Full View of the Road

Sir,—I am writing to congratulate Professor R. A. Weale on his recent account (19 October, p. 149) on the use of tinted filters by drivers at night. Some 98% of the information used by a motorist when driving is received by the eyes. The Department of the Environment, however, argues that the visual standard laid down in 1935 is still adequate for modern speeds and congestion. The effects of asthenopia, field of vision, depth perception, uncompensated extraocular muscle imbalances, poor night vision, etc. seem to be ignored.

The Association of Optical Practitioners has fought for many years to ban the advertising of so-called yellow "night-driving spectacles." Discussions with the British Advertising Association may well lead to an agreement on the use of tinted "heat-absorbing" windscreens, now being seen in increasing numbers, to be regarded as status symbols. The value of this accessory in the United Kingdom is so slight (and can easily be negated by its efforts at newspaper publication) that it is being contested by the manufacturers. Efforts are also being made at local level with consumer groups, etc. After concerted effort by ophthalmologists and ophthalmic opticians in the U.S.A., advertising of night-driving spectacles has been banned.

Similar coordinated pressure in Britain could produce the same result if not more. There is also a growing tendency for tinted "heat-absorbing" windscreens, now being seen in increasing numbers, to be regarded as status symbols. The value of this accessory in the United Kingdom is so slight (and can easily be negated by its efforts at newspaper publication) that it is being contested by the manufacturers. Efforts are also being made at local level with consumer groups, etc. After concerted effort by ophthalmologists and ophthalmic opticians in the U.S.A., advertising of night-driving spectacles has been banned.

It is indeed incredible, with the published data on reduced accidents at night with improved street illumination, that the Department of the Environment stands idly by and allows an increasing proportion of drivers to negate its efforts at a risk not only to themselves but to other night-time road users.—I am, etc.,

A. J. PHILLIPS

Loughborough, Leicestershire

Eye Colour and Oculocardiac Reflex

Sir,—During previous work we suspected that the colour of the eyes could be a factor associated with the presence or absence of an oculocardiac reflex. To confirm this a series of 198 patients having operations for squint were studied. Some of the patients had bilateral recessions or recession and resection, but in all the cases included a recession of the medial or lateral rectus muscle was performed first and the observations were made during this procedure.

The pulse was counted by the counter of a Cardioton and a fall of 10 beats/min taken as the criterion for the presence of an oculocardiac reflex. Children were premedicated with trimeprazine and atropine orally, older children with pethidine and atropine intramuscularly, and adults (over 16) with Cyclomorph and hyoscine. Four shades of eye colour were noted: blue, grey, hazel, and brown. The patient was placed in the appropriate group just prior to induction by a consensus of the nursing staff available (usually two or three persons) under the supervision of any patient who could not be fitted into one of these four categories—for example, with green eyes—was not included in the series. There were very few of these. The findings are presented in the table above.

It is concluded that patients with blue or grey eyes are less likely to show an oculocardiac reflex than patients with hazel or brown eyes.—We are, etc.,

E. N. S. FRY

North Tees General Hospital, Stockton-on-Tees, Cleveland

Consultant Contract

Sir,—I view with great concern the opinions expressed about the Government’s contract proposals (16 November, p. 421) in letters to you and also to me personally by some full-time consultants. It would appear that they are willing to accept proposals which would place their part-time colleagues at a considerable financial disadvantage. These proposals show that the part-timer would receive only 80% of the basic salary, be ineligible for any share in the career structure supplements, and also be at a disadvantage with regard to possible extra sessions. This would surely produce a situation wherein the part-timer might be paid only about half as much as
the whole-timer if we also bear in mind the additional 2/11ths factor to be paid for simply not seeing private patients. The present 18% differential between full and part-time is for an extra work commitment if one takes into account the travel time factor allowed in the maximum part-time contract. It now seems that the Government are only paying for the commitment, surely a most unusual example of distorted thinking. Whatever has become of the concept of equal pay for equal work done?

I would ask those who seem so keen to accept these proposals to consider how divisive they are when professional unity is so important. The proposals would certainly force large numbers of part-timers to go whole-time, albeit unwillingly, thus limiting the choice in the private sector in any geographical areas in Britain. If we fail, no doubt the general practitioners will be the next to be threatened by a salary service. This would be the medical profession being totally under State control, and we would therefore become civil servants with all that that could mean to our professional freedom.

One doubts if many young men and women would want to come into such a system and therefore I feel that our present stand is not, as many seem to think, a matter simply of private beds, but it is the future of our profession and with it the future of the National Health Service itself.

—I am, etc.,

IAN K. MATHIE
North Tees General Hospital, Stockton-on-Tees, Cleveland

Sir,—As one of that large and relatively silent minority of doctors employed in the National Health Service who make up 45% of consultant staff, I would like to put forward some of my views as a full-time consultant.

