Community medicine

"We have been told that the main administrative posts at regional and area level have all been filled but that no further progress has been made in filling the balance of the complement of community physician posts. There are 738 established posts in England and Wales, of which 121 are vacant—five more than in 1975. Notwithstanding the decision in May 1976 to go ahead with appointments on the special salary scale recommended in 1973 for use should it be found necessary to fill community physician posts, on an interim basis, by candidates who did not satisfy the full requirements of appointments committees, very few candidates have come forward and, so far, one such appointment only has been made. Doctors in training posts have to achieve membership of the Faculty of Community Medicine before they are eligible for appointment as fully qualified community medicine specialists, and it takes time and experience to reach this standard. However, there has been a small but encouraging increase in the number of senior registrars and registrars in post in community medicine from 59 in 1975 to 76 in 1976.

"We have been told by the Health Departments that they have been unable to agree to a proposal from the profession that a fee should be paid for domiciliary consultations by community physicians. . . . Apart from the implications of the current restraint measures, the Health Departments do not regard a fee of this kind as appropriate. . . . But they recognise that, if a new form of contract for consultants were agreed, it might well have some implications for community physicians (who are paid on the same salary scale as consultants). They have said that they are ready to discuss with the profession modifications to the contract for community physicians in the light of any future changes. They have also agreed to discuss, on a 'without commitment' basis, proposals which the profession have under consideration now for the training grade structure in community medicine.

"The number of community health medical staff (senior medical officers, clinical medical officers and other medical staff) in England and Wales has increased by 9·1% from 6285 in 1975 to 6858 in 1976. Most of them (about three out of four) work part-time only and, in whole-time equivalent terms, the increase was 5·2%, from 2084 in 1975 to 2198 in 1976."

Juniors and Review Body award

HJSC Executive writes to regions

The Executive Subcommittee of the Hospital Junior Staff Committee, which met on 28 and 29 May, has sent the following letter to linkmen and regional committees:

The Executive of the Hospital Junior Staff Committee of the BMA, which represents all hospital junior doctors in the United Kingdom, has met to consider carefully the Seventh Report of the Review Body on Doctors' and Dentists' Remuneration, which was published on 25 May 1977. It will be remembered that part of the agreement reached with the Secretary of State (in which the Hospital Junior Staff Committee obliged him to remove paragraph 204 following its unilateral insertion in our Terms and Conditions of Service) involved some doctors taking up new contracts in covering for colleagues on annual and study leave—without remuneration. The Hospital Junior Staff Committee made it clear at that time that they and the doctors they represent would not tolerate such a situation for very long and the Secretary of State agreed with them that the Review Body should be asked jointly by ourselves and the Department of Health to take the earliest opportunity of correcting this unacceptable situation.

In their report the Review Body, though expressing reservations, have agreed to this request and have used a proportion of the total money available to hospital junior staff under phase II of the Government's incomes policy to enable doctors contractually committed to covering for colleagues on annual and study leave to claim prospectively extra UMTs for so doing. The remaining money available is to be divided among hospital junior staff and would produce £2 per week. Those doctors who do not cover for colleagues absent on leave, and those doctors who are already receiving payment for prospective covering of colleagues' leave will receive just the £2 per week. This is less than the minimum recommended by the Government under phase II. However, this is an unavoidable consequence of righting an injustice in which some doctors were doing work for nothing during a period of strict pay restraint.

The committee deplore the fact that the Review Body have seen fit to attack the principle of a closed contract for hospital junior staff. You will recall that the old contract (pre February 1976) was an open ended contract, which meant that there was no limit to the duties your employing authority could impose on you. Part of the reason for introducing the new contract was that successive Review Bodies from 1960 onwards had failed to price such a contract at a level which gave just financial recognition to the extraordinarily long hours worked by hospital junior staff. The introduction of a closed contract in February 1976 was supported by the great majority of hospital junior staff, as a first step towards a just salary system, and received the sympathetic support of a large body of public opinion.

A cornerstone of the agreement reached with the then Secretary of State, Mrs Barbara Castle, during the 1975 crisis over the introduction of the new contract, and since confirmed by Mr David Ennals, the present Secretary of State for Social Services, was that the basic salary should be paid for a 40-hour week. This point is fundamental to achieving proper remuneration for work done in excess of 40 hours when pay policy permits. Despite the fact that the DHSS and ourselves, the two parties to the contract, have jointly presented this agreement to the Review Body on no less than three occasions, the Review Body has refused to accept it. We question whether matters of contract are within the remit of the Review Body, who have consistently refused to price the contract on the agreed basis. They maintain that there is a proportion of the basic salary which is paid for work done in excess of 40 hours but have repeatedly failed to quantify the amount. The logical conclusion is that for working a 40-hour week, you are worth less than your present basic salary. We do not believe that many hospital junior staff will agree with that suggestion. It is vital that all doctors realise that until the basic salary relates only to a 40-hour week, they have no hope of getting work done in excess of 40 hours properly remunerated in future.

In addition, the Review Body have questioned the agreement that a doctor fully available at home should receive A units. This also was a major concession won from Mrs Castle during the 1975 contract crisis and was a major factor in enabling the contract to be introduced with "no detriment" to those doctors on call from home. They have also criticised arrangements made by some doctors who, recognising that patients' needs are paramount and can only be met by a pattern of working which is flexible in operation, have included in their assessment of hours the frequent but irregular occasions on which they are required in their patients' interests to work into their specified off duty time. Furthermore, it has asked that the right of resident doctors to receive A units be "clarified." This could result in financial detriment to junior doctors. We believe this to be interference in contractual matters.

The Review Body have again attacked the concept of a contract which relates salaries directly to length of working hours (the basis of the junior contract) in their comments relating to the proposed consultant contract. We believe that a work sensitive contract such as this carries with it the only likelihood of achieving proper remuneration for consultants, a rational staffing structure for our hospitals, and a satisfactory career structure for hospital junior staff.

Just to reject the report in the hope of a slightly better deal under the next phase of pay policy is not good enough. We feel that there are serious questions concerning the Review Body procedure in general, and this report in particular, which should be the subject of wide debate by hospital junior staff throughout the country.

For our part, we are in no doubt that the report is not acceptable. Rejecting the report would involve, obviously, at least a temporary financial loss to hospital junior staff, though in many cases this would be very small. We are asking you, therefore, to discuss this matter fully with your colleagues, preferably having obtained a copy of the report from your administrators or HMSO. You should then inform your regional hospital junior staff representatives of your decision so that a democratic decision can be taken by a well-informed national hospital junior staff committee at its next meeting, which will be on Thursday, 16 June 1977.