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THE GENERAL PRACTITIONER AND HIS RECORDS EXPERIENCE WITH A FAMILY RECORD FOLDER

BY

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There are many ways of emphasizing the family rather than the individual as the most important unit of medical care, and of underlining the fact that it is the general practitioner who is in the best position to use family information to good effect. One practical step in this direction is to base the doctor's own records upon the family rather than the individual.

As part of an extended programme of operational studies in general practice* a small rural practice was equipped with a new record system in September, 1954. This note describes briefly the reasons for the experiment, the type of record folder which was chosen, and something of what has been learned from its use during the last year.

Need for Family Records

The concentration of so much of the general practitioner's work upon a relatively small proportion of his registered patients has made it possible in the past for doctors with small lists to rely largely upon memory to build the health histories of the families in their care. However, a practice of 3,000 individuals may well have some 1,200 families represented, and, in spite of the concentration of work, memory alone may be inadequate. Even with a patient's record card before him the busy general practitioner will have difficulty in remembering all of the family problems, of which but one part is presented by this particular case, and which are often relevant both to diagnosis and to treatment. In consequence he may not be able to consider the problem in the light of the family health and social history, and the quality of his care may suffer as a result. With the increasingly technical nature of much of his information about his patients, even the small-list man can no longer rely upon his memory, and cross-reference to the records of other members of the family or to summaries of hospital reports is becoming a necessary part of family practice.

The matter gains urgency from the rapid growth of group practice. More than ever is it likely that several doctors will treat the same family, and when this happens a summary of all the family notes will help them by supplying

*These studies were made possible by a generous grant from the Northern Ireland Hospitals Authority.

immediately the full context of the illnesses which they encounter.

Few doctors will miss the significance of the remark which occurs so often at the end of a visit to the patient's home: "And while you're here, doctor . . ." This may serve as a prelude to a request for assistance which is not regarded as serious enough by the family to warrant a special visit to the doctor. If he can spare the time it may give him a chance to practise some preventive medicine, or at least to assist in the health education of the family. Records of these consultations are of value, but they are rarely kept, because if clinical notes are carried at all they are those of a single patient and not of a whole family.

Record Folder Used

If we apply these notions to the design of general practitioners' clinical records we can guess that the ideal arrangement would bring together all the information about a family in one easily found, portable, tough, and none too costly folder, at the same time complying with the law by retaining the individual record card as its basis. Such a folder should contain a summary of family problems, records of laboratory reports and letters from consultants as well as copies of the letters of referral to hospital. Here, too, would be found space for filing of substandard radiographs, E.C.G. films, and reports from health visitors, school clinics, and others concerned with the health of the family. At present most of this material is tucked away, folded loosely in the medical record envelopes, where a chronological order is impossible and where it often hinders rapid reference to the case notes.

Of several ways that can be used to bring family records together the simplest and most commonly encountered is the rubber band which binds the medical record envelopes of all members of a family together. Although this is a time-saving device of some value, summary material is not easily dealt with. Other methods are more complicated.

The "concertina" type of folder is essentially a four-pocket pouch with a flap cover bearing the family name and address. It is of the type recommended by the Cohen Committee as a method of dealing with *individual* record cards. The four pockets carry the medical record envelopes or the continuation cards of the male and female members

of the family, with letters and summaries of family information, each in a separate compartment. It has the advantage of fitting standard medical record envelope cabinets, but the disadvantage of being costly, cumbersome, and not so easily scanned as a folder. It was rejected on these grounds.

Several quarto folders were designed, and others now in use were inspected and their value and cost estimated. Eventually the practice was equipped with the simplest of these, a quarto folder (Fig. 1) carrying two pouches for

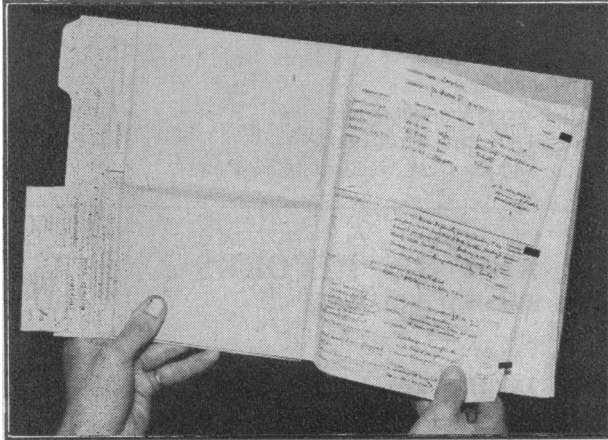


FIG. 1.—The quarto family record folder, showing summary page and pockets containing the standard medical record cards in use.

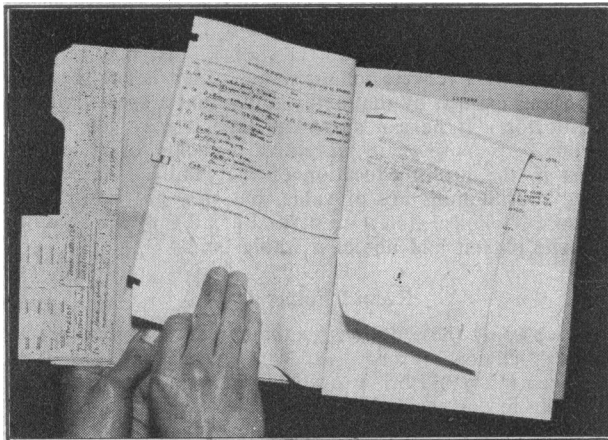


FIG. 2.—The quarto family record folder, showing summaries of hospital and pathological findings and the filing of letters.

medical record envelopes, a summary page for family information, and a treasury tag for the simple chronological filing of letters. Fig. 2 shows one of the many different ways in which the pages may be arranged to give quick and easy access to the principal family problems and to recent hospital reports. The particular folder which was chosen carries coloured metal indicators to assist filing and to show where action is most needed.

What has been Learned

In this general practice the filing of medical record envelopes by family rather than by individual has proved a valuable experiment from several points of view. For example, this step by itself saves time in the surgery, for there are, of course, rather fewer than one-third of the usual number of files in the filing cabinet. Again, this method of filing has been found particularly useful when more than one member of a family consulted the doctor at the same time.

