Health Departments have misled the Review Body the matter should properly be referred to the Ombudsman, but if it is our negotiating team the remedy can only lie in the hands of the profession.

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SIR,—The Review Body proposes a pool system for consultants. If we scramble to increase our total pay by frequent nocturnal visits to our hospitals, increase our on-call rotas, and remain uselessly at hospital in the evenings to support our claim for additional notional half-days, the 1980 and 1981 Review Body reports will depress our basic salaries still further.

But the ultimate stupidity of a pool system is that overall it does not pay for work done and is not work-sensitive as we see the term. Overall it pays for work not done. If we stop all work outside office hours, our basic salaries will increase in 1981 or thereafter. As a profession we can only increase our total income if we agree to reduce the total national quantity of NHS consultant work to the extent that we will all have time to "moonlight." If every consultant agrees to contract for only six NHDs the value of each NHD will more than double, we will earn the same salary while working less than three days a week, and we will all have time to take other jobs outside the NHS.

May I recommend a similar pool system for our brothers the miners and car workers? Regretfully I feel unable to recommend a prize for forecasts of the availability of coal, electricity, or cars.

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Community health councils, consultation, and planning

SIR,—I was most interested to read your account (26 May, p 1438) of the negotiations between Kensington, Chelsea, and Westminster Area Health Authority (Teaching) and its community health council over the future of certain hospital services in the area.

CHCs in general have been unhappy over the role they are expected to play when closure or change of use of premises is mooted by the AHA, but the particular problem I would like to comment on lies in the statement that the CHC also rejected collaboration with the district management team because it found it difficult to counter the team's arguments. As we have gained more experience in trying to make a totally new kind of body work effectively I have come to feel strongly that CHCs are not involved in the planning process early enough, and that for AHAs to invite comment on a precisely formulated plan from an entrenched position makes it difficult to find areas of flexibility for negotiation. We are presented with strategic and operational plans already typed up and bound, and although it is always stressed that they are not unchangeable there is something pretty permanent-looking about them and each side tends to argue from an established position. I am perfectly aware that planning starts sometimes with a couple of chaps sharing an idea over a foaming pint (sometimes our own ideas come that way too) and that formal consultations could not start at that point; but

one of Northumberland's administrators has recently suggested that CHCs might usefully be involved at service planning team level before the plans even reach the ATO. We recently had the opportunity to do just this—to consider an early draft of a plan and discuss it with its originators—and I think those of us who were involved found it a fascinating experience, perhaps because it is a particularly innovative scheme.

It so happens that we intend to oppose strongly the building of a new 30-bedded paediatric unit in Northumberland which has appeared regularly in official documents recently, and it seems to be a pity that this proposed major change in service has not been discussed with us in detail over the years—so that we are bound to have a confrontation over the plan with Northumberland AHA eventually. We would prefer to see additional resources being used to extend primary care and community-based facilities in our mixed small town and very rural area and feel that the area team of officers is old-fashioned in its approach. The excellent paediatric facilities in Newcastle are of course highly relevant to our outlook as there is already much patient flow from Northumberland to the services there. But the plans for the new unit are in the capital programme somewhere; we shall not miss an opportunity for discussions but I feel our opinions might more usefully have been sought two years ago.

Formal opposition procedures when undertaken by CHCs are costly in time and effort for everyone as well as in cash, and I hope that CHCs will never be tempted to chalk up their successes in terms of plans opposed and won. I believe we have a very much more positive and constructive part to play in the development of the NHS and that the statutory duties imposed upon us make it essential that AHAs consult us earlier in the formulation of their plans. A curious element in our work which has emerged is the eagerness of some doctors, nurses, and other staff to encourage us to put forward views which because of various professional constraints they feel unable to put forward themselves. We accept that we are used in this way but choose our own priorities and are not always as green as we are cabbage-looking.

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Training posts and disillusioned registrars

SIR,—Having read the report of the Council's working party on medical manpower, (19 May, p 1365), your leading article (p 1299), and the resulting correspondence (9 June, p 1559), I would be most grateful for the opportunity to comment from my position as one of a number of disillusioned registrars in a major specialty.

The bitterness which accompanies the eventual realisation that one is not going to achieve the ultimate ambition of becoming a consultant after many years of training is of two kinds. There is the bitterness associated with one's own personal disappointment and feeling of failure, and there is frequently much more deeply felt bitterness. This is the bitterness felt towards those responsible for career guidance. The feelings often exist that one has been misguided, especially about one's own career prospects, as a result of inadequate

or even totally absent advice. A large measure of responsibility for the generation of such feelings must lie with those in a position and with special responsibility to advise junior medical staff undertaking any form of postgraduate training. I refer, of course, to the individual regional postgraduate advisers and members of regional postgraduate education specialty subcommittees. As advisers to what is regarded by many as a caring profession they would do well to show much more concern for all those whom they have accepted responsibility to train. The failure to act in a responsible fashion and advise any doctors whom they considered were not progressing satisfactorily, and who would be unlikely ever to meet their requirements for specialist training, that their prospects were poor—at a stage when training in some other discipline more suited to the individual's abilities would still be a reasonable option—is morally indefensible. Unfortunately, at present all too often advice only percolates through to those who are progressing smoothly towards their ambition, while the remainder are allowed to serve on in silence with little or no hope of progress.

The concept of a new training grade at registrar level where the number of entrants would be closely linked to the number of available senior registrar posts would certainly be welcome; but those of us who live in the real world are well aware that such a training grade already exists, albeit unofficially. Entry to training posts from which progress to consultant grade is reasonably assured is already highly selective. Selection, if that is really what it can be called, is frequently by invitation rather than as a result of open competition; it occurs even before entry to the registrar grade and is most frequently controlled by a small number of influential, and perhaps well-intentioned, academics or by individuals at least within their sphere of influence. Open competition remains only for the remainder of so-called training posts, from which progress is far from assured.

I would take issue with Mr T T Irvin (p 1560), who sees disaster ahead for the patients in our hospitals. Already too many patients are receiving what they believe to be highly specialised treatment at the hands of relatively inexperienced doctors in training. Any proposals which result in the increased contact of patients with experienced highly trained specialists should be beneficial to the patients. I do realise that a greater number of specialists would be required to provide such a service; but this serves yet again to illustrate the misuse of personnel in training to provide the present comprehensive specialist services.

I am also surprised that Professor J Parkhouse (p 1560) still believes that anyone hoping to progress in specialist training to become a consultant can choose not to undertake research. The grim reality is that those who do not wish to undertake research do not proceed.

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Correction

Self-injection of veterinary oil-emulsion vaccines

In the letter by Dr P B Stones (16 June, p 1627) we regret that the following reference was omitted: Smith, M G H, *British Medical Journal*, 1964, 2, 918.