additional work such as covering for absent colleagues, because they are whole time—this we can seek to remedy. Some may gain advantage from redefinition of categories 1 and 2 but this implies reliance for income improvement on sources outside the NHS. In present circumstances is it still reasonable to accept a restriction on the individual's right to use his professional skill for financial return in those hours not committed to the NHS? Junior doctors are not now limited in this way. Every effort will be made to improve the position of the whole-time consultant but should he continue to work at such a disadvantage in the present economic climate?

CONTRACTUAL PATTERN

The closed contract offered to consultants by Mrs Barbara Castle, in December 1974, firmly discouraged the profession from further exploration of the subject. Recently, our junior colleagues have completed negotiation of a closed contract which has brought great financial advantage, difficult to reproduce by a straight salary increase for the whole consultant body. Is the profession now willing to reconsider this kind of approach to achieve a basis for substantial financial advance after the pay codes are over? If so, several alternatives should be considered:

- (a) Maximum development and improvement to the existing contract;
- (b) the ten-session contract;
- (c) the individually defined contract.

The ten-session contract. This was given a thorough review by the profession in 1974 and was eventually rejected. Do consultants wish to reconsider it, or something similar?

The individually defined contract. Most newly-appointed consultants now have a "job description," varying widely in its content, according to local need and interpretation of such items as the part-time option. Would there be general acceptance in the profession for such "job descriptions" based on a centrally agreed pattern being negotiated individually between consultants and their regional or area medical officers? The anaesthetists have recently formulated a description of the reasonable work load for a consultant anaesthetist and other groups are considering similar documents. Would consultants generally be willing to use this kind of method or a variation on it to set a baseline for their work, making it easier for additional work to be defined and paid for?

The CCHMS thinks that the time has come to invite the considered views of the consultants on these issues and it is most important that every consultant takes part in the debate and makes his views known.

TALKING POINT

Medical manpower

ROWLAND B HOPKINSON

The Department of Health and Social Security has recently made available the provisional medical staffing returns for the census conducted on 30 September 1975. These call into question the viability of the staffing agreements made between the profession's representatives on the Joint Consultants Committee and the DHSS.

The First Progress Report between representatives of the Health Departments and the JCC¹ was published in 1969. The report proposed that: "The postgraduate training of doctors should take only as long as the needs of training require and should lead without undue delay to a permanent post in a specialty. The length of training would be decided by professional opinion . . . ;

"There should be no permanent subconsultant grade; and

"A balance should be attained between the number of career vacancies anticipated in each specialty and the number in training for career posts in that specialty. . . . This would require an expansion of the consultant grade, control of the number of training posts in the various specialties, and limitation of tenure of those posts."

Drawing attention to an overall 3% increase in the numbers of hospital medical staff each year the report suggested a more rapid increase in the growth at consultant level than in the training grades. An estimated annual growth rate of 4% in the consultant grade and 2.5% in the training grades would remedy, by 1978, the imbalance

which caused so much dissatisfaction among junior doctors. The numerical example given was that by 1978, 12 446 consultant posts should balance 13 680 training posts (excluding preregistration posts). This would be a 44% increase in career grades and a 27% increase in junior grades over 10 years.

The Second Progress Report,² published in 1971, proposed new arrangements for achieving these aims by the formation of a Central Manpower Committee comprising representatives of the Health Departments and the professions to *advise* the Health Departments on planning targets for staffing in different grades and specialties, regionally and nationally, but within the strategic aims already agreed. Initially, a three-year programme was envisaged which would be reviewed annually.

Data

Table I gives the DHSS returns of all medical staff by grade on 30 September 1975, with the increase from the previous year. Numbers of staff are used rather than whole-time equivalents, though there is little difference in the percentage increase if the latter is used. The 1975 figures are provisional; however, comparison of provisional and final estimates for 1974 show the differences to be small. The differences are shown in the brackets in table II. The final figures are unlikely to differ sufficiently to influence the trends described. Table III gives the

TABLE I—All staff analysis by grade showing number of staff 30 September 1975

	All staff	Consultants	Senior registrar	Registrar	Senior house officer	House officer		All juniors excluding preregistration
						Postregistration	Preregistration	
Provisional September 1975	30503	11499	2317	5121	7709	315	2235	15462
Increase from September 1974	1485	335	108	348	625	-44	101	1038
Percentage increase	5.12	3.00	4.69	7.29	8.82	—	4.73	7.20

TABLE II—All staff analysis by grade showing number of staff 30 September 1974 (provisional)

	All staff	Consultants	Senior registrar	Registrar	Senior house officer	House officer		All juniors excluding preregistration
						Postregistration	Preregistration	
Provisional September 1974	28960 (−58)	11167 (−3)	2212 (−3)	4762 (+11)	7053 (+31)	366 (−7)	2016 (+28)	14393
Increase from September 1973	825	371	84	−72	+374	−25	+53	361
Percentage increase	2.85	3.32	3.79	—	5.30	—	2.52	2.51

Note: Figure in brackets indicate difference of provisional from final figure.

