sary." Another waste of money is the growing tendency to have routine chest x-ray examinations done before even a minor operation such as varicose vein stripping or a hernia repair. This seems unnecessary, as the result of the x-ray examination seldom seems to influence the course of the operation.

One can only hope that some learned judge should soon make a casualty officer legally liable for having subjected a patient to unnecessary irradiation rather than haranguing him for not having had the patient x-rayed.—I am, etc.,

M. C. CONNELL

Northampton

¹ Department of Health and Social Security, *Code of Practice for the Protection of Persons against Ionizing Radiations arising from Medical and Dental Use*. London, H.M.S.O., 1972.

Doctors' Pay

SIR,—Few now argue with the fact that doctors in this country have fallen at least 20% behind in the pay race. Recent awards to other groups make our 12% total over the past two years look absolutely ridiculous. Many groups, of course, such as industrial managers and other professions, have had the opportunity since the ending of stage 3 to correct their own shortfall, but we have to rely on the Review Body procedure. Based on previous experience I would like to make a forecast of coming events.

About the end of November (or later according to *Pulse*) Lord Halsbury will produce his review. Should it be unfavourable to us it will be published immediately. Otherwise the Government will keep it to themselves until the Christmas recess. A fortnight or so after Parliament reassembles, in answer to a question, the Prime Minister will announce that in his view it would be better to deal with the doctors' pay at the time the next review takes effect on 1 April. He will explain with reasonableness that after all this is only a few weeks away. During February and March there will be a period of severe industrial action by those unions concerned with the supply of power and about mid-March the Government will introduce a total freeze on salaries and wages to be followed after a few months by a statutory policy. The Prime Minister will be very apologetic but will explain that of course doctors are not among the lowest paid members of the community and that as they are a loyal and dedicated profession he is quite sure that they will accept the situation.

Is it too much to hope for that, just for once, our negotiators should inform the Prime Minister that unless, as the unions say, there is "money on the table" by November we shall no longer operate the N.H.S.? Have no doubt the money would be there.—I am, etc.,

J. M. LONDON

Redditch

SIR,—Dr. R. D. H. Ryall (12 October, p. 109) demonstrating an attitude that has always perplexed me, urges us to emphasize our poverty to the public and compare our situation to that of our overseas colleagues.

What perplexes me is that we constantly compare our pay and conditions with those of doctors in other countries. What Dr.

Ryall and many others do not realize, including the public thank goodness, is that in other countries we are *not* doctors. (I am excluding underdeveloped countries where it is not possible to exist without one's own Government's support or that of a charitable agency.) In competitive markets such as the U.S.A. or Canada our degrees are hardly worth the paper they are written on. There one must almost completely retrain and sit very difficult examinations before being allowed practise on the open market. (How many readers have seen an American State Board examination paper?) True, it is possible to emigrate to the Arctic circle, but try getting your degrees recognized in Tennessee, Chicago, or Montreal.

In Europe, and no thanks can be offered to the B.M.A. for recognizing and hastening the implementation of the Treaty of Rome's proposals, we are faced with a similar picture. Finland excludes all foreign medical graduates by statute. France, with the exception of two overpublicized clinics for foreign nationals in Paris, also does not recognize foreign medical graduates; it is a technical offence to claim to be a doctor at a road accident in France unless one is a French doctor. The Low Countries have stiff language examinations and prohibitive premiums of up to £20,000 to buy into a practice, from which one must have been offered a job before registration is granted. Germany is overdoctored and Italy boasts one doctor to every 300 people. Spain lacks the legal machinery to admit foreign doctors to work. Sweden and other Scandinavian countries admit a few anaesthetists for work in remoter areas as locums.

We must realize that we are alone, our degrees unrecognized, and in the hands of a monopoly employer, the State. This State monopoly will, with the help of its handmaidens the sociologists and community physicians, erode further the standing and worth of the British medical degree in the eyes of the international medical community, using cash shortage to replace doctors, independent professionals, with State-controlled and State-paid paramedical workers.

Dr. Ryall now wants us to admit we are poverty-stricken so that the status-conscious and greedy British public, which, like all publics from Caesar to Wilson, measures a man's success by his bank balance, can see we are failures. To admit failure is to fail, and to fail is to be a failure. Thus though we have constantly used the non-existent threat of emigration to win the public's support, though there is nowhere to emigrate to, let us not try the role of the beggar on the public or they may rumble the other lie.

