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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Revised career structure: first priority

SIR,—For almost 30 years I have respected the clarity—sometimes deliberately provocative—with which Mr D Innes Williams has expressed his views in the realms of urology. Now (13 January, p 144) he writes on the career structure for doctors and the hospital staffing structure. His contribution, eagerly read, has disappointed me.

Mr Innes Williams is too well informed not to know that virtually all—but not quite all—he says has been said before on many occasions. If he was at the Association of Surgeons meeting in Oxford as long ago as 1969 he will remember the angry and opposing sentiments expressed on the staffing structure in so far as it concerned surgeons. Even then the concept of a subconsultant grade won no real support in the profession and the situation has not changed, although much "consultant" work is done by junior staff. The proposal for a new senior consultant rank is worthy of attention but may well prove logistically difficult to arrange. Unfortunately, the introduction of such a higher salaried grade except by an age qualification would necessitate either the introduction of a new committee structure, with its obvious constitutional problems, or an extension of the functions of the Distinction Awards Committee—not the most popular of committees with consultants at the present time. Mr Innes Williams suggests that it could be "open to the health authority to advertise and appoint a senior from outside." It is difficult to imagine existing consultants—some of whom might well be members of the health authority—agreeing to such an arrangement, particularly since "newly appointed professors would automatically obtain senior consultant status with a distinction award as of right." A newly appointed consultant to a professorial post (aged say 38-40) would thus assume permanent senior status before he (or she) had the opportunity to demonstrate his abilities, his temperament, or indeed his industry to those colleagues with whom he was to work. And what of the understaffed specialties which care for the aged, the chronic sick, and those who are mentally ill or handicapped? Must all newly appointed consultants in these fields automatically become senior in order to boost the recruiting drive for applicants especially in "superficially unattractive areas"?

On standards and staffing, the writer states "the colleges must ensure that the standards are high and rising as appropriate to the status of a nation with a reputation for expert medical care." Rousing words, indeed, but addressed to whom? Surely not to the Colleges, which, through the appropriate specialist advisory committees have worked unceasingly to promote and to achieve significant improvements in postgraduate education. The nub of Mr Innes Williams' contribution lies, I believe, in one sentence—"The DHSS must provide the facilities which will enable doctors to attain the standards set and must not, for reasons of temporary expediency, seek to lower them." You, Sir, know only too well that your columns each week echo to such sentiments.

As chairman of the medical board of the Royal Liverpool Hospital—the newest and probably the last 820-bed university hospital to be built in this country—I am only too conscious that the DHSS, through its cumbersome administrative structure, has failed abysmally in its obligations to the hospital staff and hence to the sick of South Liverpool. The details have been widely publicised in local and national media—yet at the time of writing, and four months after a long-delayed opening, we are facing grave difficulties and still cannot plan for elective admissions. The junior staff residency will not be ready for occupation before August of this year. Imagine the DHSS knowingly approving, indeed urging, the opening of a large acute general hospital where on-call medical staff must bring in their night attire and sleep on the wards, not for a month or so while things settle down, but for a year. Imagine also an AHA(T) which appears to be unable to resolve industrial strife in the kitchens so that breakfasts are delivered up to two hours late, choice of menu is eliminated, and both patients and staff frequently have to use disposable eating utensils. There are other spheres of industrial unrest but this is not the place to air them. I wish merely to point out, as a relatively senior consultant with no personal axe to grind, that unless the climate in which we work improves significantly medical education and a restructured profession are of little avail—indeed they become truly "unavailable". Here then, surely, is the first priority.

Finally, I agree that there must be innovation, new thinking on priorities in health care, and, of course, more consultants appointed. Some mobility of consultants might help; but is there not a danger that, although "the services and the individual would benefit considerably at times from the stimulus provided by a new post and a new challenge," this might prove to be just the directive power required by Authority to bring our profession smartly to heel? After all, in another country, dominated by authoritarianism, such honeyed phrases could describe a one-way trip to Siberia.

The problem is pressing and Mr Innes Williams has done a service by forcing it on our attention. The profession must get on with