Career structure in community medicine

SIR,—Few would dispute that the public health service set up in the 19th century and nurtured through the first half of this one was in danger of becoming an obsolete and antiquated organisation. Neither would anyone deny that it had rendered a unique and magnificent service in the interest of mankind. However much the need to restructure both its form and content Britain, in being the first of the Western nations to dismantle its public health system, has done in its turn a disservice to its citizens. Not only have such services as immunisation and child health suffered a body blow but as Dr J S Horner, the chairman of the Central Committee for Community Medicine, said in his speech to the Annual Conference of Community Medicine (29 July, p 376), despite the Department of Health and Social Security's protestations, the public health service is out of fashion and is not reaching many problems, such as caring for the elderly, the overstressed mother, the inner city resident, and the adolescent potential drop-out. It has only tenuous links with the social services and education departments of the local authorities. The impact of medical opinion in matters of physical and chemical pollution has lessened.

The pre-reorganisation public health service produced a unique blend of professional experience such that a doctor had to go through service in community health and gain experience in related social problems before he could hope to reach the upper rungs of public health echelons. The reorganised Health Service has split this apart. The present aspirants to careers in community medicine can no longer claim to have experience in basic community health. On the other hand it is obvious that hospital doctors and general practitioners cannot take the additional burden of community health in the foreseeable future. Dr Horner has stressed this point. It does not, therefore, come as a surprise that the annual conference passed a motion to emphasise the need for a career structure in the community health service distinct from that in the hospital service and in general practice.¹

The split in the career structures—and therefore in community medicine—of community physicians and community health practitioners has now become obvious. It does not bode good for either community medicine or the NHS.

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¹ *British Medical Journal*, 1978, 2, 377.

Negotiating rights for junior hospital doctors

SIR,—I share Mr Tom McFarlane's belief (22 July, p 282) that the motion concerning the representation of hospital doctors, No 104 at the recent Hospital Junior Staff Conference, was important. I regret the matter was not discussed.

I must, however, make clear my association's position. The Junior Hospital Doctors Association has asked to be allowed to represent its members in negotiations on terms and conditions of service. The various ways in which this may be achieved are being

considered by ACAS, and a new joint negotiating body which would unite the representatives of the different organisations is clearly one solution. I respect Mr McFarlane's opinion that such a body "would be less efficient than the negotiating rights being contained within the Hospital Junior Staffs Committee." I know of no evidence to support this view and indeed suggest that, now the HJSC and JHDA alike have rejected the Review Body, unity is more essential than ever. I must ask that Mr McFarlane respects the rights of other doctors who wish to have a choice of representative organisation.

As far as the JHDA is concerned, such a new structure would not involve any "coming and going" as our negotiating committee has full constitutionally mandated authority to act on behalf of the executive and membership. I appreciate that neither the HJSC nor its negotiating committee has a constitution, but that is a matter for the BMA to rectify. We have always found it strange that BMA members should allow non-members to influence the affairs of its subcommittees. To suggest that members of one trade union should be specifically allocated seats on a committee of another union is ludicrous.

The issue is simple. Is the freedom of the individual doctor important? We believe it is. We believe that any attempt to constrain the doctor's choice of representative organisation is an abrogation of democratic principles. We will not abandon our claim and any doctor who suggests that we should is effectively denying to his colleagues a very basic right. The JHDA's claim may be inconvenient to some, but it is fair.

RICHARD RAWLINS

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Junior Hospital Doctors Association

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*.*Mr Rawlins is misinformed. The HJSC does have a constitution within the BMA framework and furthermore it has comprehensive standing orders which include the conduct of all subcommittees.—Ed, *BMJ*.

Ballot of consultants and registrars

SIR,—Mr Russell Hopkins's letter (22 July, p 283) refers to a letter of mine (1 July, p 58) in which I reported the experiences of myself and 28 colleagues in the matter of the circulation of ballot papers to consultants and senior registrars.

It would be tiresome to your readers and fruitless to answer point for point, giving the reasons why, despite the procedures described in his letter, colleagues found themselves disenfranchised. He must be aware that postponement of the closing date from 9 June to 13 June, which occurred during the short voting period without press notice, was unknown to many colleagues who, finding they had not received ballot papers, judged it too late to apply through the local BMA office. For this reason it is contemptible that he should denigrate my colleagues' interest in voting. By describing my motives as mischievous Mr Hopkins demonstrates that he cannot understand the point of view of the many, including myself, who have written letters giving examples how the BMA's self-appointed task of determining the opinion of all consultants and senior registrars had failed. This blinkered attitude is unworthy of a linkman chosen to keep open the lines of communication and common interest between

BMA and non-BMA members on this one particular issue. Are all of the many who have written on this topic, including the consultant and BMA member of 17 years' standing who received the *BMJ* and BMA correspondence on innumerable occasions but *not* the ballot paper (8 July, p 128) motivated by mischief? The main purpose of these letters, certainly mine, was to show that in our opinion the mechanics of holding the ballot, which includes all the "fail safe" procedures designed by the BMA to capture the total electorate and detailed in Mr Hopkins's letter, had failed. Further there was the implication that too much must not be read into the result; but now the details of the voting are known and the contract has gone for pricing a second ballot must be conducted but *under revised procedure*.

