134
Paid medical work after retirement from NHS	None (worn out at 65)	Five years' whole-time contract in Australia providing a second pension at age of 60 when he finally retires from medicine (no abatement of NHS pension at any time)

*Increased by 5·5% in December 1978 = £4742.