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Correspondence

Letters to the Editor should not exceed 500 words.

The Consultant's Job

SIR,—I write as a member of the Godber Working Party to comment upon the anxieties which the Working Party's Report[1] has provoked in the profession. I should stress that I express my personal views, not those of the working party.

The particular objection to the working party's report appears to be that it implies a reduction in future in the number of junior staff in non-teaching hospitals. If I understand the views of my colleagues in non-teaching hospitals correctly, they argue that this must mean that they will in future have to carry out work which has hitherto been regarded as "subconsultant" in nature. Hence they feel that the status of non-teaching hospital consultants, and the standards of care provided in non-teaching hospitals, will fall. I am confident that the working party would view either of these eventualities as a disaster. The belief that changes in the number of junior staff are likely is to some extent a misapprehension, but is to some extent valid. In so far as the belief is valid, the causative factors are unfortunately beyond the power of the working party (and I suspect of the profession) to alter.

First, the misapprehension. The working party recommended a considerable increase in the number of consultants (which it is hoped will take place gradually in a transition period of about 10 years), but over this period there will also be an increase in the number of junior staff in training. This fact, made possible by the increasing output of the British medical schools already planned and the continuing presence of overseas graduates seeking postgraduate medical education in this country, will mean that the total number of junior staff will not in fact fall at all, although there may well be some redistribution between specialties. The statistical background to this assertion will I hope shortly be published by the Department of Health,* whose representatives, speaking at meetings in various parts of the country, have quoted similar figures. There is no reason why junior staff should be concentrated in the teaching hospitals. In my view, they should be placed wherever the profession (as represented by the various specialist advisory committees) considers that suitable training is available. Since training at this level must be predominantly a matter of the acquisition of clinical experience (and therefore not primarily a concern of the universities), the trainees should go where the patients are to be found. They should therefore be in non-teaching hospitals as well as in teaching hospitals.

Second, the facts. In essence these are three in number:

(1) There is an irreducible quantum of "subconsultant" work to be done in the hospital service.

(2) The British Medical Association has rejected a permanent "subconsultant" grade, and

(3) The acceptance of the Todd report[2] implies, firstly, that doctors will rarely spend more than eight years in junior grades, and, secondly, that the number of junior staff will be adjusted so that it matches the number of consultant and general practice vacancies.

If these three propositions are accepted, it follows that four (and, so far as I can see, only four) courses of action are open to the profession.

(1) Doctors from overseas could be brought into this country on short-term contracts, without prospect of promotion to the consultant grade, probably in jobs adjudged unfit for training, to carry out "subconsultant work."

(2) General practitioners could be brought into the hospitals.

(3) Presently unemployed married women doctors could be brought back into the hospitals.

(4) The consultant establishment could be expanded so that each consultant could do some of this work. This, essentially, is the proposal of the Godber working party.

The first course is undesirable and might even be thought to be unethical. It is, however, the only short-term "solution," although to accept it means that the population of this country would depend for medical care partly upon a large number of overseas doctors whose availability and training were beyond our control. On 30 September 1968 47% of all junior staff were born overseas. The second solution is almost certainly unrealistic at the present time, since general practitioners are already fully committed. It should, however, be encouraged as a future possibility. The third course is most desirable, but would have only a marginal effect, and, because of the taxation system in Britain, is unattractive to the doctors concerned. The fourth solution appears to be unacceptable to existing consultants in non-teaching hospitals.

Can we therefore alter any of the three "facts"? The first obviously cannot be challenged, although by altering current practices some of this work could be delegated to medical auxiliaries (assuming that such personnel could be recruited). It must, of course, be realized that, because the total number of junior staff will not fall, the volume of "subconsultant" work which will have to be carried out by the consultant grade will be small, and that only certain specialties (namely, those currently over-subscribed) will be affected in this way. The second fact could be altered by the Annual Representative Meeting of the B.M.A., but the B.M.A. would then lose its credibility as a serious body fit to negotiate on the profession's behalf. The profession's representatives (through the Joint Consultants Committee) endorsed the medical assistant grade in the Panel I negotiations[3] and were then repudiated by the A.R.M. The A.R.M. can hardly now repudiate itself. Even if the medical assistant grade were accepted by the B.M.A. it is doubtful if more than a handful of United Kingdom graduates would serve in it. To reject the third fact would be to reject the Todd report. Many of the Royal Com-

* See Appendix A, *Supplement*, p. 55.