Of the different ways in which to keep the medical record envelopes of a family together, a quarto family folder has some advantages which we believe outweigh the disadvan-

tages of the cost of the folders (about 1s. 6d. each) and of the filing cabinets necessary to house them. Firstly, there are the practical advantages of access to letters and reports about the family. This material, since it is mounted on a treasury tag at the back of the folder, is in a chronological order along with the copies of letters sent out from the practice about the family. It is our experience that such a method of filing correspondence is a great advance upon the more usual method of keeping it loosely arranged and folded in the medical record envelope. Secondly, the use of a summary page has been found an invaluable *aide-mémoire* as well as a method of drawing attention to the vulnerable family or to the family particularly threatened. A preventive approach to family problems is thus facilitated. Thirdly, chronological records of pathological and biochemical examinations are essential if trends in the disease pattern are to be observed, and summaries have been found to assist this process. Finally, the use of a family record folder itself serves in a small way to impress the practitioner with the interrelations of family health problems.

Scottish News

GENERAL PRACTITIONERS AND THE HOSPITAL SERVICE

SCOTTISH SCHEME

Following discussions between the Joint Consultants Committee (Scotland), the General Medical Services Subcommittee (Scotland), and the Department of Health for Scotland, the Department has issued a circular on the policy which these bodies have agreed should be followed to encourage practitioners to combine hospital work with general practice. While it is not expected that at first any great number of hospital posts will be suitable for combination with general practice, nevertheless it is thought that even a few openings of this kind would be of real value to the hospital service and to general practice.

The intention is, firstly, that a training scheme combining at the same time experience in general practice and hospital work should be offered to doctors who have completed the pre-registration year or National Service. Secondly, that entry into general practice on a part-time basis should be made easier for those who have reached the level of registrar but who have decided not to devote the whole of their career to hospital and specialist work.

Combined Training

The basis of the scheme is that a practitioner accepted for training should work for approximately half his time in hospital as a senior house officer or registrar, according to the needs of the particular hospital, and the other half as a trainee assistant in general practice under an experienced practitioner approved for the purpose by the regional selection committee. The training period should be two years.

So far as possible the trainee would spend half of each day in hospital and the other half outside. But modifications to suit local conditions might be necessary: for example, alternate months, or even alternate periods of up to one year, might be spent whole-time in hospital and in general practice. Since the trainee will have to be an effective member of the hospital staff, the latter type of arrangement would be practicable only when two trainees are simultaneously employed, exchanging between general practice and hospital so that there would always be one in each field.

There would be a tripartite contract between the hospital, the training practitioner, and the trainee, covering the whole period of two years. If the hospital post is that of senior house officer, the trainee would receive £745 for the first year and £775 for the second; if it is a registrar post, the first year's rate would be £775 and the second £850. The

training practitioner would be entitled to the usual £150 training fee and £150 (maximum) for additional car expenses, in each case spread over the two-year period.

Part-time Practice

For practitioners who have completed their appointments as registrars, openings, the circular states, should also be sought for part-time employment in general practice as a partner (probably after a preliminary period as assistant with a view) combined with part-time employment in hospital in any of the recognized hospital grades (including the "general practitioner" grade under paragraph 10(b) of the Terms and Conditions of Service). In such cases the remuneration for general practice would be a matter entirely for the practice in which the practitioner participated, and no question of a consolidated payment covering both forms of employment would arise.

Administrative Arrangements

On the administrative procedure to be followed in filling combined appointments, the circular stresses that this should be a matter for those familiar with local conditions. This means, it states, that hospital medical staff themselves, acting through medical staff committees, where these exist, and after preliminary consultation with the appropriate local medical committee if desired, should make it their business to consider what particular hospital posts might suitably be filled by trainees and by part-time practitioners. It might be appropriate to employ two part-time officers in one whole-time post. The local medical committee, with the hospital staff, should decide whether such openings in the hospital service could be linked with complementary opportunities in general practice of the appropriate kind.

When complementary openings in hospital service and general practice are identified in this way, recommendations should be made by the hospital staff to the hospital board concerned, and by the local medical committee to the executive council. When the board and the council have accepted the recommendations, the board will advertise the vacancy, and associate the practitioner or practitioners concerned (as trainer or potential partner) in the selection of the successful applicant.

LEGAL AID CASES

FEES FOR EXPERT EVIDENCE

Regulation 14 (4) of the Legal Aid (General) Regulations, 1950, allows the Law Society to give general authority to solicitors acting for assisted persons in any particular class of case to obtain a report or opinion of one expert, and to tender one person's expert evidence. If this authority is given, the Law Society is to state the maximum total fee to be paid. Pursuant to the power conferred on it by this Regulation, the Law Society has given a general authority to solicitors acting for assisted persons in proceedings for damages for personal injuries to obtain a report or opinion of one medical expert at a fee not exceeding £3 3s. and to tender one medical expert's evidence at a fee not exceeding £15 15s. for the first day (£10 10s. for half a day or for any subsequent day) and his proper expenses for attending the hearing.

Fees Open to Arrangement

The Regulation quoted above, and the action which the Law Society has taken under it, refers only to fees which the Law Society will pay out of the legal aid fund or which can be recovered by a successful litigant (having a civil aid certificate) on taxation of costs. It is pointed out that no medical practitioner is bound to assist in a case as an expert witness for these fees. It is always open to any practitioner *before* becoming involved in a case to make a bargain with the solicitors whom he is assisting, or their client, as to the amount of his fees. But this bargain should make it clear that he will be entitled to receive his fees irrespective of whether the legal aid fund will pay this amount or whether

it can be recovered from the unsuccessful opponent. Unless a special bargain is made a medical expert witness who does appear in one of these cases will not get more than the maximum fees stated. Therefore to avoid any subsequent misunderstanding the doctor would be wise to make his bargain when he is first approached by the solicitor.

WAS IT A DRUG?

Regulations 16 and 17 of the National Health Service (Service Committees and Tribunal) Regulations, 1948, provide that where a practitioner prescribes under the National Health Service preparations which are not drugs or medicines, and therefore outside the scope of the Act, the executive council may recover their cost from him. If he challenges their action, the matter may be referred to the local medical committee, with the possibility of appeal to referees.

