their proposals will be heeded. The profession should unite and understand that with the support of our patients the independence of the profession will be assured and no government can claim a mandate to curtail it.

Perhaps it is not too late for the negotiators to reconsider. Theirs is not the way. This is not the time. Much has already been lost, but if the present militant factions get their way I fear that the profession may be discredited irrevocably.

MICHAEL BLACKMORE

West Moors, Dorset

Consultants and the Government

SIR,—We, the consultant general surgeons of Gloucester, wish to express in the strongest terms our total rejection of the decision of the Central Committee for Hospital Medical Services restricting consultants' work to emergency cases only. We find this concept abhorrent, undignified, and totally unfair to the general public, whose sympathy for our case will be rightly alienated by this action. The presidents of the royal colleges have our support and congratulation on their condemnation of this proposed action.

We are equally in no doubt that the only course for the BMA to take, along with the Hospital Consultants and Specialists Association, is the collection of undated resignations from the NHS. Our opposition to the proposed Government legislation on pay-beds cannot be by any form of strike action or work-to-rule, the effects of which earlier this year were totally disastrous and ineffective. We require firm leadership at this time and the CCHMS appear again unable to give this.

May we as surgeons make a plea that at least our colleagues in surgery stand up and be counted in an endeavour to preserve the dignity which in our profession so badly needs restoring. Present holders of consultant positions are the curators of these positions, and junior specialists in training expect some resolution on our part to preserve these positions as we found them on entering consultant life. Anything less than a clean resignation is a betrayal of ourselves, our juniors, and our patients.

D G CALVERT
M W L GEAR
J O KILBY
W H F THOMSON

Gloucester

SIR,—I wonder if those consultants accepting the call for further selective strike action have really thought out the consequences in terms of the future of the profession.

Until recently most doctors have had the privilege of being highly respected and trusted by the general public in comparison with other occupations because of a certain dedication to their work and a reputation for caring. It is this which makes the job worth while and indeed makes it possible to accept the heavy responsibility of life-and-death judgments that come our way. Without that respect our task would be almost impossible and the advice we give often ineffective because it depends on trust. Yet we are in danger of throwing all this away and there will be no going back.

Of course it may be argued that such action is necessary to prevent deterioration

of standards in the Health Service, but the means do not justify the ends and I am convinced that it can only damage irretrievably our good name. Other ways must and can be found to remedy the situation.

DAVID VULLIAMY

Dorset County Hospital,
Dorchester

SIR,—I am appalled at the present attempt by senior hospital staff to have a show-down with the Government. There are only three possible results.

Firstly, the Government might climb down and permit the continuation of private beds. In this case there will be an outcry on behalf of the other unions representing hospital staff and the in-fighting will continue.

Secondly, the Government will not climb down and the consultants will either have to submit in a humiliating way and withdraw their resignations or press their resignations into effect. Either of these results would mean that 90% of the population who rely on the NHS and have no interest whatever in private practice will be deprived of their hospital medical services. Patients will be unable to return to work because they are unable to have treatment that they need.

There is therefore a need for the third possible result—a compromise. The BMA has pointed the way by inviting the Government to refer the matter of private beds to the royal commission. I believe it requires, as a further concession on the part of the Association, a clear statement of the Association's belief in the future of the NHS, either in its present form or modified, but fulfilling the basic fundamental principle of free medical care for any citizen of the UK at the time of need.

The dispute will have no winners, only losers—our patients.

M J ILLINGWORTH

Alva, Clackmannanshire

Junior hospital staff contract

SIR,—In a leading article in *The Times* (27 November, p 15) it is stated that the hospital junior staff are trying to break the pay code. It is clear that the press in general is creating the same impression. In Cheltenham this is not so. We wish for a renegotiation of the contract and its pricing within the pay code. We believe that the current national proposals (the so-called Oxford proposals) for which industrial action is being taken would, if implemented, break the pay code. In our opinion the problems are two: to achieve a contract with adequate safeguards against possible exploitation by the employing authority and to price it with no or minimal detriment within the pay code.

We think the best solution to the first problem is to have a system of extra payments for hours worked over and above the assessed contract hours. Thus as long as the work load of a contract was assessed correctly by the employing authority such payments would not be necessary. Such a system would minimise the need for a cumbersome and time-consuming appeals mechanism and would also retain the principle of a pay scale based on a fixed contract without the professionally demeaning need for regular overtime claims.

The second problem, which has had far more publicity, is, we believe, soluble, and we also believe that the Government is suppressing this to foster a poor public image of the juniors. During the period of pay restriction the pricing mechanism should be modified so that any pay increases resulting for one group of doctors (that is, those working between 40 and 80 hours) would be very small, and thus the losses thereby sustained by another group (that is, those working more than 80 hours) would be correspondingly very small.

