Registration

The congress fees are as follows:

Any member or member of an affiliated association
—for example, Australia, Canada, Ireland £50

*In the case of British doctors only BMA members
will be eligible to attend.*

Late registration fee after 31 July 1981 £60
Any doctor from the USA, Central, or South
America US \$75

No registration fee will be charged for accompanying persons.

The congress fee includes morning coffee and attendance at
any of the scientific sessions at the Town and Country Hotel,

two tickets for the keynote address and welcome reception on
19 October, transport to medical visits, and one ticket for a
morning tour for accompanying persons.

Advance registration forms for BMA members from the
UK and affiliated members (except Canada) are available from
the assistant secretary (San Diego Congress), BMA House,
Tavistock Square, London WC1H 9JP, and *must* be completed
for attendance at the congress. Doctors from the USA, Canada,
or Central or South America should apply to Mr G Denney,
associate executive director, San Diego Medical Society,
3702 Ruffin Road, San Diego, California 92123.

In the case of UK doctors the DHSS has recognised the
congress as four full sessions to contribute towards general
medical practitioners' educational requirements for the post-
graduate training allowance but the DHSS will not approve
the payment of expenses for courses held outside the UK.

TALKING POINT

Junior hospital doctor politics in the Oxford Region

DESMOND MURPHY

Apathy, reluctance to be seen to be controversial in the eyes of
consultants, short-term posts, and frequent changes of hospital.
These are the most frequently used explanations for the com-
parative inactivity of junior hospital doctors in medical politics.
Nevertheless, almost every organisation that expresses the
medical view to districts, areas, regions, or the DHSS has a
place for junior representation. But are the juniors unique? Do
hospital consultants fight for representation on their committees?
Do GPs flock to their BMA meetings? For that matter, do
our much vaunted trades unions and political parties have
large numbers at their regular meetings? Of course not. Thus
junior doctors are not unusual in their reluctance to take part
in decisions that so obviously affect their career and in fact
their livelihood.

What happens, therefore, when there is an absence of a
formalised expression of junior doctor opinion? The Oxford
region may serve as an example. Obviously, much of the
information is sketchy, secondhand, and affected by retro-
spection, memory, and opinion. It seems, however, that at some
point in the early 'seventies the Oxford regional hospital junior
staff committee ceased to exist. The Oxford Area Medical
Committee wanted a formal expression of junior opinion and,
late in 1974, set up the Oxford Junior Doctors Cabinet. This
was intended to represent all juniors in the Oxfordshire area
and was to be chaired by the area medical officer or his deputy.
In fact, when the juniors have been persuaded to attend, it has
tended to be over-representative of the main Oxford teaching
hospital and in particular of the major specialties in that hospital.
Not unnaturally, since it is nominally at least under the wing of
"management," its decisions may be affected strongly by local
pressure and national agreements tend to be of secondary
importance. The junior representative on the postgraduate
medical education committee was selected on an empirical

basis by the consultants on that committee, and he and a junior
nominated by the regional consultants committee (the regional
committee for hospital medical services) became the junior
representatives on the study leave committee two years ago.
The study leave committee's two junior doctors should have
been "two members nominated by the regional hospital junior
staff committee." Of course, the consultants who co-opted
juniors on to these committees had laudable motives, but
the junior doctors had no mandate and were unlikely to be
outspoken in their discussions with the people who had placed
them on the committee. Most of the other committees func-
tioned without a junior voice.

Why is it that there is now a viable or, dare I say, a thriving
hospital junior staff committee in the Oxford region? I believe
there are two reasons. The first is an obvious external threat.
Oxford has been seriously affected by the financial constraints
that have influenced hospital services and will continue to do so
in the foreseeable future. A reduction in the numbers of posts
of junior doctors at the time of an increase in the numbers of
medical graduates, inadequate study leave and removal expense
arrangements, and inadequate financial provision for locum
cover were all threatened—though the BMA has now persuaded
the Oxfordshire AHA(T) to rescind some of these. The second
reason is the work of an active man: Dr John A D Spencer is
primarily responsible for the resurrection of Oxford junior
doctors' organised political expression. Two years ago he tried
to contact every junior in the region with any active interest in
medical politics and the mess presidents of the 75 hospitals in
the Oxford Region. By finding interested juniors in as far-flung
places as Northampton and Reading he was able to stimulate the
growth of the numbers in the present regional hospital junior
staff committee.

So what does the Oxford Regional Hospital Junior Staff
Committee do? Essentially it feeds information from its
"constituency" to the central representatives of the profession
and in the opposite direction it tells junior doctors of the
decisions and national agreements that the profession has
negotiated with the DHSS. The minutes of all its meetings
are sent to every hospital mess in the region. Ideally, it should

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collect the opinions of local juniors' committees and mess committees throughout the region and weld these into coherent regional policies to influence regional decisions. The RHJSC must ensure that nationally negotiated terms and conditions of service are interpreted properly in the region. It does this with its representation on the regional medical advisory committee, the regional committee for postgraduate medical education and training, the regional study leave committee, and the regional manpower committee, and it sends observers to the regional

committee for hospital medical services. The RHJSC is also a policy-making body forwarding motions to the national Hospital Junior Staff Committee, on which it has two representatives, and that committee's Negotiating Subcommittee deals directly with the DHSS on terms and conditions of service.