The findings of the referees in two recent appeals under the Regulations are reported below. The decisions in these, as in all cases, are related to the circumstances of these particular cases only and are not binding on the referees who may hear other cases.

"Fli-flap"

Dr. Y prescribed 4 oz. of fli-flap for a patient suffering from alopecia on the greater part of her scalp. The matter was referred to the local medical committee, who decided that this was a drug which the executive council was bound to provide. The Minister then referred the matter to the referees.

Mr. Z, appearing for the Minister, said that, further evidence having been produced to the Minister, he did not desire to proceed with the reference.

The referees decided that this fli-flap was a drug which the executive council was bound to provide.

"Casilan"

Dr. Z prescribed 8 oz. of casilan for a patient suffering from senility, cachexia, severe anaemia, dysphagia, oedema, and depleted protein reserve. The executive council decided that this casilan was not a drug which it was bound to provide. Dr. Z appealed to the local medical committee, who upheld the decision of the executive council. He then appealed to the referees.

The referees said that it had often been held that the absence of salt from casilan could be regarded as a medicinal character when a high-protein diet was essential but salt was dangerous because of oedema. This was just such a case. It was argued on behalf of the local medical committee that since Dr. Z also mentioned senility, cachexia, severe anaemia, and dysphagia he could not really have meant the casilan to be used for the treatment of hypoproteinaemia and oedema. The referees did not accept this argument. They thought that the prescription of casilan should be regarded in relation to the diseases for which it was appropriate. Other remedies might have been prescribed for the other ailments.

The referees decided that this casilan was a drug which the executive council was bound to provide.

MINISTER RECEIVES T.U.C. DEPUTATION

The Minister of Health on March 1 received a deputation from the Trades Union Congress. It is said that there was full and frank discussion on, among other things, membership of regional hospital boards, boards of governors, and hospital management committees; Health Service charges and travelling expenses of hospital out-patients; development of health centres; and the miniature mass radiography service. The Minister promised to consider the points raised by the deputation.

MEDICAL PRACTICES COMMITTEE**AMENDMENT OF CLASSIFICATION OF AREAS**

The following areas have been reclassified by the Medical Practices Committee as "designated":

Cheshire.—*Crewe and Haslington (subdivision "A" of Crewe and Nantwich).

Lancashire.—*Irlam.

Middlesex.—Borough of Hendon: *Burnt Oak Ward.

Northamptonshire.—*Corby (including Greast Easton).

Nottingham County and City.—*Carlton and Netherfield.

Birmingham.—*Harborne.

Monmouthshire and Newport.—*Urban District of Bedwelty.

The following areas have been reclassified as "intermediate":

Buckinghamshire.—Marlow.

Cheshire.—Greasy (subdivision "D" of Hoyle and West Kirby).

Derbyshire.—Urban District of Heanor.

Essex.—Borough of Barking: Urban District of Hornchurch.

Hertfordshire.—Urban District of Stevenage.

Lincoln (Lindsey).—Borough of Scunthorpe.

London.—Borough of Woolwich: Middle Park, Horn Park, Eltham Green, and Sherrards Wards.

Salop.—Wellington Town.

Worcestershire.—Oldbury; Cofon Hackett and Rubery.

Yorks (West Riding).—Urban District of Meltham; Urban District of Dearne.

Leeds.—South-west Division.

The following areas have been reclassified as "restricted":

Buckinghamshire.—Langley, Wexham Court and Stoke Poges (Slough and Cippenham District).

Kent and Canterbury.—Rural District of Sevenoaks (except Otford and Shoreham).

Sussex (West).—Urban District and Rural District of Crawley.

Carmarthenshire.—Pontyberem and Pontyates.

S.H.M.O.s' CLAIM

The Association's claim for increased remuneration for senior hospital medical officers (*Supplement*, February 18, p. 54) will be heard before the Industrial Court on April 11. The B.M.A. has briefed counsel to present its case.

**NEGOTIATING COMMITTEE
COUNSEL TO BE BRIEFED**

A meeting of the Negotiating Committee which is to negotiate the claim for increased betterment for general practitioners and hospital medical staffs was held at B.M.A. House on March 7, under the chairmanship of Dr. A. TALBOT ROGERS. The meeting was attended by Professor R. G. D. ALLEN, Professor of Statistics in the University of London, and Mr. N. Leigh Taylor, Solicitor to the British Medical Association.

The Committee gave preliminary consideration to the preparation of the joint claim and authorized the use of the services of Counsel in the drafting of the statement of claim. It was decided that the representation of the public health medical service on the Committee should be increased by the inclusion of two additional members to be nominated by the Public Health Committee of the B.M.A.

The following is the present membership of the Negotiating Committee:

Professor Ian Aird, Sir Russell Brain, Bt., Sir Harold Boldero, Dr. J. D. S. Cameron, Dr. T. Rowland Hill, Mr. Charles D. Read, and Mr. T. Holmes Sellors (representing the Joint Consultants Committee); Dr. A. Beauchamp, Dr. H. Guy Dain, Dr. A. B. Davies, Dr. F. Gray, Dr. A. Talbot Rogers, Dr. C. J. Swanson, and Dr. S. Wand (representing the General Medical Services Committee); and Dr. J. B. Tilley (representing the Public Health Committee).

The Chair will be occupied alternately by Sir Russell Brain and Dr. Talbot Rogers.

Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Doctors' Remuneration

SIR,—I have been reading with interest the letters and statement from Sir Russell Brain and Dr. A. Talbot Rogers (*Supplement*, February 11, p. 44), and also the replies from other members of the profession to this question of increased remuneration. I have also had the opportunity of listening to a very excellent talk by Dr. D. P. Stevenson recently in Bournemouth.

I cannot help feeling that a lot of the objections raised by various members of the profession to a claim for increased remuneration are missing the point completely. They seem to forget that we joined the Health Service on the assurance by the Government that the Spens recommendation would be the yardstick by which our remuneration would be gauged. This yardstick was applied to begin with and then has been continually forgotten by the Government and various members of the profession, including, I am sorry to say, the Royal College of Physicians of Edinburgh (*Supplement*, February 18, p. 55). I cannot help feeling that the members of the Edinburgh Royal College are sitting behind very nice merit awards and would be embarrassed by any increased remuneration, and that is one of the reasons why they dissociate themselves from this claim, which is a just claim and one which is made in the spirit in which it was intended—namely, adjustment in pay based on the cost of living. This was agreed to by all at the inception of the Health Service, and, so far as I know, has never been abandoned by anyone in the profession.

