Earnings of G.P.s and Hospital Doctors

SIR,—The tone of the letter from Professor A. R. Prest (28 July, p. 238) in response to Mr. C. R. Sandison's article in the *British Journal of Hospital Medicine* concerning the earnings of G.P.s and hospital doctors was entirely predictable. The fact is that those of us who are whole-time regional hospital consultants do not need the financial wizards to argue endlessly about the details of our remuneration. We know the size of the gulf that exists between the earnings of hospital specialists and general practitioners, because quite simply many of us have good friends and colleagues in general practice and some of us have general practitioners in our families. It is as simple as that.

The remuneration of hospital specialists is now causing widespread dissatisfaction. The general practitioners are doing very well because they have been organized and unified; consultants will also have to learn this lesson.—I am, etc.

R. D. H. RYALL

Liverpool Regional Radiotherapy Centre,
Clatterbridge Hospital West,
Bebington, Cheshire

General Practitioners' Superannuation

SIR,—Sympathy with colleagues who retired before March 1972 should not prevent a more fundamental appraisal of changes in general practitioners' superannuation. Most doctors who have retired, or who are about to retire, will have spent their entire time in the National Health Service as well-established principals. Comparison of pensions dynamized and not dynamized must produce differences of a high order where the incomes on which the pensions are based are themselves of relatively high order.

On the other hand zero dynamized remains zero, and those whose career in the National Health Service includes a number of low-paid posts might well find little to get excited about. Nearly 18 months after the change in calculating benefits and a year after the increase in contribution rate there is still no announcement on the level of pension accruing from hospital appointments. The acquiescence of the Review Body in the Governments' economic policy has taken the zip out of dynamism. Large numbers of general practitioners are unable to calculate the current worth of their pension rights, and their future worth is even more nebulous.

Despite the predilection of the profession for hurrying slowly, recent correspondence indicates how delay in this type of negotiation can lead to hardship. No doubt advances have been made, but there is little cause for complacency until an equitable and satisfactory scheme has been published in its entirety.—I am, etc.,

PHILIP A. JONES

Redditch, Worcs

Women Doctors' Pensions

SIR,—We did not expect an apology, so honour on both sides will be satisfied with the admission by the Chairman of the Compensation and Superannuation Committee (28 July, p. 237) that the words complained of were only a joke. We are grateful to him for his clear explanation of our pension prospects. Indeed, these look so favourable that we ought perhaps to campaign for those of our male colleagues to be brought to the same level, since it is equal, not preferential, treatment that we are seeking.

We are certainly all behind our negotiators in working for an improvement in the miserable pension that any doctor gets for working in the National Health Service.—I am, etc.,

MARY DUGUID

Wallasey, Cheshire

G.P.s and Management Posts

SIR,—It would appear from the advertisement for the new posts of regional and area medical officer under the National Health Service reorganization (21 July, p. xxxviii) that the Department of Health and Social Security has decided that the humble general practitioner is ineligible to apply for these posts.

This dictatorial development is most surprising in view of the intentions stated in the "grey book"[1] to involve all doctors in management. Certainly pp. 124-127, describing the roles of area and regional medical officers, make no mention of previous public health or N.H.S. hospital administrative experience. As far as I am aware this has been done without prior consultation with either the medical profession or any of the area joint liaison committees.

How can there be equality in membership of area or even district management teams if any G.P. is precluded from exercising his administrative ability by applying for one of these posts?—I am, etc.,

D. A. WOODRUFF SANSOME

Leicester

1 Department of Health and Social Security, *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

Management in the Reorganized N.H.S.

SIR,—Having recently attended a course for consultants and general practitioners on the reorganization of the National Health Service, I feel compelled to ask you to publish my observations in your columns.

There can be no doubt that in the new structure of the N.H.S. an immense bureaucratic machine of full-time officers will be established. These officers will be, at the lowest level, those of the district management team. It must be made absolutely clear to doctors that whatever double-talk is put forward about "consensus management" and so on, the full-time officers (the district nursing officer, finance officer, administrator, community physician, etc.) are in fact in a managerial subordinate position to their opposite numbers at area and regional level. This is, of course, denied by the "grey book"[1] but one must remember that the district officers will be "monitored" by the area team of officers and their promotion will ultimately depend on references made by these, their superior officers. If you realize that, for example, the district community physicians' salary range runs from £5,085 to £7,599, the area community physician's from £7,695 to £9,354, and the regional officers' top rate is £10,248, it must be clearly seen that the district officers cannot allow themselves to be identified as a "source of difficulty" by their superiors.

Such a recognition of fact immediately puts the hierarchical officers in a totally different position on the district management team from that of the part-time clinicians—the consultant and the general practitioner. I suggest that the hierarchical officers will not be able to afford to take a stand against the "guidelines" coming down from on high via their superior officers (whatever the "grey book" calls the area team of officers) and that, in fact, a straight managerial line will be established via the full time officers from the Department of Health and Social Security down to the periphery at district level. The two elected clinical doctors will be in a minority and will be impotent unless they are backed all along the line by a vigorous, vocal, and unified force of the working medical profession who will speak out, not only for themselves but also for their patients who, in the future service as set out, will have to be content with a consumer council arrangement —and we all know how much use consumer councils are!

There is good sense in unifying the N.H.S. but we must constantly watch that the hitherto greatest confidence trick ever perpetrated upon a profession—that is, the "Salmonization" of the nursing profession—is not exceeded by an even greater "con" on the patients and their doctors.—I am, etc.,

A. H. CLARKE

Norwood Medical Centre,
Sheffield

1 Department of Health and Social Security, *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

Points from Letters

Dangers of Corn Starch Powder

Dr. R. HERRERA-LLERANDI (Universidad de San Carlos, Guatemala) writes: Your leading article (2 June, p. 502) on the hazards of starch glove powder is timely. . . . For reasons of economy we looked for a substitute for the commercial preparations and found the the locally grown "yuquilla" or arrowroot (*Manihot sculenta*) fulfilled practically all the requirements. Experimental studies in dogs[1] showed this starch to be totally absorbable, and there was no formation of granulomas even when a mass of 100 mg was placed on the omentum or subcutaneous tissues. No granulomata or peritonitis secondary to our "yuquilla" have been encountered in the 15 years of its use.

1 Herrera-Llerandi, R., *Revista del Coledgio Medico de Guatemala*, 1958, **9**, 254.

Prevention of Hyaline Membrane Disease

Dr. A. E. B. DE COURCY-WHEELER (Mullingar, Westmeath, Eire) writes: I can support the contention of Dr. L. B. D. Courtney (28 July, p. 236) that delayed clamping of the cord after delivery may be important in the prevention of respiratory distress syndrome. When I was a student in the Rotunda Hospital, Dublin, in 1934, we were taught not to clamp or tie the cord until pulsation had ceased, thus allowing a greater flow of blood into the fetus. This practice appears to have gone into abeyance in a number of places due, no doubt, to haste in producing the babies and getting on with the next case.

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