Mr Hopkins asks for constructive criticism. It is possible to do this now that a second ballot is almost inevitable. To avoid another misunderstanding I will state my point of view quite simply—the first step in any ballot is the construction, well in advance of the voting, of a full electoral list from which the members of the electorate can check that they are included. To help in the construction of this list should be the proper function of the linkman in each region. He should not engage in expressing his pique when somebody writes on behalf of a large body of persons to report that something has gone wrong.

JOHN LEOPOLD

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Part-time training open to all?

SIR,—There are serious difficulties ahead unless part-time training and employment, in those specialties in which it is possible, become accepted as a normal way of medical life in Britain. If we are not prepared to make part-time medical work respectable we should be trying hard to discourage schoolgirls from wanting to be doctors and medical schools from admitting them. But anyone who has tried will know how unrealistic it is to expect 17-year-olds girls to be able to see far enough ahead to understand the difficulties they would face trying to combine pregnancy and motherhood with preregistration service or even with half-time specialist training.

However, if men who have trained and worked full time were able to see in part-time training something which might benefit them later in their careers it is likely that they would be more sympathetic to the earlier needs of women. Through a combination of the National Health Service and the Sex Discrimination Act Britain has given its medical profession a serious problem which will not, at least for the time being, affect other Western countries. Because our medical manpower is, in effect, controlled by the State, employment can be created for the increasing number of women entering medicine as a result of the Sex Discrimination Act. This is not the situation in the USA or in the other EEC countries where part-time training is not recognised at all, presumably because there are as yet so few medical women to demand it, and where, in a more highly competitive medical profession than now exists in Britain, the "part-timer" would in any case be even less likely to achieve a chosen career.

Before long at least one-third of British doctors in training will be women. Most of

them will be able to work only part time during some or all of that period. Because of their widely differing domestic circumstances and needs many more part-time hospital posts, individually arranged and personal to each holder, will be needed along the lines of those already created in recent years. Many similar posts will also be needed for women wishing to enter vocational training for general practice. The very nature and purpose of these personal posts demand that there should be enough of them and that they should be obtained without competition. It is this that may increasingly be seen by some as unfair when other posts in medicine are obtained in open competition and their numbers strictly controlled. However, many of us will continue to accept that there is a need to discriminate in favour of these women sufficiently to compensate them for their particular disadvantages, even though this may be seen as discriminatory against the full-timer.

In order to qualify for a personal part-time post under the present arrangements a woman (or now also a man) should have domestic commitments, illness, or disability. These qualifications, which were presumably devised without the prospect of any substantial male demand in mind, are perhaps unduly restrictive. It might be of considerable benefit to the NHS, as well as to certain individuals, if those who had served as consultants or principals in general practice for, say, 15 years were enabled, *without financial loss*, to undergo half-time "in-post" training for a second career in another specialty—perhaps even a "shortage" specialty. There might, for example, be overworked surgeons who would welcome a quieter evening to their lives in radiology or anaesthetics; or physicians in geriatrics or rehabilitation. One would hope that higher training committees might agree that some credit should be given for experience gained in the first specialty so that half-time training in the second need not be unduly prolonged.

In this way part-time training could be used to benefit men in the second half of their careers just as it will continue to help women earlier on. It is my impression that there are consultants, and perhaps general practitioners too, who would welcome the opportunity of a second career—something which is nowadays quite usual in other spheres of employment. Indeed, it would be surprising if there were not some who already feel frustrated in their present work; or others who have found themselves disgruntled in posts which are not what they really wanted. It is regrettable that it has now become almost impossible to change from one specialty to another. "In-post" part-time training would change this undesirable state of affairs; it would also help to avoid increasingly bad feeling between the sexes being added to all the other divisions and disputes at present rending our unhappy profession.

JOHN POTTER

Oxford

New consultant contract

SIR,—I am aware that many doctors are as worried as I am about the proposed new consultant contract, but I have seen little published evidence of their concern. It seems to me that an alarm should be sounded now,

before it is too late, pointing out that the proposals were designed to further the quite legitimate interests of those engaged in the "sharp end" specialties and suggesting that those who are not so engaged had better look to their defences.