TABLE III—Posts approved by Central Manpower Committee

	Registrar			Senior registrar		
	1973	1974	1975	1973	1974	1975
Approvals	182	138	140	97	140	82
Increase from returns	103	−61	348	175	81	108

number of senior registrar and registrar approvals by the CMC for the past three years from 1 October each year. These figures are not strictly comparable with those from the census but are none the less useful indicators of trends.

An analysis of specialty figures shows major discrepancies in the two specialties where the career imbalance has been greatest—general surgery and obstetrics and gynaecology. In general surgery, where there had been no approvals of either senior registrar or registrar posts by the manpower committee over the last three years, the increase in the year to September 1975 was 17 (11%) and 23 (3.5%) respectively. In gynaecology and obstetrics the registrar grade increased by 30 (7.25%) when the committee had given no approvals for two years.

Combining the 1975 provisional estimates with the final figures for the previous years has enabled a collation of the expansion of all grades over the past five years (table IV).

Discussion

Statistical information provided by the Government—especially the DHSS—has been shown on several occasions to be notoriously unreliable—for example, junior hospital doctors' overtime payments. In this case, the trends are of such magnitude that they cannot be accounted for in terms of statistical error, nor can they be ignored.

The failure to achieve the propositions of the staffing agreements is clearly shown in table I. By September 1975 the numbers of junior staff in England and Wales had exceeded, by nearly 2000, the illustrative projection for 1978 contained in the First Progress Report, while consultant numbers were 1000 less than the 1978 projection. More detailed analysis gives even greater cause for concern. Though senior registrar expansion has been limited, those of the registrar and senior house officer grades have been disastrously high, over 7% and 8% respectively. The SHO grade is not controlled in any way, with posts being created at the discretion of employing authorities, which, until the advent of the new junior staff contract, found it cheaper to employ junior doctors to provide a service rather than consultants.

The CMC seems to have had no effect on the expansion of the registrar grade (table III) and little effect on the senior registrar grade, particularly in specialties such as general surgery where

there is an imbalance in the career structure and where the need for strict control is greatest. It is difficult to explain away an 11% increase in the grade in this specialty where the committee had allowed for no expansion. In other specialties some of the discrepancy may be accounted for in the delay in taking up manpower approvals from the previous year.

Table IV demonstrates an upsurge in the number of consultant posts up to 1973, though expansion has occurred mainly in the specialties with recruitment problems—for example, geriatrics and mental illness rather than in the oversubscribed specialties such as surgery and obstetrics. Since 1973 the rate of expansion has decreased to below that of 1970.

UNPRECEDENTED INCREASE

By comparison, the expansion of the junior grades has increased in an unprecedented manner over the past year. The total increase is over 1000 posts (7.18%) in the year for all junior hospital staff excluding preregistration posts. How can this have occurred? There are two possible explanations. There has either been an increase in the number of honorary posts (not overseen by the manpower committee), which would be contested by university representatives, or employing authorities are ignorant or, as is more likely, are ignoring the recommendations of the DHSS.

Representatives of hospital medical staff, especially trainees, must view these figures with dismay. It is impossible to marry the "teaching hospital" staffing system to the hospital service as a whole, and the staffing agreements cannot be implemented in practice. This is particularly true in a clouded financial future of "cash limits," with resources being reallocated from the acute sector.⁴

The profession needs to look anew at methods of staffing the hospital service: an urgent task that cannot await the report of a royal commission.

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- ² *British Medical Journal, Supplement*, 1971, **3**, 119.
- ³ *Hospital Medical Staff—England and Wales, National Tables at 30 September 1975* (provisional), Statistics and Research Division, DHSS. April 1976.
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TABLE IV—Expansion of all grades since 1971

Year	Consultants			Senior registrars		Registrars		SHOs		Postregistration house officers		Preregistration house officers		Total							
	Index No	Increase/ decrease		Index No	Increase/ decrease		Index No	Increase/ decrease		Index No	Increase/ decrease		Index No	Increase/ decrease							
		No	o _o		No	o _o		No	o _o		No	o _o		No	o _o	No	o _o				
1971	9979	278	2.8	1831	152	8.3	4656	82	1.8	5339	316	6.0	427	-18	-4.2	1696	45	2.7	25669	887	3.5
1972	10308	329	3.2	1953	122	6.2	4731	75	1.6	5978	639	10.7	409	-18	-4.2	1723	27	1.6	26894	1225	4.6
1973	10825	488	4.5	2128	175	8.2	4834	103	2.1	6679	701	10.5	391	-18	-4.6	2053	330	16.0	28153	1259	4.5
1974	11184	359	3.2	2209	81	3.7	4773	-61	-1.3	7084	405	6.0	359	-32	-8.9	2134	81	3.8	29018	865	3.0
1975 (provisional)	11499	315	2.7	2317	108	4.7	5121	348	6.8	7709	625	8.1	315	-44	-14.0	2235	101	4.5	30503	1485	4.9