If we fail to make this claim now, I feel certain that the Government will be only too delighted to abandon Spens for good and all, whereas it must be plainly clear to everyone in the profession that, unless we get back to some yardstick such as Spens, we will be lost in the various claims made by other professions for increased remunerations based on the cost of living.

Since the Danckwerts award for 1950, the cost of living has increased by a further 30%, and at no time have the consultants' fees reached this figure. The most the consultants appear to have reached is 60%, and the award made to them in 1954 was only a partial adjustment, not based on Spens, but to try to rectify the differentials between the general practitioner and the consultant. Now, I am glad to say, we can go forward together and make this claim, but, unless the full support of the medical profession is forthcoming, obviously the claim will founder in the usual way, which will delight, no doubt, the College of Physicians in Edinburgh.—I am, etc.,

Parkstone, Dorset.

J. R. HINDMARSH.

SIR,—A sign of true personal greatness is the ability to achieve a detached vision on the vicissitudes of this life. Politics, religion, fashions, financial crises, and many other factors in this complex structure of civilization may deviate us from the truth. A privileged young man, a member of a partnership surrounded by co-operative colleagues, working amongst decent people in pleasant environment on the outskirts of Birmingham, samples the quintessence of a general practitioner's life. However, neither my neighbour, Dr. Deryck C. Artingstall, nor I should fall into the danger of measuring the lot of other doctors by our own yardstick.

Dr. Artingstall asks (*Supplement*, March 3, p. 71): "Should not our aim be toward a greater economic and cultural equality?" It is surely an ill-chosen and confused conjugation of thought for a single sentence. In the last ten years "it has of necessity meant that the differential between the medical profession and other groups has narrowed." Surely in some cases the differential has greatly widened—e.g., law, accountancy, industrial management,

and dentistry. Why does Dr. Artingstall pick upon his own profession to lead unbridled to the sacrificial slaughter? Moreover, does he honestly also believe that culture can be equated thus? Always doctors and their families have been leaders in the cultural life, and this has often called for economic sacrifices. If the down-levellers have their way, the only method to get, for instance, culture from travel will be to join one of the many political parliamentary or local government official visits overseas.

It is sad to read that my neighbour, as a medical practitioner, does not render any greater service to the community than the teacher, sanitary inspector, or the health visitor. I suggest he pulls up his socks. From the earliest of recorded history the desire for doctoring has been present. From experience it does not seem that the demand has diminished. Furthermore, of course, a good doctor is, in part, a teacher, sanitary inspector, and the health visitor.

Perhaps all this is a matter of opinion. However, I do know that many of my less fortunate colleagues are in desperate financial straits. Often it is difficult for them to acquire the necessities even for their professional life. Now Dr. Artingstall expects us to forgo our traditional privilege, which, for a cultured doctor, is an accepted traditional responsibility.—I am, etc.,

Birmingham, 26.

J. D. LACON.

SIR,—I am sure the majority of doctors were delighted to read your exhilarating leading article (*Journal*, February 11, p. 336) regarding the new negotiations for an increase in our remuneration. As a surgical registrar I express the views and experiences of junior hospital staff. We welcome the announcement, and are most relieved to know that we may soon receive a salary in keeping with our past training, present duties, and responsibilities.

The B.M.A. deserves our deepest gratitude, but let there be no mistake; let it be a forceful and determined policy adopted this time. I would like to endorse the very sound views expressed by Dr. E. A. Humphrey (*Supplement*, February 25, p. 64). Unfortunately, recent letters from some general practitioners indicate there are a few in our midst who are most content with their own financial security, and appear to have little regard for the many less fortunate. Surely this clearly indicates how lamentably out of touch they are with the present very low standard of living forced upon registrars, house officers, and their families. The B.M.A. needs the whole-hearted support of all doctors in its efforts to procure an adequate salary for the underpaid sections of our profession. When these increases materialize there always remains the opportunity for individual non-supporters of the claim to decline their own share.—I am, etc.,

London, W.9.

N. H. HARRIS.

SIR,—I entirely agree with the letters of Drs. M. Sheridan, E. A. Humphrey, A. Wattison, and C. Dowding (*Supplement*, February 25, p. 64). The Royal College of Physicians of Edinburgh may be making a gesture deserving the highest praise, but this is not the time to do it, when many of their humbler colleagues among general practitioners are finding it exceedingly hard to make both ends meet, owing to the rise of the cost-of-living index since the Danckwerts award.

In my opinion, only a really strong Government measure to apply to all classes of society—pegging wages—can stop the tendency to inflation. In which case prices would stabilize and start to drop, and also in which case doctors as well as all other workers would not require rises in pay. Until this does happen it will be essential for remuneration to increase with the cost-of-living index. And a gesture from a small minority such as the medical profession would be wasted nobility and would only make us ludicrous in the public eye.

When untold millions of money are being spent on the armed Forces and modern weapons, all designed to destroy human life, surely it is at least as important for the Government to safeguard the financial well-being of a body of men and women whose life-work is dedicated to preserve human

life? How can medical men and women give of their best if they are denied the blessing of peace of mind? In any case, the lessons of the past must have showed us that it simply does not pay to go on behaving like little gentlemen and ladies in the hard world we live in now.—I am, etc.,

Newton Ferrers.

G. N. FOX.

SIR,—Now that we are at last entering the lists for a wages increase, is it not opportune and reasonable to seek a revision of the maximum list? In these days of high-pressure medicine and crowded surgeries, the present ceiling of 3,500 patients is ridiculously high and does not square with the stigma of unemployment in the profession.—I am, etc.,

Luton.

W. D. HOSKINS.

SIR,—Dr. Hugh Mannington's case for increased remuneration for G.P. hospital sessions (*Supplement*, March 3, p. 73) is unassailable. Discrimination has gone on for far too long against this increasingly vital grade, which, for some reason, has been excluded from every salary increase awarded to every other branch of medical practice over many years past.