First of all, the greatest advantage is the clinical freedom to provide the best available service to the patient without having to consider the financial relationship between myself and my patient. My clinical freedom is not in any way undermined as to whether it is more profitable to me to operate on the patient or to treat him conservatively such as would be likely to arise in an item-of-service system. I also appreciate the freedom of not being remunerated on an hourly basis. I am not placed in the position that if I should take a little longer over an operation I would receive additional payment, or if I delay seeing an emergency for half an hour I am eligible for an out-of-hours payment.

There is always a possibility that dedication to clinical work may be exploited and most of us would wish for protection from this. I will never forget the additional work load and perpetual on-call responsibility which fell upon me when a colleague was taken ill. At least if we were substantially remunerated for such additional work load employing authorities would have an incentive to provide relief. I should like a system of off-duty entitlement basically similar to that negotiated on behalf of junior hospital staff and I would only wish to be paid extra when an agreed normal work load was exceeded.

The 1% of hospital patients in private beds generate a great deal of emotion. It seems to me wrong that the treatment of such a small proportion of the population should bring such disproportionately high rewards to a minority of consultants and that so many others should try to emulate their more successful colleagues in private practice. If the N.H.S. is to attract the best of the profession to devote the whole of their energies to the Service the Department of Health must pay them to do this. I cannot see why a total commitment payment should in this context be termed a bribe unless it is done for the purpose of furthering a particular political ideology.

Merit awards, to most of our minds, seem a most unseemly purpose if we do not have one. Surely payment for merit should be attached to posts which demand merit to fulfil them. The profession would be in a position to compete for such senior posts in an open market. Such posts would be available in every district and the definition of seniority would cover the additional clinic, research, and administrative responsibilities of such posts.

I would ask for a substantial basic salary which does not have to be made up by additional payments to any great extent. Politicians and the public are not deceived by a remuneration which is made up of many different items, they all know about “overtime” and “bonus.” A factor which must act to the detriment of the consultant starting at the bottom of the salary scale is the public image of the consultant earning up to £16,000 a year. With this image in front of the public how can we expect the support of the country in an improvement of the profession’s claim for more remuneration? There must be a reduction in the differential between the lowest and the highest paid members of the profession if the lowest are to get anything worthwhile.—I am, etc.,

J. F. PATRICK
Rehabilitation Department, Pinderfields General Hospital, Wakefield, Yorks.

Sir,—The following motion was passed at the last meeting of the Executive Committee of the Lewisham Division of the British Medical Association.

“The Executive Committee of the Lewisham Division of the B.M.A. express their full support for any sanctions that the consultants may use in their struggle for a just contract.”—I am, etc.,

A. H. W. BAIN
Hon. Secretary
London S.E.6

Sir,—One of the causes of the long waiting lists for admission to N.H.S. hospitals in some areas has been the closure of wards owing to the lack of cleaning staff. MIGHT I suggest that an urgent priority for our employers should be to prevent the diversion of our skilled manpower into private work outside the N.H.S.? To this end these admirable ladies and gentlemen should be asked to sign a contract of employment committing themselves to full-time N.H.S. work and undertaking not to work for any private employers in their spare time; and those who decline to sign such a contract should have their N.H.S. wages reduced.

This would solve the problems facing the N.H.S. at a stroke.—I am, etc.,

M. J. LOCKWOOD
Andover, Hants

Common Approach

Sanctions

Sir,—Like other consultants I may soon be asked to take industrial action in support of the profession’s claim for more remuneration. It is my intention not to take such action for the following reasons.

(1) Working to contract (that is, 11 x 3½ hours per week) will limit my freedom to work to a variable time-table according to patient needs and my own convenience. This freedom I consider a valuable and necessary privilege earned by “continuous responsibility.” We already bear demands to “clock in,” and working to contract will support those who wish to see us regimented.

(2) Working to contract may increase surgery, waiting lists but only for benign conditions. I presume cancer will still be called urgent as it was during the ancillary workers’ strike. How sensitive is the Government to large waiting lists for hernias or varicose veins, or even painful hips? If I, as a physician, see fewer outpatients there will be no epidemics of death or disability such as may follow interruption of water and sewage services. Remember how few private patients I have seen, which does not mean consultant care but remember also that in certain cases our work is too important to be interrupted by strikes. Some patients die or get near to death while awaiting consultant care which could prevent it. Moreover, much of our work is directed to preventing illness—for example, by treating hypertension or diabetes. Our opponents will not be influenced by an increased incidence of vascular disease in 10 years’ time.

(3) We already regret the decreasing continuity of patient care. This tendency will be aggravated if consultants adopt a clock-watching attitude or even appear to do so.

(4) The B.M.A. Secretary has written “It is sad that sanctions are bound to cause inconvenience to patients.” This remark