The importance of the regional hospital junior staff committee is obvious. Interest in it should be maintained in every region. If not, junior doctors and their successors will suffer. That is especially likely to happen in times of financial difficulties.

Oxfordshire AHA(T)'s proposed economies

Threat of "black box" removed

In December the BMA's Hospital Junior Staff Committee criticised the Oxfordshire AHA(T) for unilaterally changing junior doctors' terms and conditions of service in its search for cuts in the authority's budget. The committee asked for the BMA Council's support (3 January, p 85). At its meeting on 7 January the BMA Council had recommended "That the Executive Committee of the Council be instructed to place Oxfordshire AHA(T) in the Important Notice section of the *BMJ* at its meeting on 4 February unless that authority has recognised nationally agreed terms and conditions of service by that date" (17 January, p 245). On 2 February representatives of the BMA met officers of the authority and a large measure of agreement was reached. The Council Executive considered the following letter setting out the points of agreement from Dr Alexander Gatherer, area medical officer. It decided that in the light of the assurances the authority should not be placed in the *BMJ*'s Important Notice. (A leading article appears at page 506.)

AMO's letter

The first point I would like to emphasise is that we confirm unequivocally that my authority's policy is to comply with nationally negotiated terms and conditions of service. This was also stressed by Lady McCarthy as chairman of the authority when we met her later in the morning.

Removal expenses—The main area of dispute concerned the payment of certain parts of removal expenses. The authority had already changed its decision and accepted that it could not exercise a general discretion. While this issue is therefore no longer a matter of disagreement between us, we agreed that we would consult with Mr Coley [the BMA's IRO] concerning the general approach to be used on removal expenses and in addition we would consult locally with the junior medical staff at POWAR regarding any individual decision where difficulty may arise.

Study leave expenses—Our discussions on study leave expenses were complicated by the still unsettled appeal of one doctor against the regional study leave committee decision and by the fact that as mentioned to you, the guidelines from that committee are currently being redrafted. However, we agreed that we will from 1 April 1981 pay reasonable expenses

relating to attendance at examinations and we will make our view known to the next meeting of the regional study leave committee. We will be trying to obtain an additional allocation of money to cover these expenses.

Student assistantships—We have, I believe, already reached agreement with you on this point. We stress the need for a properly planned approach to the use of student assistants locally; this will normally mean that they will usually cover periods of a week or so. However, we confirm that it is our intention to pay student assistants for shorter periods when they are in fact requested to work.

Family planning in hospitals—The only item remaining under the "family planning in hospitals" issue concerned our consultation arrangements. We accept the words of the original circular and that consultations in future will include representatives of the main specialties involved.

Employment of locums—We repeat our assurances concerning the employment of locums. The outline of Dr Vaughan's statement in the *BMJ* 31 January [p 410] covered exactly what we are trying to do in Oxford. In the notes of our meeting I will briefly list the important but generally background factors in the health service in Oxfordshire which I mentioned. These simply stress the reasons for the very real need for us to review our local work "so as to minimise the need for employment of locums."

It was a mistake on my part to use the word "policy" when in fact this was not the intention nor was it a tenable position to take. I can only repeat Dr Vaughan's words that it is "unacceptable for doctors to be expected to provide cover beyond contractual obligations."

I can add that we have never had any intention of unilaterally altering the contracts of present doctors and I stress to you that we are

very willing to see any junior hospital doctor who feels that his contract does not reflect the work he is doing. Also, I will remind our doctors that they have the appeal mechanism which was originally accepted and established locally, though it has never in fact had to be used.

Finally, we agreed that local consultation and communication arrangements should be improved. We are certainly happy on our side that we can avoid similar difficulties and misunderstandings from arising in future.

BMA's comment

In a statement after the Council Executive's meeting the BMA said that "the Hospital Junior Staff Committee has been particularly concerned about the dangers which could result from junior staff in the area being expected to work excessive hours as a result of the policies of the health authority. The chairman of the HJSC, Dr Michael Rees, welcomed the agreement as the culmination of a series of negotiations to resolve the problems being faced by junior doctors in the Oxford area."

Mr Michael Lowe, who headed the BMA's negotiators, said, "I believe that health authorities in general will now realise that they cannot ignore or break agreements negotiated by the BMA at national level." Dr Michael Rees, chairman of the juniors, added: "We are keeping close watch through our regional hospital junior staff committees to ensure that any reported variations on national agreements are quickly registered centrally by the BMA. We are also encouraging our regional committees to ensure that appropriate measures are taken to draw attention to any inadequacies in the hospital services in their areas."

Lodging charges for hospital doctors

Advance letter (MD)4/80 set out revised rates and abatements for lodging charges backdated to 1 April 1980 (10 January, p 167). At the recent Hospital Junior Staff Committee meeting there was criticism that health authorities could demand back-payments in the form of a lump sum (24 January, p 335). The BMA

raised the matter with the DHSS, and regional treasurers have been asked to take a reasonable line when doctors find it difficult to pay the lump sum and to allow back-payments to be made by instalments. Junior staff who continue to have problems about lodging charges should contact their BMA regional office.