In some specialties where the S.H.M.O. grade has been abolished and where there is lack of recruitment at registrar level, the clinical assistant grade is being more and more widely utilized for the maintenance of junior specialist staffing, the occupant being often a fully trained ex-registrar. In such cases the clinical assistantship may well have to provide the main source of income. There is no scale of increments for length of service, and financial hardship is bound to prevail.

It is relevant to contrast the case of general-practitioner members of industrial injuries medical boards, who need possess no special qualifications or training and are now to be remunerated at the rate of £3 3s. for a session of approximately two hours. How, then, can the long-continued freezing of the clinical assistant's pay at £3 7s. 3d. for a nominal three and a half hours session (often exceeded by the exigencies of swollen out-patient attendances) be justified?

The position is surely ludicrous and has been tolerated for far too long. I suggest that clinical assistants everywhere should, through their local B.M.A. representatives, press for immediate action to redress this unjust state of affairs.—I am, etc.,

Wolverhampton.

H. W. CHADFIELD.

SIR,—Any increase in our remuneration can be safely left, I hope, in the care of our negotiating committee. I do feel, however, that the time has come to alter our quarterly payments to monthly, with a final adjustment at the end of each quarter.—I am, etc.,

Sunderland.

HENRY F. GOLDMAN.

SIR,—I would like to reply to the letter of Dr. Deryck C. Artingstall (*Supplement*, March 3, p. 71). He says "it would be an unjustified contention that the medical profession renders any greater service than the sanitary inspector, the health visitor, or the teacher." I suggest there is no comparison. No man in this country works the 24-hour day, 7-day week of the doctor, or carries his enormous responsibility of life and death to the community. These good people finish at tea-time. To us that is just half-time. Surely Dr. Artingstall has an evening surgery, often puts in a round of visits after that, and is out again often in the night seeing all sorts of emergencies. Quite apart from the very responsible nature of our work, if he takes the trade union attitude of "overtime," we are entitled to extra financial reward for the very long hours of duty. In the country we have also to contend with fog, icy roads, and the usual hazards. Some places are approached only by a track, and it is quite easy to go over an edge and get killed. I am not complaining—just pointing these things out.—I am, etc.,

Meole Brace, Shrewsbury.

ALBERT E. NICHOLLS.

SIR,—We note with interest that the Joint Consultants Committee and the General Medical Services Committee propose to put forward a claim for an increase in remuneration on behalf of doctors in the N.H.S. This proposal has been widely supported by the profession, but there has not to our knowledge been any expression of opinion as to the manner in which any increase that may be granted should be distributed. In our view, this matter is of at least as great importance as the actual amount of the increase. In particular, we would point out a simple increase in the capitation fee would not constitute an equitable method of distribution of any increase in general-practitioner income, for, while there is undoubtedly a case for increasing the earnings of the lower income groups, those who would benefit most from a simple increase in the capitation fee would be those with the biggest lists, who are least in need.

In our opinion, a satisfactory remuneration scheme for general practice should fulfil the following conditions: (1) Account should be taken of the very much higher ratio of expenses to income of the small practice. (2) It should not be more profitable for a principal to employ an assistant than to take a partner. (3) The drop in income on taking a partner should be reduced or eliminated. (4) It should be possible for an adequate income to be earned without allowing the maximum list to exceed a level at which good medical care can be given.

We consider that the recommendations of the Working Party did not go sufficiently far towards attaining the above objectives, and that advantage should be taken of the present opportunity to review afresh the distribution of the central pool. Entry into practice is still as difficult as ever, and relatively few new partnerships are being offered. We believe that the above conditions could be largely fulfilled within the present framework, and, while we do not wish to put forward any particular scheme to the exclusion of other possibilities, we should like to offer the following suggestion for discussion.

Our proposal is that a large capitation fee should be paid for, say, the first 1,000 patients, and the capitations reduced at successive stages in the size of the list; at the same time the maximum list should be reduced from 3,500 to 3,000 patients. The principle of "notional loading" for partnerships should be retained. Such a scheme would assist the small-list practitioner by bringing him the benefit of a large capitation fee in respect of his first 500 patients, who are at present excluded from the loading. At the same time, the single-handed doctor whose list was approaching the maximum would find it easier to take on a partner. The actual capitation fees required could be worked out at a later stage, when the amount of the increase in the pool is known and consideration has been given to the various expenses ratios of different sizes of practice.—We are, etc.,

H. P. HILDITCH.

A. C. J. SAUDEK.

London, N.W.6.

Maternity Medical Service

SIR,—Now that remuneration from the National Health Service is to be reconsidered, the time is ripe for revision of the fees and the rules of the maternity medical service.

Some G.P.s to-day, conscientiously practising domiciliary midwifery, do so much more work than is laid down by the rules that the fees of the maternity service are ludicrous. On the other hand it is possible to receive £7 7s. per confinement for totally inadequate maternity care. Maternity service should include not less than six antenatal examinations, personal supervision of labour, at least three visits in the puerperium, and one or more post-natal examinations as necessary, the first at the sixth week. In addition, blood-grouping and chest x-ray should be done or arranged for early in pregnancy, preferably at the first antenatal examination, and perineal tears should be sutured as soon as possible after delivery. This scheme is based on the antenatal care given by good hospitals, and many G.P.s in busy practices find time to give this amount and often much more.

I suggest a fair fee for this form of maternity service would be £11 11s. per confinement. Such revision of fees and rules would do a great deal to encourage a higher standard of domiciliary midwifery.—I am, etc.,

Dunstable, Yorks.

J. G. RIDER.

Registrars

SIR,—I wonder how much longer we shall continue to rush headlong towards disaster with the present arrangements for filling registrar posts at hospitals. Every consultant needs an assistant of registrar grade to help him with the work of his department, and nearly every such registrar imagines that he is training to become a consultant. But during his tenure of office each consultant can train five or six successors for his own post. Even allowing for the "export" market, it is clear that the number of consultants must be quadrupled every generation or most of these trainees will never reach consultant status. While the service was being expanded all was well; but now we already have a large body of fully trained specialists of consultant standing who are unable to get suitable appointments, while at the other end of the scale it is becoming increasingly difficult to fill registrar posts—for obvious reasons.

