BRITISH MEDICAL JOURNAL

SATURDAY 11 SEPTEMBER 1971

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5775 BRITISH MEDICAL JOURNAL 1971 VOLUME 3 593-652 WEEKLY PRICE 35p
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR TELEPHONE 01-387 4499

CORRESPONDENCE

Correspondents are asked to be brief

Superannuation in an Integrated Health Service

SIR,—A Scottish joint working party concluded[1] that the case for integration of medical work is overwhelming and that a breaking down of artificial barriers between general practice, specialist practice, and community medicine is overdue. I suggest that, especially in times of inflation, different superannuation regulations may hamper integration by complicating and, in some cases, penalizing, transfer from hospital or community medicine to general practice, or vice versa.

As the superannuation of hospital and community medicine staff depends on earnings during the last three years of service, it is protected from inflation until then. The value of this protection is shown by the calculation that if remuneration increased by 7·2% annually, the benefit attributable to a given period of service (without change in incremental point or grading) would double every ten years. Because general-practitioner superannuation is based on career earnings the benefit derived from earlier years of service depreciates geometrically. To compensate (inadequately) for this earnings during later years, which will be greatest mainly because of inflation but partly because of the receipt of seniority allowances increasing each decade, are more heavily weighted in calculating benefit. Transfer to or from general practice entails loss of much of both forms of protection because benefit accrued by the time of transfer is frozen until retirement (except when a former hospital doctor obtains a post as a general-practitioner clinical assistant) and the period in general practice will not be long enough to attract full, if any, seniority allowances or increased weighting in calculating benefit.

Transfer might entail another penalty. If a former hospital doctor worked as a clinical assistant (or in a general-practitioner hospital), the whole of his hospital service would be assessed for superannuation at the rate for that grade even although this might be much less than that of his former post. On the other hand, this rule would be very advantageous if the rate of the former hospital post was less than that of the latter.

If work in any branch of the Health Service were taken into account in assessing general practitioner seniority payments and the weighting to be applied in calculating benefit (and if option were open to assess hospital work before transfer separately from that after), doctors who transferred to general practice would be near to parity with other general practitioners, but not with hospital or community medicine staff. Equity for general practitioners, including those who transfer to other work, would need some more radical change.

A fully integrated superannuation scheme, similar to the present hospital one, would simplify transfer to or from general practice and would give general practitioners much better protection against inflation than they now enjoy. In objection, it is said that a general practitioner's earnings may not be highest in his last years of service. With continuing inflation, this is unlikely to happen frequently, but the point could be met by basing superannuation calculations on the three best consecutive financial years, subsequent years (if any) being assessed separately. This provision could benefit hospital staff if they undertook fewer domiciliary consultations shortly before retiral, and it would benefit anyone who, for any reason, transferred to a less well remunerated post.

Himsworth[2] considered that crystallization of career structures would endanger the healthy development of medical science. I suggest that it is important to modify the superannuation regulations, probably by introduction of a fully integrated scheme, so that interchange between hospital or community medicine and general practice is less complicated and, sometimes, penalizing.—I am, etc.,

H. G. EASTON

Ruchill Hospital,
Glasgow

1 *Doctors in an Integrated Health Service*, p. 52, Scottish Home and Health Department, H.M.S.O., Edinburgh, 1971.
2 Himsworth, H., *Lancet*, 1952, **2**, 741.

Malignant Hyperpyrexia

SIR,—Your second leading article on malignant hyperpyrexia (21 August, p. 441) in just over three years[1] emphasizes the clinical importance of this frequently fatal complication of anaesthesia.

However, we would like to stress that, in addition to suxamethonium and halothane, both ether and trichlorethylene can trigger off malignant hyperpyrexia, and that methoxyfluorane, cyclopropane, and chloroform are suspect. On the other hand, local, regional, or spinal anaesthesia is safe in individuals susceptible to malignant hyperpyrexia, and we have used this type of anaesthesia successfully many times over the past 11 years in susceptible individuals in a large family in which prior to 1960 there had been 10 deaths due to ether. If general anaesthesia is unavoidable, the best choice of anaesthetic at present would seem to be thiopentone, nitrous oxide, and D-tubocurarine.

Rather than assume that patients over 20 are likely to suffer from the non-rigid type of malignant hyperpyrexia and therefore not have an inherited anomaly, we would like to suggest that it would be safer to assume that all patients who develop malignant hyperpyrexia have an inherited disease of muscle, and that all their close relatives should be screened by serum creatine phosphokinase (CPK) estimations, so that other individuals at risk can be detected. By this means overt muscle disease in relatives may also be found. In fact, one of our patients with malignant