restricted. A total of 32 beds were to be closed so that the nurses could be transferred to the district hospital because of an acute nursing shortage. Prior to this decision (made in the absence of the GP member of the DMT) no consultations whatsoever took place with the general practitioners, who were suddenly confronted with the prospect of seeing nearly half their hospitals closed at a stroke. No assurance has been given that the wards will be reopened after the appointed time. Even more disturbing is the fact that the nurses at these hospitals had previously been interviewed by the district nursing officer and asked if they would be willing to help out by working at the district hospital and advised not to discuss the matter with anyone else.

It is not the purpose of this letter to harp on such misguided and discourteous mismanagement, a matter which must be sorted out in due time locally. Nor is it to disclaim the duty of small hospitals to support the district hospital's acute services in times of crisis, or even from time to time on a properly planned basis (the impending shortfall in nurses in north-west Surrey had been recognised for three months). What I wish to make clear is that the closure of beds at peripheral hospitals does nothing in the long term to solve the problems of nurse shortage but rather to aggravate them. The reason for this is that a large number of those who work in the small hospitals choose to do so for convenience and practicality. Without the presence of the small local hospital their services might well be lost altogether. Attempts have been made in north-west Surrey to introduce a clause into nurses' contracts wherein they promise to work at any hospital in the district rather than a specific one. I fear that such a policy would be self-defeating because many nurses would choose not to work at all rather than commit themselves in this way.

There are some 350 GP hospitals in England and Wales, which are with official encouragement assuming their proper role in the overall pattern of hospitals. One of their major contributions is the provision of local nursing care. These hospitals are small and therefore still vulnerable. District management teams in wielding the power of responsibility must remember that, whereas two wards in a district hospital represent a fraction of the whole, the closure of whole wards in hospitals with a total of 35-40 beds total is seen as a major calamity locally, and even if not intended to do so could lead to the destruction of those hospitals. Such action could serve to reduce rather than increase the total number of working nurses.

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A "specialty" for second-class doctors?

SIR,—I have recently been reading a document entitled *Criteria for the Selection of Trainers in General Practice*, issued by the Joint Committee on Postgraduate Training for General Practice.

Great emphasis is laid in this publication on the use of self-assessment as a clinical teaching tool, on the need to be able to form harmonious relationships with patients and colleagues, on the need to understand the patient's interpersonal relationships, on the need to understand social and environmental factors. When it comes to the area of clinical competence, the document becomes vague.

Nowhere is it mentioned that the trainer should be able to carry out thorough clinical examination in all specialties; nowhere is it mentioned that the trainer should have a thorough knowledge of therapeutics and the side effects of all available drugs; nowhere is it mentioned that the trainer should be competent in simple clinical procedures and in the use of such diagnostic equipment as ECGs.

There is no doubt that general practice needs to put its house in order, but it is noticeable that the great majority of doctors over the years have been held in high regard for their sympathetic handling of their patients. It is in the area of clinical competence where our deficiencies have been so blatant, which has led so many of our patients to regard the GP as the second-class doctor and the hospital specialist as the first-class doctor.

I would be interested to know if there are many doctors who, like me, believe that by making vocational training mandatory we have sold the soul of our profession to a highly motivated minority, who may take a totalitarian stranglehold on us and lead us down the wrong road. Shall we not merely deter the highly qualified senior registrar or registrar from making the switch to general practice and condemn ourselves for ever to be the second-class doctors?

My critics may say that general practice must now be considered a specialty in its own right—namely, "primary care," which is the fashionable terminology. But many may believe, like me, that this is a contradiction in terms and that "general practice" is a discipline that runs in partnership with "hospital practice," within which all the specialties exist. Or am I a lone voice crying in the wilderness?

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New consultant contract

SIR,—The new consultant contract is beginning to resemble a tower block: it gained great acclaim for its architects, but nobody wants to live in it. On the assumption that we should start again, may I offer a few thoughts?

Firstly, in industrial terms, it is nonsense to have a wage structure which depends on overtime (recall fees and other extra payments) to achieve an adequate living wage. This could give people a vested interest in not improving a service in which their income depends on a deficiency of junior staff. It should have been obvious, in any case, that no one would repeat the UMT farce a second time, though it was a surprise to find the recall fees priced below that of a plumber's visit. What is clearly required is an adequate basic salary, irrespective of specialty, so that gross inequalities between consultants in different specialties are avoided and recruitment can be maintained in those specialties with little emergency work. Having been one myself, I have every sympathy for the overworked regional (that is, non-teaching) hospital consultant; but I would have infinitely preferred adequate junior staff and satisfactory working conditions to additional payments. Advisers appointed by the Royal Colleges to sit on appointment committees should exercise their right more frequently and more forcefully to tell employing authorities that a particular post is unsatisfactory.

Secondly, in any future negotiations it is to be hoped that our negotiators do not abdicate

their responsibilities to negotiate. In the new consultant contract the negotiations for the extra NHDs would have been left to an individual argument between *each* consultant and the employing authority, which puts the consultant in a ridiculously weak bargaining position, and leaves the RHAs and AHAs with the task of negotiating hundreds of individual contracts.

Thirdly, it was naive to build into the new contract the assumption that every consultant would be doing private practice. It is obvious that at some stage the DHSS or the Review Body would take into their calculations on the basic salary the fact that additional money could be earned in private practice. The facts are that in many specialties and in many areas private practice is simply not there to be had. Moreover, many consultants prefer to concentrate on hospital work, without the distraction of other commitments.

Finally, I was depressed to see that the profession is now pressing for more facilities for private practice. We are already dangerously near a "two-tier" system. If we, as a caring profession, wish to retain a hospital service which is for everyone, we should be working towards improving it rather than setting up a competing parallel private service. If our hospital service deteriorates any further, it will be a poor man's service and the articulate (who can complain) will forsake it. So far no politician has had the courage to tell us what it would cost in additional taxes to fund the NHS adequately. I believe that the public would choose to pay more for a better service if the facts were presented to them clearly and honestly.

JOHN BLACK

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Review Body Report

SIR,—A close reading of the 1979 Review Body Report reveals a difference of understanding between the Health Departments and our negotiators on several very important issues.

Paragraph 22 of the report states: "The Health Departments indicated that it was not the intention to provide additional funds to cover recall fees, but the profession assumed that, as the Government had agreed to the introduction of separate payments, it would be prepared to make financial provision for them." And later in the same paragraph, in referring to the pricing of the new contract, the report states: "It had not been established clearly between the parties whether or not extra provision would be made to cover the cost of paying separately for work which was covered by the previous contract, but which under the new contract would attract separate payment and was now being described by the professions as 'new work.' The professions assumed that such provision would be made, but the Health Departments assumed that, where the source of finance had not been identified, the professions were content for the cost of each item to be found within the overall cost of the new contract."

Surely this vital series of understandings, presumably agreed at meetings, were confirmed in approved minutes written after the meetings. There must be written evidence of such understandings, and it would be most appropriate for this evidence to be published so that the profession can lay the blame for the disastrous report, so far as consultants are concerned, on the party responsible. If the

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.