Shortage of radiologists

SIR,—The situation described in the letter from Mr P Dawson-Edwards and Dr Michael Barrow (11 June, p 1531) on the shortage of anaesthetists in the Birmingham region could equally well apply to radiologists on a national scale.

At this hospital, for example, we are approaching a crisis point in regard to our radiological services. At the present time we have an establishment for four consultant radiologists and we participate in a local rotational scheme with the Royal Infirmary nearby so that we receive from them a senior registrar and a trainee registrar. One of the four posts, newly created, has so far failed to attract any candidate and within the past few weeks an established member of the existing staff has accepted an appointment in Australia, which will reduce our consultant staff to two part-time radiologists. Between us at present we provide 15 sessions of coverage per week. As our work load is 50 000 patient attendances per year such a reduced radiological staff will clearly be quite unable to cope.

Locally, then, we are faced with a situation in which we will have to reduce our *x*-ray services very considerably, concentrating on inpatient and emergency outpatient work only. All contrast investigations for local family practitioners will have to cease until replacement radiological assistance becomes available. However, it is clear that this situation is not confined to our particular hospital. It is apparently affecting many hospitals in the country and if the trend continues it will affect many more in the near future. The official emigration figures for last year were 52 radiologists, 14 of whom were evidently consultants. This has evidently been about the average figure now for several years, and of course many of our bright young consultants and registrars are included. The question that faces those of us who remain is, should we disregard the flow or try to rectify the situation?

Our colleague who is going to Australia is being attracted to a large extent by better pay and one suspects that this is the reason for most other migrations. The area he is going to has a radiological staff of 40 in a total population of 700 000, a ratio about three times as high as that which exists in Bristol and its environs, with a similar population. Each radiologist receives about three times or more the salary paid over here—a good many of them are, in fact, British! Salary arrangements in the Australian hospitals are different from ours in that half the salary is evidently a guaranteed amount and the other half is a share-out in the department of an item-of-service scheme whereby every examination carried out generates a standard fee, which is the same for, say, a chest *x*-ray film or an arteriogram. In this way security is provided and hard work is rewarded.

It seems that unless we in Britain study some of these schemes and adopt one or some of them our young radiologists will continue to go abroad. We all know that radiology here offers few chances of marginal rewards such as domiciliary consultations, private practice, etc, and that our pay may thus compare unfavourably with that of some other specialties. Internationally, of course, we are just not in the same league as many other countries. And yet radiologists are a relatively small but vital group in hospital practice and are often the linchpin that holds the service together. A determined effort to alter our terms of service could well be rewarding.

Many of us in fact feel strongly about our responsibilities to our fellow colleagues and to our own particular hospital and would wish to continue a satisfactory service to them both. We would also like to provide an attractive environment whereby our younger colleagues would wish to join us and stay with us. At the present time this is clearly not the case. Surely some action should be taken to put the matter right before it is too late.

J L G THOMSON

X-ray Deartment,
Frenchay Hospital,
Bristol

Revenue sources for community health services

SIR,—In these times of financial strigency for, inter alia, the NHS it is becoming apparent that one major saving would be to transfer as much work to the community health services as posible. Therefore it is necessary to assess the capability of these services to meet this expanding need. To do this one must review the methods of funding them.

Following reorganisation in 1974 the community services came under the aegis of the NHS. Previously they had been, in the main, departments of the local authorities with a very small component hospital-based. The funding, of course, had derived from the parent authorities. Part of the function of the joint liaison committees was to identify the moneys involved, their source, and their destination in order that the services and their funding could be continued. As was shown by Buxton and Klein,[1] the distribution of hospital provision was riddled with discrepancies and inequalities, both between regions and within regions. This was after the hospital services had been organised by a single Ministry, ultimately the Department of Health and Social Security, for a period of 26 years, the aim of which department was to provide a uniform service.

The size, function, and budgets of the community services had been based on priorities decided by a multiplicity of local authorities which had many other departments to fund, so that the provision reflected the authorities' interpretations of need as seen against the requirements of other services and demands for cuts in the rates. The resultant hotch-potch taken over by the area health authorities varied widely in quality but was generally inadequate to meet the standards required of the Health Service.

The funding now being provided comes through the normal NHS channels and is subject to normal NHS practice. Thus, given the present cash limits imposed by the Government, any increase in funding can derive only from four sources: (1) revenue consequences of consultant appointments; (2) revenue consequences of capital schemes; (3) development revenue; and (4) reallocation of funds within a district. Of these, by far the greatest source of increased revenue is the second.