We in Cheltenham have taken industrial action on a number of issues, which include the above two. We think that the above proposals could achieve a solution and should be put to the Government as conditions for withdrawing this action.

P J MILEWSKI

and 10 other members of the junior staff

Cheltenham General Hospital,
Cheltenham, Glos

Dare they resign?

SIR,—As a past member of the Central Committee for Hospital Medical Services and of Council, may I applaud the actions of 20 and 26 November and express the hope that Council will now make provision for measures to come?

In our resistance to tyranny mass resignation is almost certain to be necessary and, to be effective, must be as near unanimous as possible. I know that many members of hospital staffs view the prospect with dread and it is the duty of the BMA to relieve this anxiety as soon as it reasonably can. The responsible officers of the Association should already be preparing and disseminating advice to hospital staff on how to survive a short period of unemployment.

This advice should include a list of "bull" points to be used in convincing bank managers of the justifiability of increasing overdrafts on this account; accompanying assurances should state that pension rights will not be sacrificed and that any future agreement will contain clauses to ensure "no detriment," no victimisation, etc.

I am sure the above action or action on similar lines is essential if we are to carry with us many hard-pressed members of hospital staffs (and their wives and husbands, of course).

H LESLIE LEAMING

Middlesbrough, Cleveland

Fees for family planning in hospitals

SIR,—I note that Dr M P Coplans (8 November, p 349) broadly agrees with the first paragraph of our letter (11 October, p 105), but he is confusing "surgeon's/anaesthetist's" fees with "operation/anaesthetic" fees and is incorrectly relating a general average of the former to a particular of the latter.

It is difficult to determine how much of a surgeon's fee relates solely to that amount of his work which corresponds with that of the anaesthetist, but it is established practice (in agreed fees where the amounts of operation and anaesthetic work are not comparable) that the anaesthetic fee is equal to^{1,2} or greater than^{2,4} the operation fee, reflecting variations in the respective amounts of clinical work involved.

Dr Coplans rightly draws our attention to paragraph 10 of HSC (15) but overlooks that the portion of the surgeon's fee for separate consultation and counselling is defined in paragraph 10 and is nil. The portion of the surgeon's fee for separate postoperative care and follow-up is defined in paragraph 14 and is also nil. The work for those nil fees need not be carried out by the recipient of the operation fee (paragraph 9).

I would suggest to Dr Coplans, the Anaesthetists Subcommittee, the CCHMS, and colleagues in all specialties that they demand that the surgical fee be paid in three parts, not necessarily all to the same individual, as follows: (1) Fee for operation including immediate pre- and post-operative care—equal to fee for anaesthetist's services. (2) Fee for outpatient consultation, examination, and counselling—60% of balance of surgeon's fee. (3) Fee for subsequent post-operative care and follow-up—40% of balance of surgeon's fee.

This professionally honourable arrangement should be agreeable to all and requires no renegotiation of moneys to the unfair benefit of one doctor at the expense of another; it should eliminate the public opinion that half the surgeon's fee is for doing the work and the other half is a bribe for being persuaded to do the work; and it would eliminate the inequity of the gynaecological surgical junior being paid more than twice the fee of the consultant anaesthetist for a lesser amount of work. (In 1974 in this district about 70% of anaesthetics for (female) sterilisations were by consultant anaesthetists, but over 90% of the operations were carried out by junior surgeons.) This arrangement would also defeat the (? deliberately) divisive effect on consultants of Mrs Castle's specialty-differential fees.

I would not pretend to understand how Mrs Castle, in the present financial climate, reconciles her introduction now of these additional payments with her interpretation of the Government's anti-inflation policy.^{5,6}

HAROLD G SAUNDERS

Department of Anaesthesia,
West Lane Hospital,
Middlesbrough, Cleveland

1 Review Body on Doctors' and Dentists' Remuneration. *Fifth Report 1975*, appendix C, para 24, item 5. London, HMSO, 1975.

2 National Health Service, *Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales)*, 1971 (with amendments to date), para 141.

3 National Health Service, *Statement of Dental Remuneration (1973)*, pursuant to Reg 23 of NHS (GDS) Regs, 1973 (with amendments to date).

4 Review Body on Doctors' and Dentists' Remuneration. *Fifth Report 1975*, appendix C, para 24, item 6. London, HMSO, 1975.

5 Shennan, J M, *British Medical Journal*, 1975, 4, 229.

6 Saunders, H G, *British Medical Journal*, 1975, 4, 411.

Failure of communication

SIR,—In reply to Dr E T Griffiths (15 November, p 410), at that time no member of the junior medical staff of the South Gwent District had been approached by the local BMA executive for election to that committee. We have since been approached and have elected one of our members to attend.