The problem is essentially a mathematical one. Each consultant in charge of a department must have an assistant for the efficient running of the department and to ensure the economic use of his own services, but, taking the country as a whole, not more than one in four of such assistants should be trainees for future consultant status. How then can the remaining posts be filled?

There would appear to be only one answer to this problem—namely, to bring back the general practitioners into the hospital service to a far greater extent than has been done hitherto, as permanent first assistants on a part-time basis in the various departments of the hospital. Before they enter general practice they should have, say, two years' training in their chosen specialty to make them eligible for such posts. In many departments of the smaller hospital the, at present, unobtainable registrar would no longer be necessary. In the larger hospitals both registrars and general practitioners could be employed. Development on these lines would therefore retain sufficient elasticity to ensure efficient staffing of all hospital departments, while at the same time it would then be possible to keep the number of trainees within proper limits. The consultants would then have a permanent responsible assistant and deputy; registrar posts would be easily filled by those destined for general practice, and better liaison and co-operation between general practitioners and hospital staffs would be fostered. Selection could then be made from the trainee registrars of those who wished or were recommended to continue their training with a view to achieving consultant status. Their numbers also could then be kept within reasonable bounds, so that they would not eventually find themselves fully trained, middle-aged, and unemployed.—I am, etc.,

London, S.E.1.

T. T. STAMM.

Salaries of Locums

SIR,—Since 1948, when I did my first "locum," the scale of salaries as recommended by the B.M.A. has remained at the basic 16 guineas per week, with a car allowance that just covers the running expenses. With a living-out allowance a locum thus receives roughly £20 per week. This may be a fair minimum for a small list, but hardly covers the hours of work and responsibility in looking after 2-3 heavy surgeries plus visits of the large industrial practices, whose principals inform me that the B.M.A. suggested 16 guineas to them. The B.M.A.'s locums office has plainly given me to understand—whenever I asked them to support a larger claim—that the Association feels that these matters should be settled among colleagues. In that case they should make no suggestions at all and let each locum arrange his own terms to suit both parties. Every principal knows quite

well what he gets for a certain amount of work done minus expenses, and if he wishes a colleague to do this amount of work in his absence there seems no reason why he should expect him to do this for any less than he himself nets.

This is an ideal which may not appeal to most of my colleagues, so as a step towards it may I suggest a basic 16 guineas for lists up to 1,500, with an extra 4 guineas per week for each extra 500 patients—that is, 32 guineas for a maximum list of 3,500? I may add that the locum who does not know the patients or the district has to work harder than the principal. To those who may accuse me of being mercenary, I would like to say that for the past six months I have looked after a small practice in London for 10 guineas per week gladly. It was fair remuneration for the work and responsibility.—I am, etc.,

London, W. 11.

ELEANOR ETLINGER.

Payment of Compensation

SIR,—While agreeing with Dr. W. G. B. Halliden's letter (*Supplement*, February 18, p. 56) I would like to go further and ask the B.M.A. to press for immediate payment of the compensation that is still owed. All other concerns that have been nationalized have received compensation for loss of ownership. Why should the doctors have to wait until they retire or die? The money owed, on which interest at present paid is 2½%, cannot even be used as security for an overdraft on which we now have to pay 5½%. It seems ludicrous that doctors who are in need of capital have to resort to auctioning their compensation and thereby probably losing a considerable proportion of it.—I am, etc.,

Hodnet, Shropshire.

K. J. HARVEY.

SIR,—Now that the subject of professional remuneration is being discussed, I think the present time would be a suitable opportunity to reopen the question of the fund which was established to compensate general practitioners for the loss of the right to sell the goodwill of their practices. Suggestions have been frequently made that practitioners should be repaid the value of the estimated compensation due to them, and I believe a resolution to that effect was accepted by the Association last year. I would like to suggest that the whole financial basis of the compensation fund has altered in recent years, and that certain theories and arguments which seemed cogent in 1948 no longer have the same validity.

The most frequently used argument against the immediate payment of compensation was that in pre-N.H.S. days a practitioner was quite content to have his capital tied up until his retirement, and that therefore it was illogical for him to demand the immediate repayment of the capital invested in his practice and at the same time remain in possession. However, by 1956 thousands of new principals have been established in practice. These newly established principals are equally fully in possession of their practices and yet they have not been obliged to invest any capital sum whatsoever. It would appear, therefore, on the face of it, that the old-established practitioners are at a disadvantage. In fact, it is surely illogical and even unreasonable that within the same practice this unfair discrimination should exist.

It is a matter of great concern to the practitioners involved that their capital should constantly be depreciating in value and at the same time, by to-day's standards, earning a very low rate of interest. The reply to another reason advanced against immediate repayment—namely, that it would increase inflation—surely is that a large proportion of the fund is already in circulation, because advances have been made by finance companies. But here again the practitioner is at a disadvantage in having to pay twice the rate of interest he receives from the Ministry, plus initial fees and legal expenses connected with negotiating a loan on his own money.—I am, etc.,

Bath.

R. LYNN.

The Way Out

SIR,—I feel that Dr. Kenneth I. E. Macleod's letter (*Supplement*, January 28, p. 29) may be very misleading. Since 1950 I have practised medicine in California, Virginia, Washington, D.C., and Alberta, Canada. I have worked in hospitals, in general practice, private practice, and am at present doing an obligated two years in the United States Navy. Most states require foreign graduates to take their state examination. This limits you to practice in that particular state. Often U.S. citizenship is required, and this takes five years' residence. All licensed physicians are liable to draft into the armed Forces for a minimum of two years until aged 45. Professional liability insurance can be as high as \$300 a year for general practice, and in some specialties is difficult to obtain. \$30,000 annual gross income may sound like a lot of money, but with 40–50% office expense and high cost of living it soon disappears. In Alberta, Canada, practice is partly on a pre-paid system, and there is increasing pressure to have some pre-paid system in the United States. There are many intangible differences in the U.S., Canada, and the United Kingdom which make adjustment difficult, especially for older people.

