of hypomagnesaemia and hypocalcaemia in infancy is much commoner than had been suspected. Hypomagnesaemia should always be looked for when hypocalcaemia cannot be corrected by the usual treatment. Since plasma calcium and magnesium can now be easily and quickly measured by atomic absorption spectrophotometry there is a good case for asking laboratories serving units for care of the newborn to estimate them both as a routine, even when calcium alone is requested.

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Phase 3 and Beyond

Phase 3 of the Government's counter-inflation policy was approved by Parliament last week. Its writ will run for 12 months from 7 November, and after 18 months of tightly controlled pay rises the latest pay code[1] gives more scope for increases above the norm (7% a year or £2·25 a week, with a maximum of £350 a year) than did the phase 2 code. Can this flexibility help N.H.S. doctors? To find the answer to this was one reason for the B.M.A.'s recent visit to Sir Keith Joseph (*Supplement*, p. 44). The other reason—and in the long term the more important issue for doctors—was to inquire how the Review Body would fare during a continuing statutory incomes policy.

The meeting and the subsequent exchange of letters have done little to lighten a dark and confused scene. While most doctors are prepared to accept a national incomes policy fairly applied, Mr. Walpole Lewin was right to protest to Sir Keith that a policy drawn up for a mainly industrial/commercial context was difficult to apply to N.H.S. doctors, who should be able to have at least as much chance as other people to protect themselves against inflation.

Thus the B.M.A.'s Joint Evidence Committee will be driven to seeing whether any of the many wordy paragraphs in the pay code can be interpreted to give the profession such protection. Premium payments for unsocial hours seem as likely winner, except that in a last minute amendment the Government has blocked this route for those earning more than £5,000 a year. Productivity agreements sound a promising idea; but how can increased productivity in medicine be measured by the industrially-orientated criteria described in seven subparagraphs of the code? Working hours can be reduced outside the pay restrictions but neither the present open-ended hospital nor the general practitioner's contracts lend themselves to this approach. Anomalies in relation to links with other groups will not help N.H.S. doctors, though conceivably they might do so for armed Forces doctors who are linked to their N.H.S. colleagues. Perhaps the most likely avenue for any improvement above the norm is the "flexibility margin" where the pay limit applicable to a group of workers may be increased by 1% of the average pay bill to cover certain changes such as remedying anomalies within a staff structure, holiday pay, and sick pay schemes. New work, and family planning services spring to mind, may also attract additional rewards. The code applies only to net pay; practice expenses are outside its restrictions.

It is relatively easy to apply an incomes freeze or even a policy decreeing a flat rate percentage increase for all. But the more flexible a pay policy becomes the greater the problems in drafting legislation to have the intended effect and to ensure a fair result for everyone. The Pay Board has the unenviable task of interpreting the code and vetting awards. It is at this point that the reality of the Review Body's independence is questionable. Should the profession ask for an award uninfluenced by the code or should it take acount of the Government's policy in its submissions? Can Lord Halsbury and his colleagues make the recommendation they think fit regardless of prevailing economic circumstances and leave it to the Pay Board or the Government to pare the recommendations for reasons of "compelling national interest"?[2] Or should the Review Body clear its proposals with the Pay Board before sending them to the Prime Minister? Sir Keith Joseph has proposed this last procedure.

The Review Body was fathered by a Royal Commission[3] on N.H.S. doctors' and dentists' pay, which had been set up to find a way of avoiding the recurring and often acrimonious confrontations between the professions and successive governments over pay. Despite occasional rough periods Lord Kindersley's Review Body had the confidence of the two professions, who recognized it as a valuable umpire between themselves, the public, and a monopoly employer. Unhappily, arbitrary Government action in 1970 destroyed the Review Body's own confidence in its independence.[4] The members of the second Review Body[5] had barely acquainted themselves with the field of action before Mr. Heath decided an incomes policy was in the national interest. As Dr. J. C. Cameron told the Secretary of State the profession is now uneasy about the Review Body's independence. Sadly, this unease is not entirely attributable to Government action; some of it stems from a feeling that the Review Body itself has adopted a narrow, arithmetic approach to its task—almost reinforcing the Government's incomes policy. Whitehall contains more than enough bureaucracy and doctors will be rightly alarmed at any sign of it spilling into the Review Body machinery.

[1] Statutory Instrument 1973, No. 1785, *Counter-inflation*. London, H.M.S.O.
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[4] *British Medical Journal*, 1970, **2**, 615.
[5] *British Medical Journal*, 1971, **2**, 548.