I urge all my colleagues to press for early recognition of our degrees in Europe. Only with that recognition of the right to practise in Europe can we have a valid yardstick by which to measure our pay and conditions against the State monopoly.—I am, etc.,

MYLES F. HARRIS

Long Crendon, Bucks

SIR,—I have read with interest the letter from Mr. A. F. Robinson (5 October, p. 48). Though he agrees that disparity exists in the earnings of various hospital consultants because of additional remuneration from domiciliary consultations and merit awards, he wants to justify it on the basis that the

clinicians are in clinical charge of patients after a long and rigorous selective training. The comment regarding differences in professional ability and skill may have been true at the turn of the century but they were probably untrue in 1948 and are certainly not applicable to 1974. The fact is that all consultants have to go through an exacting selection technique used by examining bodies and long, arduous training. The length of preconsultant training may vary by a year or two, at the most, in some more popular specialties because of greater competition. The consultants who stay longer in preconsultant training are duly compensated and are given up to four increments at the time of appointment. Remuneration from domiciliary consultations is not meant to compensate for longer preconsultant training.

Frankly, I do not understand what is meant by "rigorously selective training" and "grounding in the complexities of dealing with the great British public," since general practitioners without such training are able to deal with them. However, most clinicians will agree that they will not be able to stop medical bucks without the help of the "ancillary and subcontractual specialties."

It is my considered view that a system of remuneration which allows a substantial additional sum of money to be earned per year, amounting to 25% of a full-time consultant's maximum salary, and provides better pension benefits for the rest of life for certain groups of consultants is quite unjust and basically wrong in principle. I am sure that the domiciliary system is largely abused and that the occasions when a G.P. really needs assistance and the patient cannot attend the hospital are very few. I do not see any reason why these few patients in need of urgent consultation or opinions cannot be brought to the hospital for assessment. The money thus saved can go towards the improvement in basic salaries of all consultants, as pointed out in the letter from Dr. S. Mehta and others (14 September, p. 690).

Applied consultant egalitarianism will not only solve the problem of recruitment in less popular specialties but also, above all, will help to unite the profession.—I am, etc.,

R. S. NARANG

Wigan, Lancs

A Bad Week

SIR,—I read with great interest the letter by Dr. A. A. Stephen (19 October, p. 169). I fully endorse every point he makes regarding the abuse of the N.H.S. and am greatly concerned about its future.

Though I am a foreigner, my feelings for the welfare of Britain and her people are no less genuine. A few months ago I joined general practice after a year as a trainee. I am appalled by the abuse and the exploitation of the service, probably one of the best in the world, by a considerable section of the population. These people, ill-educated and ignorant beyond belief, are under the misapprehension that doctors, particularly in general practice, should be at their beck and call 24 hours a day.

I have learned from life that, in general, people do not appreciate things for which they do not have to pay. If every patient,

with the exception of old age pensioners and children, had to pay even a small fee for a home visit (including those at night) it would go a long way towards providing better service for those who really require it, in addition to increasing the finances of the N.H.S. It is not unusual for one to do 25 home visits in one day.

I firmly believe, after eight years' stay in Britain, that the alleged deterioration in the standard of health care is not due to importation of ill-trained doctors from abroad, as has been suggested, but to the increasing abuse of the Health Service by the public in general.—I am, etc.,

K. RAGHAVAN

Mansfield, Notts

Trade Union Tactics

SIR,—I was delighted to read in "Round-up" (5 October, p. 57) that the B.M.A. is now officially registered as a trade union. Having grasped this nettle, dare we hope that the B.M.A. will now proceed to behave like a trade union—namely, to obtain the best terms and conditions of service possible for all its members? In particular, it means ensuring that we are adequately paid by our monopoly employer the N.H.S. and also have a realistic level of fees negotiated for non-N.H.S. services. In recent years the B.M.A. has failed in this respect and must have the worst record of any trade union in the country with regard to pay negotiations.

I suggest that what we need is a nucleus of highly skilled and therefore highly paid, possibly non-medical, full-time professional negotiators who would be a match in all respects for the politicians and civil servants of the D.H.S.S. With all respect I do not believe that our present part-time, amateur negotiators are equal to the task, and their recent record would confirm this. There is still a lot of naivety in the profession where politicians and the Review Body are concerned. For proof of this one only has to read recent letters in the *B.M.J.* concerning the fees being offered for family planning services.

The B.M.A. must produce the necessary results, for if it does not there is a great danger of further division within the profession, and that can only be detrimental to us all.—I am, etc.,

T. J. MALLINSON

Tamworth, Staffs

SIR,—Dr. D. Lynch (12 October, p. 109) appeals for non-members to join the B.M.A. and for those who have resigned to rejoin (12 October, p. 109), the idea being to show that we all support our leaders (?) in their negotiations on our behalf. With all respect to our colleague I believe that we should all do just the opposite to what he advocates.

