Crisis in the Health Service

We continue to receive far more letters on this subject than we can possibly publish. We print below a representative selection, some necessarily in abbreviated form.

SIR,— . . . As dean of a medical school which, like all others in the U.K., is faced with unprecedented numbers of outstanding applicants for admission and which, despite a savage recent reduction in university finance, hopes to accept more of these able and dedicated young people, may I be forgiven if I ask whether we are producing new doctors who will serve, not in our under-privileged Health Service, but in other countries where their services are likely to be appropriately appreciated and remunerated? The warning flags are flying and I earnestly request our colleagues and the Government to take note of the following points.

(1) A few years ago there was some evidence of a partial reversal of the "brain drain," but in the past few months five key members of the academic and teaching staff of this school (a reader in physiology, a senior lecturer in obstetrics, a senior lecturer in pathology, a consultant nephrologist, and a consultant radiotherapist) have accepted posts in the U.S.A. or Canada which have offered them lavish facilities for teaching, practice, and research and also personal salaries which in real terms are generally about twice as great as those which they are now earning. Emigration has again begun to escalate with a vengeance.

(2) I do not wish to deny my junior hospital colleagues just rewards for their arduous labours, but the acceptance by the Government of a new closed 40-hour contract with payments for extra duties will undoubtedly exacerbate the present remarkable situation in which some senior registrars are earning very much more than certain consultant colleagues, even those with several years of service. And university lecturers and first assistants who share in emergency duty rotas are not eligible for such payments, so that a vast salary differential between N.H.S. and university clinical staff of comparable status has been created, with devastating effects upon recruitment to academic posts. I deplore the fact that the principle of overtime pay to any members of a learned profession was ever accepted. If salaries for junior staff had been pitched at an appropriate level this would never have been necessary.

(3) Frustration and bitterness among consultants have had the inevitable effect of reducing recruitment, *despite* extra duty payments, to the training grades in all specialties so that there has been a sharp decline in applicants for specialty vocational training schemes (except for general practice) and inevitably in a few years the numbers of consultant vacancies throughout the service will become unacceptably high and services will be yet further curtailed. . . .

(4) I have no personal axe to grind on the private patient issue, but it is a pity that this problem, unrelevant to much of the present issue, was ever allowed to muddy the waters of discussion. . . . I believe passionately in the quality of British medicine, in the N.H.S., and in the principle of medical care freely available to all according to need. I could not happily practise my profession in an environment where medical priorities were determined by the patient's ability to pay. But sadly we have now reached a position where these priorities are being determined and where medical care is effectively being rationed by the *Government's* ability to pay. I cannot be alone in believing that eight months' experience of N.H.S. reorganization has shown the new administrative structure to be disastrously cumbersome, despite the devoted efforts of administrators, lay members of authorities, and doctors alike. I am deeply concerned that all of the current posturing over the new consultant contract could prove to be the last nail in the coffin of our ailing N.H.S. Mrs. Castle must heed the solemn warning that she could go down in history as being the Secretary of State who presided over its final disintegration.

May I therefore urge our negotiators, the Review Body, and the Government to consider the following measures.

(1) To reopen negotiations such as those in the Owen Working Party, which seemed to the outside observer to be relatively close to a satisfactory compromise when the door was calamitously closed.

(2) To reconsider the whole principle of whether a closed consultant contract is what the profession really requires. I believe that the present open contract with full-time or part-time options would be acceptable to many members of the profession provided this were realistically reappraised in monetary terms and if whole-time consultants, especially in regional hospitals, were eligible for substantial supplementary commitment allowances, over and above their basic salary, to acknowledge the very substantial additional work they undertake outside normal hours. Such awards might well be complementary to the existing merit award system, or alternatively this whole system could be revised to take much more account of work load and commitment as well as the current criteria of distinction. Is it really out of the question that a similar revised contract might also be negotiated for our junior hospital colleagues in order to abolish once and for all iniquitous and divisive extra duty payments?—I am, etc.,

JOHN N. WALTON

University Medical School,
Newcastle upon Tyne

SIR,—The consultants are isolated. The junior doctors and the general practitioners have accepted from Mrs. Castle promises of reasonable settlements. We have lost sympathy from public and press. The contract offered by Mrs. Castle to us is unacceptable. Do we need a long, bitter industrial struggle to reject it? In 1972 in a letter signed by 21 consultants on the staff of this hospital (7 October 1972, p. 54) we pointed out the dangers of a closed contract and the folly of imagining that this would assure us of a better income. Now the Central Committee for Hospital Medical Services has sacrificed our professional standing without the financial gain needed to attract and keep good doctors in the Health Service.

May I therefore suggest a new approach to Mrs. Castle on the following lines. (1) Stop all negotiations on our contracts for a cooling-off period. In the meantime the present contracts to be continued, including merit awards. (We cannot accept the politically motivated awards that Mrs. Castle suggests, and we cannot give up this major part of our total income without compensation.) (2) Obtain an undertaking that the Review Body will ensure in April that no full-time consultant earns less than any senior registrar with his extra-duty pay. (3) Ensure that action on phasing-out of pay beds be delayed until the Department of Health and Social Security agrees with the profession how this is to be done. All unofficial action against pay beds to be declared illegal by the D.H.S.S. (4) Make an urgent review of pensions, including credit for war service or full-time hospital service before 1948.

In return, the consultants could give certain undertakings. (1) To assist in checking undesirable practices, such as queue-jumping. (2) To join with the D.H.S.S. in seeking ways to make more efficient use of facilities. (3) To offer to the D.H.S.S. constructive advice to get them out of the expensive chaos that they have produced in their administrative reorganization. (4) To offer to the D.H.S.S. advice from the profession as a body of how to turn the Salmon scheme from a system of nurse management to a system of patient care. (5) To abandon finally any claim to an item-of-service payment.

Such an approach might give us a chance to meet in a better atmosphere and find a solution that both the consultant and the D.H.S.S. would accept.—I am, etc.,

LESLIE J. TEMPLE

Liverpool Cardio-Thoracic Surgical Centre,
Broadgreen Hospital,
Liverpool

SIR,—The demand for "free" medical services is steadily increasing and is probably without limit. The resultant strain on the service supplied by general practitioners combined with the pressure exerted by patients increases the demand for hospital treatment.

My own opinion is that at least one-third of my ophthalmic outpatient cases could well have been treated by their own doctors, and from consultation with my colleagues, I would think that this state of affairs pertains in many other departments. If this process of sending so many unnecessary patients "down the line" continues to increase, and there is every evidence that it will, then certain effects can be expected: (1) the hospital service will continue to grow until curtailed by the enormous expense; and (2) rationing of demand will be effected by extremely long waiting lists. . . .

Except for certain specialties I do not believe that appointing more consultants with their ancilliary staff is the answer to the problem. Over the years one has observed that however many sessions are staffed, within a short time these are fully booked, and soon after this the waiting lists have grown to a level similar to those before the additional services were made available. Rationing by prolonged waiting lists has many disadvantages in that it tends to produce unnecessary suffering and, when the patient eventually attends, the causal condition is either cured or has deteriorated. In addition it results in the abuse of the "urgent" referrals.