I, like Dr. Macleod, like the American way of living and methods of practising medicine, but I have met several doctors and their wives from the United Kingdom who have regretted making the change.—I am, etc.,

San Diego, California.

CYRIL G. HARDY.

Remuneration of Medical Teachers

SIR,—The Association of University Teachers has the right to approach the University Grants Committee to negotiate about salaries. If the views of medically qualified university teachers are to be put forward by anyone other than the various professors and vice-chancellors I would prefer the Non-professional Medical Teachers and Research Workers Group of the B.M.A. to do so. The B.M.A., on behalf of this group, should therefore press for a right at least equal to that of the Association of University Teachers. The matter is urgent, for the next quinquennium begins in 1957, and salary changes must be negotiated before then.

Improvements in the pay of medical teachers, and particularly of those in preclinical departments, are urgently necessary, as letters in recent issues of the *Supplement* clearly indicate. If the pay remains too low the number of medically qualified teachers will continue to fall. A most ominous warning is the present dearth of medical applicants for preclinical appointments, especially in physiology and pharmacology. There is only one way to avoid the undesirable situation of having preclinical departments staffed largely by non-medical graduates—increase salaries to a level sufficiently high to attract enough medical graduates of suitable calibre. Recruitment of medical graduates to university staffs is directly related to the attractiveness of the university jobs in comparison with other opportunities.

If the forthcoming negotiations between the B.M.A.—through the Negotiating Committee—and the Minister of Health result in a rise of pay for doctors in the Health Service, it will be even more difficult to recruit medical staff for the universities unless the university jobs are made more attractive. It is important, therefore, that the non-professional group should take account in their plans of any possible changes in Health Service remuneration. The best way to keep the group informed of such changes would be for their chairman, or other representative, to be present as an observer at meetings of the Negotiating Committee. Such an arrangement has already been made with the B.M.A. Public Health Committee, which looks after the interests of a group of people who are in a similar position to university teachers, both being paid by an authority other than the Ministry of Health. Medical officers in the Services might like to be similarly represented.—I am, etc.,

Leeds, 2.

GEORGE MOGEY.

H.M. Forces Appointments

ROYAL NAVY

ROYAL NAVAL VOLUNTEER RESERVE

Surgeon Commander E. G. Brewis, V.R.D., to be Surgeon Captain.

Surgeon Lieutenant-Commanders C. E. Shafto, V.R.D., and D. R. Tipping to be Surgeon Commanders.

Surgeon Lieutenants A. A. Cochrane and N. M. I. Pantou to be Surgeon Lieutenant-Commanders.

ARMY

Major-General E. P. N. Creagh, C.B., Q.H.P., late R.A.M.C., having attained the age limit for retirement, has retired on retired pay (Reserve Liability).

Brigadier (Temporary Major-General) W. A. D. Drummond, C.B., C.B.E., late R.A.M.C., to be Major-General.

Brigadier (Temporary Major-General) E. H. Hall, O.B.E., late R.A.M.C., has retired on retired pay, and has been granted the honorary rank of Major-General.

Colonels (Temporary Brigadiers) C. E. Eccles, O.B.E., and F. McL. Richardson, D.S.O., O.B.E., late R.A.M.C., to be Brigadiers.

Colonel D. H. Murray, late R.A.M.C., has retired on retired pay.

Lieutenant-Colonels J. B. Macfarlane and A. P. Trimble, from R.A.M.C., to be Colonels

ROYAL ARMY MEDICAL CORPS

Majors A. R. T. Lundie, M.C., and D. S. Milne to be Lieutenant-Colonels.

Major E. J. Bowmer, M.C., has retired, and has been granted the honorary rank of Lieutenant-Colonel.

Captains A. T. Cook and S. A. Biggart to be Majors.

Association Notices

Diary of Central Meetings

MARCH

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| 20 | Tues. | Constitution Committee, 11.30 a.m. |
| 21 | Wed. | Council , 10 a.m. |
| 22 | Thurs. | Radioactive Substances Committee, 12 noon. |
| 22 | Thurs. | Central Consultants and Specialists Executive, 2 p.m. |
| 23 | Fri. | Assistants and Young Practitioners Subcommittee, G.M.S. Committee, 2 p.m. |
| 26 | Mon. | Subcommittee on Future of Ophthalmic Services, Ophthalmic Group Committee, 11.30 a.m. |
| 27 | Tues. | Alternative Edition Subcommittee, Joint Formulary Committee, 11 a.m. |
| 28 | Wed. | Forensic Medicine Subcommittee, Private Practice Committee, 2 p.m. |
| 28 | Wed. | Registrars Group Executive Committee, 2 p.m. |

APRIL

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| 13 | Fri. | Public Health Committee, 12 noon. |
| 13 | Fri. | Drug Addiction Committee, 2 p.m. |
| 19 | Thurs | G.M.S. Committee, 10.30 a.m. |
| 27 | Fri. | Consulting Pathologists Group Committee, 2 p.m., followed by general meeting of the Group at 4.30 p.m. |

Branch and Division Meetings to be Held

ASHTON-UNDER-LYNE DIVISION.—At Broadoak Hotel, Ashton-under-Lyne, Wednesday, March 21, 8.30 p.m., annual general meeting.

BIRMINGHAM DIVISION.—At 154, Great Charles Street, Birmingham, Tuesday, March 20, 8.30 p.m., meeting. Lecture by Mr. W. Martin Walker: "Ophthalmology in Relation to General Medicine."

BOURNEMOUTH DIVISION.—At Board Room, Royal Victoria Hospital, Friday, March 23, 8.15 p.m., meeting. Address by Mr. N. Alders: "Episiotomy." The remuneration issue will also be discussed.

CITY DIVISION.—At B.M.A. House (Committee Room C), Tavistock Square, London, W.C., Tuesday, March 20, 8.30 p.m., joint meeting with St. Pancras Division. Address by Dr. M. R. Penry Williams: "Medical Work in Prisons." The annual general meeting of the City Division will follow.

DARTFORD DIVISION.—At Joyce Green Hospital, Dartford, Thursday, March 22, 2.30 p.m., clinical meeting.

