priced. The new contract, based on the notional half day, allows some definition but preserves "professionalism" by its time-honoured flexibility. Only through this mechanism will it at last be possible to recognise the long hours at present worked by the majority of full-time consultants.

The notional half days above the standard 10 must remain "uncertain." Otherwise they will become an integral part of the basic contract and the value of the notional half day would be reduced accordingly. It is important to realise that no consultant need work more than 10 notional half days. We did not design the contract so that consultants would have to work their present large number of hours in order to earn a professional salary. If the standard contract is adequately priced the financial imperative to take on extra notional half days will be removed, and because of the present high rate of taxation it is unlikely many consultants will think it worth working more than 13 notional half days.

The new standard contract will indeed mean the end of the present concepts of full time and maximum part time. In practice, if the present level of service is maintained, as the Secretary of State has promised, full-time consultants working a five-day week will get an extra two notional half days added to the standard 10. Thus there will be a "differential" over the standard week based on the work they do. More consultants will be able to engage in private practice even on a very modest scale because there will be no "fine" for doing so.

Last year's ballot was on the principle of the contract. It received the support of 70% of consultants. It was properly conducted by the Electoral Reform Society. The pricing of the contract has always been recognised by the BMA as a separate issue. A second ballot has already been budgeted for and hospital consultants have been asked to notify the BMA of their addresses to ensure that a voting paper may be sent to them.

The new contract will initially require extra administrative work, but once operational it should not need more supervision than any other contract if the consultants' pattern of work does not change. Preserving an option of the open-ended undefined contract as well as this new defined contract would be even more difficult to administer. The principle of the 10 notional half-day contract has gained favour over the last 10 years. A very large majority of senior registrars voted for the new contract and the contract was endorsed by the Hospital Junior Staff Committee. Our immediate successors are therefore in favour of it. The new contract does provide the mechanism for paying the consultant the professional salary for his professional work and it is now up to the Review Body to recognise the full worth of consultants in the Health Service.

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SIR,—There are numerous valid objections to the new consultant contract but I have not so far noted in your correspondence columns any discussion of one that seems to me to be of great importance.

A consultant's remuneration would depend on the number of NHDs he works in excess of the basic 10 and also on his on-call commit-

ment. This is to be subject to review (normally every two years and at least every five years). If the service were to be improved by an additional consultant appointment in one's specialty, the employing authority could justifiably argue that it should no longer be necessary for one to work as many NHDs as previously and, in many cases, that one's banding for on-call commitment should be downgraded.

While it is disturbing enough that a consultant's salary might be greatly reduced by an additional appointment, it is even more worrying that the interests of an individual consultant and those of the Health Service should be in conflict. How can we be expected to advise dispassionately on the development of the service when that advice which may best serve the community in which we work is likely to result in a reduction of our own salaries?

It is inevitable that if we abandon a "professional" contract with its open-ended commitment and adopt a contract of the type proposed we shall have to face serious dilemmas and abuses. Mr David Bolt and his fellow negotiators do not hesitate to remind us that the overwhelming majority of consultants appear to want a contract such as they have negotiated. Those of us who feel that acceptance of this contract would be a disaster, both for the profession and for the Health Service, must continue to expose the shortcomings of the new contract, of which the negotiators must be aware but of which they say nothing.

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"Time-expired" senior registrars

SIR,—As one concerned with the training of registrars and senior registrars in obstetrics and gynaecology, I would like to support the comments made by Mr C Wastell in his letter (17 March, p 493). Like general medicine and surgery, obstetrics and gynaecology is one of the popular specialties and there is therefore a log-jam produced by too many applicants for too few consultant posts.

In a free market it would be reasonable to allow market forces to apply but there would then be more than one employer. With a single employer, the NHS, and emigration now virtually impossible, this is manifestly unfair, particularly as consultant posts are not filled exclusively from the senior registrar ranks but are also filled from university posts of lecturer and senior lecturer and, as in some recent appointments, from abroad.

The defence of the monopolistic employer, the DHSS, and the senior registrar training committees—that senior registrars were aware when they signed it that their contract was for four years only—really must not go unchallenged. In the past four years this has been honoured in the breach rather than in the observance, and there are many eminent consultants who have had senior registrar posts for as long as twice that time. Indeed, at one time the DHSS positively directed that senior registrars must not have their appointments terminated after four years. In any case, with only one employer what else can a registrar do but sign a contract for a post which is a mandatory step to eventual promotion to consultant, whatever its terms?

In the popular specialties there are few, if any, unfilled consultant posts. A recent *Health Trends* showed only one unfilled post in obstetrics and gynaecology. Are all the posts filled really desirable, or are they filled by "time-expired" senior registrars desperate to avoid dismissal? It is difficult not to conclude that the employing authority in finding itself with too many fully trained obstetricians (that is, senior registrars) is using the four-year rule to fill unattractive posts.

To conclude, I would repeat what Mr Wastell has already said, that to dismiss a fully trained surgeon, physician, or obstetrician who has nowhere else to go and no other reasonable way of earning a living is an appalling waste, and would certainly not be tolerated if it were applied to a member of the ancillary staff at the hospital where the same senior registrar was working.

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¹ *Health Trends*, 1978, 10, 63.

Emergency recall fees and extra-duty allowances

SIR,—Medical assistant and assistant dental surgeons should be receiving emergency recall fees from 1 April 1979 in common with other senior hospital medical staff. However, the Medical Assistants Subcommittee of the CCHMS, which is negotiating our new contract, decided that they would prefer to retain extra-duty allowances and voted against the present implementation of the emergency recall fee system. This decision was apparently made without reference to the members whom they represent, and as only approximately one-third of assistants receive extra-duty allowances it is biased in favour of a minority. It would be interesting to hear how they justify their action. I personally am not eligible for extra-duty allowance but am expected to be available for emergency recall. It would appear therefore that some medical assistants are now the only group of hospital medical staff who can be called in for emergency duties without remuneration.

I feel strongly that the subcommittee should urgently rethink its policy, return to the negotiating table, and correct this anomaly.

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Recall and on-call fees for radiologists

SIR,—Dr N Simmons¹ (*World Medicine*, 10 March 1979) has drawn attention to a statement in the 1978 Review Body Report—that "the joint view of the professions and the health departments is that certain groups of specialties . . . do not normally involve an on-call commitment for emergency admissions." The decision to include radiology in this category was based, we understand, on the results of a survey of the pattern of consultant work carried out by the DHSS. None of us in this department can remember being asked about this matter, nor has the subject been discussed at any meetings of our local CHMS.

In this teaching hospital an on-call radiologist rota limited to consultants and