Since the inception of the National Health Service the B.M.A. has shown itself to be singularly inept as the profession's representative in negotiations with the Government. It has been suggested by some doctors that this is because the Association's negotiators have been incompetent and out of touch with reality but I believe that the main problem is that it is difficult, if not impossible, for one panel of negotiators to represent all branches of the medical profession at one and the same time.

All holders of medical qualifications are members of the same profession in broad general terms, but when it comes down to job specification we really form several professions in one. Surely each branch of the profession would do better if they negotiated their own pay and terms of service. Let the Hospital Consultants and Specialists Association represent their own members, the Junior Hospital Doctors Association theirs, and I am sure that the up-and-coming National Association of Doctors in Practice could do more than justice in representing the interests of general practitioners.

Of course, this could only come about if the B.M.A. was stripped of its undeserved power by all members doing as I am doing today, sending in my resignation as a vote of no confidence.—I am, etc.,

ALAN PORTER

Preston, Lancs

Consultants' Salaries

SIR,—Stage 3 is now at an end and the Prime Minister has assured us that there is no need to restrict fair remuneration. Lord Halsbury is now being reappraised on the question of remuneration.

It is hoped that Lord Halsbury will not go back on his word. In his Fourth Report¹ he said or implied two things: (1) that the Review Body must act "as honest brokers between the Government, the profession and the public" and (2) that he could not regard the profession as a "special" case—that is, "of a peculiar or restricted kind" (*Pocket Oxford Dictionary*).

The average rise in remuneration of the population in 10 years has been 160%, whereas that of consultants has risen only 81%. The salaries of ministers of the Crown have risen by 160% and 10 years ago a basic consultant's pay was 89% of that of a minister. The responsibilities of both jobs have remained much the same. Consequently it is a matter of social justice (about which we hear so much) that consultants should have some honest brokering and be treated as others. A minister now receives £13,000 a year + £3,000 parliamentary pay, but I would hope that consultants would feel that they were treated justly if they were to be paid 89% of only the £13,000—that is, £11,646 a year.—I am, etc.,

BRYAN O. SCOTT

Oxford

¹ Review Body on Doctors' and Dentists' Remuneration, *Fourth Report 1974*. London, H.M.S.O., 1974.

Points from Letters

Fainting during General Anaesthesia in Supine Dental Patients

Dr. C. B. BURKE (Hanover, New Hampshire) writes: With regard to the suggestion that fainting in the dental chair due to visceral pooling can best be treated by placing the patient in a steepish head-down position (Dr. J. G. Bourne, 7 September, p. 627) I can only suggest that this position may lead to a reduction in cerebral perfusion due to increased cerebral venous pressure. Also a head-down tilt in the non-intubated patient presents obvious complications.

Sir Albert Cook's Case Notes

Mr. E. P. HOARE (Nairobi) writes: In his interesting article on Makerere Medical School (14 September, p. 675) Dr. W. D. Foster refers to the fine medical library and mentions Sir Albert Cook's own books which are kept there. Particularly noteworthy are the bound volumes of Cook's original Mengo Hospital case notes. Nearly five years ago arrangements were made for these notes to be microfilmed, but for a number of more or less obvious reasons the project has not yet started. . . . Perhaps a fiftieth anniversary offers suitable incentive to preserve the work of a much admired pioneer.

Sheet Anchors and Mainstays

Dr. F. W. S. WEBB (Ipswich) writes: Distinguished land-based professors of rheumatology are fond of referring to the salicylate group of drugs as the "sheet anchor" of treatment for rheumatoid arthritis (Dr. P. Lee and others, 9 March, p. 424)

without apparently knowing much about their anchors. A sheet anchor is the largest and heaviest anchor which a ship carries and is used only in an emergency . . . This description scarcely fits the salicylates and is more apt for the various cytotoxic drugs. To preserve a nautical term "mainstay" would, I think, carry the message better . . .

Swimmers' Ears

Mr. P. MCKELVIE (The London Hospital) writes: In your leading article (27 July, p. 213) it is stated that ototoxic antibiotics should not be used in the local treatment of external otitis. An intact middle ear is surely an adequate barrier to these agents and in any case the threat to the inner ear is far from established even when there is a perforated ear drum.

Overseas Doctors

Mr. R. K. BANERJEE and Mrs. G. BANERJEE (Sunderland) write: In the past few weeks overseas doctors have been successively held responsible for unsatisfactory casualty services, poor communications, practice of sub-standard medicine, falling standards in recruitment of consultants (for example, geriatrics, V.D., etc.), and deterioration of standards in general practice . . . The overseas doctors have become scapegoats and are blamed for all the possible shortcomings in the N.H.S. They are now probably patiently waiting for a person in a responsible position to come out with a statement which would put the blame on them for the high rate of inflation, sexual permissiveness, and poor weather in Britain to complete the picture.