DUNDEE DIVISION.—At Station Hotel, Dudley, Tuesday, March 20, 7.45 for 8 p.m., supper; B.M.A. Lecture by Sir Zachary Cope: "Change in the Treatment of Acute Abdominal Diseases." Medical guests are invited.

DUNDEE BRANCH.—At Royal British Hotel, Dundee, Friday, March 23, 8.30 p.m., meeting. Lecture by Professor R. B. Hunter: "Diagnosis and Management of Allergic Disorders"; Film: "Allergic Diseases in Man."

EAST HERTS DIVISION.—At Hertford County Hospital, Tuesday, March 20, 8.15 p.m., joint meeting with Hertford and District Branch of Pharmaceutical Society. Mr. F. A. Robinson, M.Sc., F.R.I.C.: "Isolation and Chemistry of Insulin"; Mr. W. A. Broom, B.Sc., F.R.I.C.: "Pharmacology of Insulin"; Dr. B. A. Young: "Clinical Application of Insulin." A short film will follow on the administration of insulin.

EAST SOMERSET DIVISION.—At East Lounge, Grand Atlantic Hotel, Weston-super-Mare, Thursday, March 22, 8 p.m., general meeting; 8.30 p.m., meeting to discuss the "Co-operation of Clergy and Doctors" to which clergy of all denominations are invited. Opening speakers, Dr. E. E. Claxton (Assistant Secretary, B.M.A.) and Reverend Jim Wilson.

ENFIELD AND POTTERS BAR DIVISION.—At St. Michael's Hospital, Chase Side Crescent, Enfield, Friday, March 23, 8.30 for 8.45 p.m., general meeting.

FURNESS DIVISION.—At Duke of Edinburgh Hotel, Barrow-in-Furness, Monday, March 19, 4 p.m., general meeting to discuss proposed claim for increase in remuneration. Dr. E. E. Claxton (Assistant Secretary, B.M.A.) will answer questions.

GLASGOW DIVISION.—At Glasgow Regional Office, 234, St. Vincent Street, Glasgow, Friday, March 23, 8.30 p.m., annual meeting.

HYDE DIVISION.—At Pack Horse Inn, Mottram, Wednesday, March 21, 8.45 p.m., meeting. Short paper by Dr. D. N. Ross: "Development in the Care of the Aged." A discussion will follow.

KENSINGTON AND HAMMERSMITH DIVISION.—At Royal National Throat, Nose and Ear Hospital, Gray's Inn Road, London, W.C., Friday, March 23, 3.30 p.m., clinical meeting. Mr. C. Gill-Carey: "Common Diseases of the External Ear."

LAMBETH AND SOUTHWARK DIVISION.—At Lambeth Hospital, Brook Drive, Kennington Road, S.E., Sunday, March 25, 11 a.m., clinical meeting.

LANCASTER DIVISION.—At Midland Hotel, Morecambe, Saturday, March 24, 7.30 for 8 p.m., annual dinner. Guest of honour and principal speaker, Sir Hector Hetherington.

NORTH MIDDLESEX DIVISION.—At Committee Room, North Middlesex Hospital, Silver Street, Edmonton, N., Tuesday, March 20, 8.30 p.m., meeting. Paper by Mr. D. N. Matthews: "Plastic Surgery" (illustrated). Members of Enfield and Potters Bar Division are invited.

NORTH STAFFS DIVISION.—At Grand Hotel, Hanley, Tuesday, March 20, 8 p.m., supper meeting. Lecture by Dr. W. W. Jones: "Pneumoconiosis."

SALISBURY DIVISION.—At Salisbury General Hospital, Saturday, March 24, 8.30 p.m., meeting. B.M.A. Lecture by Sir Henage Ogilvie: "Biliary Apparatus and its Problems." Non-members of the B.M.A. are invited.

SHROPSHIRE AND MID-WALES BRANCH.—At Lion Hotel, Shrewsbury, Wednesday, March 21, 7.30 for 8 p.m., annual dinner dance. Guests are welcome.

SOUTH BEDFORDSHIRE DIVISION.—At Out-patient Department, Luton and Dunstable Hospital, Friday, March 23, 8 p.m., clinical evening.

SOUTH ESSEX DIVISION.—At White Hart Hotel, Romford, Friday, March 23, 8.30 for 9 p.m., meeting. Any Questions? Panel, Mr. E. Bergdahl, Dr. J. Graham, Dr. S. J. Hadfield (Assistant Secretary, B.M.A.), Dr. W. P. Hedgcock (Assistant Secretary, B.M.A.), Mr. W. O. J. Robinson, and Dr. G. G. Stewart. Non-members are invited.

SOUTHAMPTON DIVISION.—At Polygon Hotel, Friday, March 23, 7.30 for 8 p.m., annual dinner dance.

SOUTH-WEST ESSEX DIVISION.—At Thorpe Coombe Maternity Hospital, Forest Road, Walthamstow, E., Wednesday, March 21, 8.30 p.m., meeting. Address by Mr. Julian Taylor: "Advantages and Dangers of Specialism in Surgery."

STOCKPORT DIVISION.—At Alma Lodge Hotel, Tuesday, March 20, 8.30 p.m., meeting. Address by Dr. F. E. Camps: "Methods of Murder." Members of the Stockport Incorporated Law Society are invited.

STRATFORD DIVISION.—At Great Hall, West Ham Municipal College, Romford Road, Stratford, E., Tuesday, March 20, 9 p.m., meeting. Discussion: "The Background of the Remuneration Problem and its Future." Speakers, Mr. T. Holmes Sellors and Dr. H. N. Rose. Members of the Tower Hamlets Division and all resident hospital medical officers are invited.

WAKEFIELD DIVISION.—At Clayton Hospital, Wakefield, Thursday, March 22, 8 p.m., meeting. Address by Mr. C. H. Stabler: "The General-practitioner Service."

WALLASEY DIVISION.—At Hotel Victoria, New Brighton, Sunday, March 25, 11 a.m. to 12 noon, meeting. Dr. E. E. Claxton (Assistant Secretary, B.M.A.) will be pleased to meet any members of the medical profession who would care to discuss the remuneration claim.

WEST BROMWICH AND SMETHWICK DIVISION.—At the Red Cow, High Street, Smethwick, Friday, March 23, 8 p.m., annual dinner dance.