The decision in 1948 to treat all specialties alike so far as NHS work was concerned was a major factor in securing a high standard of hospital care over the whole country. The total potential professional reward was, and still is, greater for those engaged at the sharp end because of the opportunity for private practice, and I have heard no one complain about this. It is entirely reasonable for any young doctor to have this in mind when considering his future and for him then to have to accept the consequences of his choice. The fact that, so far as NHS work is concerned, we were all treated alike did ensure that my own and a number of other specialties secured a reasonable proportion of the abler graduates: pathology, radiology, radiotherapy, and community medicine may serve as examples. This will cease to be so if work at consultant level is no longer to be uniformly rewarded. Only the most dedicated people—and there are never enough of those to go round—will opt for a specialty in which, at junior doctor or at consultant level, they cannot hope for a reward equal to that received by their colleagues. I find the equanimity with which some of those working in the acute specialties regard the prospect of falling standards in the diagnostic services both puzzling and alarming.

Let us be clear, too, that we have been warned. The Review Body itself has said that if some people are to receive more than the amount being suggested at present, then some will receive less. I find it difficult to understand how a responsible group, knowing this, can request the Review Body to price the proposed contract and at the same time ask for unity in the consultant body.

Surely there are only two appropriate ways of paying professional people: by salary or by a fee from the patient or client. I accept that the apparent impossibility of securing a just reward on such a basis is serious indeed and that it has led to alternatives such as the new proposals being considered. Nevertheless we will allow this consideration to become the determining factor only at our peril. If we desert the high roads we may too easily find that other paths lead, in the end, into the wilderness.

I believe that those of us who practise one of the specialties likely to fare badly under the proposed arrangements (and particularly if looming retirement protects us from a charge of self-interest) should be asking ourselves what the likely effect of the changes may be not on ourselves but on our specialty. If we find, as I think we shall, that the effects are likely to be seriously damaging, then perhaps we should go further and ask for evidence that the BMA is demonstrating any concern for those of its members who are likely to be adversely affected. So far as pathology is concerned I hope that the committee of the Consulting Pathologists Group will find time to give this vitally important matter the most urgent and serious consideration.

F HAMPSON

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*.*The Secretary writes: "All the evidence suggests that the present contract is currently

failing to maintain recruitment to the service specialties. Once the principle is breached of all consultants being paid alike the opportunity will exist to seek special arrangements for the shortage specialties. Would Dr Hampson be opposed to this?"—Ed, *BMJ*.

Authority in the NHS

SIR,—At last the profession has woken up to the needs of medical administration, as evidenced by the resolution from Bristol at the recent Annual Representative Meeting "deploping the increasing derogation of the doctor's authority in the National Health Service" (29 July, p 365). Unless the doctor is the chief officer of the hospital, as the head of a school is a teacher and the head officer of a ship (the captain) a sailor, there will not only be a failure of the administrator at the head to understand fully the needs of those engaged in that particular activity, such as teaching pupils, sailing ships, or treating patients, but the staff, realising this, will not be inspired by good leadership. It is not surprising that, whatever grade of staff at the hospital one speaks to, there is a tremendous feeling of frustration and hopelessness which has considerably reduced morale.

However, the profession has only itself to blame for this loss of position and status, for ever since the inception of the Health Service doctors have denigrated medical administration and successfully rid themselves of medical superintendents who were experienced in management by virtue of their training in a practical school. There is bound to be one leader if a hospital is to run efficiently, and if it is not a medical man then it will be a lay administrator, nurse, or even it seems, a cleaner. Unfortunately neither Dr A W Macara nor Dr J S Horner can now turn the clock back and undo the foolishness of the profession. They can but bend their heads in slavish submission.

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Medical Superintendents
Society

Taunton, Somerset

Money for old rope

SIR,—Dr S P Deacon's letter (5 August, p 437) smells of sour grapes. The role of the trainee GP is to learn general practice. How else is he to do this other than by doing the work? I agree that the balance between training and service work is fine and varies with each training situation; some trainees resent the interference of the trainer.

It is invidious to compare figures for advertisements for "situations vacant." Stable partnerships require a continuity of medical care, not a series of one-year services as given by trainees. Of course all trainers are grateful for the work done by trainees, but a trainee is not ultimately responsible for his actions—the trainer is. While a trainee is working the trainer accepts the responsibility, both legal and for the good name of his practice.

A good trainer earns his grant; if a trainee is good, then life is easier, but the trainee with problems still earns the same grant. It is not an unfair system at all, though improvements can be made. Perhaps Dr Deacon has some ideas.

J C OAKLEY

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