B J BRITTON
KP GIBBIN
P D LI EDWARDS

Royal Gwent Hospital,
Newport, Gwent

Points from Letters

A safer antidepressant?

Dr J GRABINAR (London SE6) writes: Viloxazine (Vivalan) is recommended as an antidepressant to replace amitriptyline by Dr C L Brewer (15 November, p 409). . . . The median lethal dose (LD₅₀) for experimental mice, if extrapolated to humans, gives an improbable result. Suppose we take an average 57 kg woman. At 1000 mg/kg of viloxazine she would have to swallow 1140 50-mg tablets to have a 50% chance of dying. Admittedly a similar figure for amitriptyline is 659 tablets; still, these figures are grossly above the usual lethal doses for humans and therefore the animal experiments should be viewed with extreme caution. It would be of more value to record the smallest known lethal dose as a guide to safety margins. In fact, Dr Brewer's own figures elsewhere indicate that the maximum dose of amitriptyline survived is 188 25-mg tablets compared with only 130 50-mg viloxazine (this is the only marketed strength of Vivalan). . . .

Swallowed foreign bodies

Dr T LOUGHNANE (Rampton Hospital, Retford, Notts) writes: I cannot allow to go unchallenged your statement (leading article, 15 November, p 368) that an open safety pin usually sticks in the oesophagus and needs extraction urgently. I have done a research service in a special hospital for a period of some six years on "Understanding of swallowed." During this period three open safety pins were swallowed, one of which was regurgitated some 10 days after swallowing. Another was passed per rectum without any problem but the third, which was possibly opened before swallowing, necessitated operation because it became impacted in the caecum and this operation was performed some six weeks after swallowing. . . .

Deaths in asthma

Dr H HERXHEIMER (London N3) writes: I completely agree with Dr G K Crompton (22 November, p 458) that death in asthma is not due to excessive inhalation of isoprenaline but to the lack of adequate corticosteroid treatment. However, he has not mentioned that this lack is particularly dangerous as patients who inhale isoprenaline aerosol every one or two hours, or more often, rapidly become tolerant to it and thus have no longer any protection from their severe bronchial obstruction. I have referred to this important factor before.¹ Patients should never be permitted to use catecholamine aerosols more often than every three hours.

¹ Herxheimer, H, *Lancet*, 1969, 2, 642.

Site of carotid atheromatosis

Professor ERIK ASK-UPMARK (Uppsala, Sweden) writes: Mr P M Perry and his colleagues (25 October, p 215) . . . state that "the usual site for atheroma in the neck is at

the bifurcation of the common carotid artery extending into the internal carotid artery for 1-2 cm." In my opinion it would be better to maintain that the site is that of the carotid sinus, hence the proximal part of the internal carotid, corresponding to the third bronchial artery during fetal development. The increased distensibility of the arterial wall of the carotid sinus depends on its anatomical structure . . . since it is much more elastic and much less equipped with muscular tissue than the rest of the carotid system. This fits in very well with its function, since the nervous receptors of the carotid sinus are located in the adventitia. On the other hand, this increased distensibility favours the localisation of atheromatosis; such is also the case with the origin of the cranial mesenteric artery, with the occipital artery, and with that part of the coronary system where the movements of the heart tend to bend and extend the arterial wall—that is, in the proximal part of the descending branch of the left coronary artery. . . .

Emergency call systems

Dr FRANCES SORRELL (Greenwich) writes: . . . Ideally, every doctor and nurse may be able to intubate, but in my experience this ideal is not found universally. I consider that intubation should be widely taught, but even if this is done the difference between being able to intubate quickly and merely being trained to intubate may mean the difference of life and death. For this reason I feel an anaesthetist should be on a crash-call team whenever possible. As a rider to this I should like to point out the importance of all doctors and nurses being able to hold a mask firmly on the face and hold the jaw or chin correctly to maintain an adequate airway. This . . . is not as simple as it sounds, especially if both these procedures have to be done with one hand while the other hand squeezes a bag. Yet the ability to do this properly may save a life if nobody present can intubate quickly or if no intubation equipment is to hand. . . .

Top-heavy administration

Dr MYER GOLDMAN (Fazakerley Hospital, Liverpool) writes: The figures given in your Parliamentary report of 22 November (p 475) show that . . . the increase in "doctors and consultants" between 1964 and 1974 was just over 21%, whereas the increase in "administrative and clerical" over the same period was 64.8%. What is more, the 1974 figures have been adjusted to exclude staff formerly employed by local health authorities. If we now include these in the administrative and clerical grades, as shown in your Parliamentary report of 15 November (p 416) the increase in the 11-year period was in fact 87.9%.

Kilopascals

Drs A HOLLMAN and A F RICKARDS (Committee for the Protection of the Millimetre of Mercury, University College Hospital,