The first source cannot bring any money to the community services. The second is limited in that the only capital schemes in the community are either health centres or clinics, neither of which draws big revenue consequences and may in fact, by concentrating resources in a few such centres, create a vortex which sucks revenue from other parts of the district, causing further deprivation in the periphery. The third and fourth sources place the community services alongside other departments in the district, in competition for any meagre moneys not already irrevocably committed. In deprived areas in deprived regions these moneys can be very meagre indeed, depending on the financial climate and on the varying forces which have already led to the gross inequalities of the NHS.

The community services therefore find themselves in a dilemma from which there is currently no escape—they are a low capital cost service with high revenue requirements in a financial environment which relates revenue to capital cost. Thus if they are to develop to parity with the hospital service some different principle of funding must be conceived and put into effect. It is only necessary to look at any area strategic plan to foresee the future. The list of priorities for primary care is there, but none attracts any revenue, while the priorities for general and acute services all involve capital schemes with high revenue consequences.

As at present funded the community health services cannot respond to the demand and may well become less able to do so. There is therefore an increasing urgency for the powers that be to "get this one right." Unless there is change the high-flying ideals of reorganisation with regard to the development of medicine in the community will founder in a morass of financial incompetence, no one having had the foresight to see just what the revenue consequences would be.

Plus ça change, plus c'est la même chose.

A P TAIT
Chairman
G I BENSON
Vice-chairman,
Derbyshire Local Medical Committee
Matlock, Derbyshire

[1] Buxton, M J, and Klein, R E, *British Medical Journal*, 1975, **1**, 345.

Home Office v the NHS

SIR,—Administrative inflexibility and policy misinterpreted have always been a handicap to large organisations, including the NHS; but one wonders how often the Health Service is jeopardised further by the cryptic policy of other ministries. An example follows.

A 25-year-old graduate (BSc) in physiotherapy, of European parentage and having English as her home language, planned to increase her professional experience and elected to visit Britain. After correspondence, during which she effected the necessary professional registration in Britain and communicated with senior hospital personnel, it became apparent that most instructional courses were of short duration and the most satisfactory approach would be to practise as a physiotherapist in a hospital department with the object of attending instructional courses perdiodically. Entry to long-term courses customarily is by interview selection and thus these posts could not be arranged in advance.

She was advised that since she had a professional qualification in an undersupplied field of the Health Service she would likely be assisted with entrance formalities. However, on arrival in Britain with adequate financial resources and personal sureties she was refused permission to work and directed to remain no more than two months, and her passport was endorsed accordingly. The immigration official declined to inspect her documentation but suggested she appeal to the Home Office if so inclined. This she did, but was told that the endorsement now in her passport was an immutable restriction and that it would be illegal for her to discuss or arrange employment while in Britain.

As planned, she proceeded with visiting various physiotherapy centres, where it materialised that without exception a shortage

of physiotherapists existed, and she was approached by each unit requesting that she consider working—to date 20 units. However, the Home Office restrictions prevent her from doing so. The sequelae to this negative approach are that the NHS will not benefit from the services of a skilled individual, bringing with her the experience of a famous unit abroad, and that her colleagues will be likely to be deterred from attempting to gain entry to Britain in the future, availing themselves instead of the more encouraging attitude offered by other countries.

J P DRIVER-JOWITT

London WC1

The Minister and the consultants

SIR,—Many of your readers will have seen "Panorama" on BBC TV on 17 October. In it the Minister of Health informed the country that consultants were perfectionists. I was gratified to here this. It is the first piece of praise that the consultant body has received from that quarter for some time. However, he used this statement to imply that our repeated cries of deficiencies and of falling standards in the hospital service were therefore not to be taken seriously. He stated further that if there were any real deficiencies in the service we would no doubt inform him of these.

I suggest that the consultant body take up his valuable suggestion. It should not be difficult for each of us to find serious inadequacies in the hospital service, say, twice a week. Perhaps 22 000 letters per week may shake him out of his cloud-cuckoo land.

It would be remiss of us to introduce political bias in our efforts to educate our political masters, so I suggest that copies of any letters should be sent to the Conservative shadow minister for his information.

J A K DAVIES

Pembroke County War Memorial Hospital,
Haverfordwest, Dyfed

Payment for on-call duties of clinical assistants

SIR,—The medical staff committee at this hospital has directed me to write to you concerning reimbursement for on-call duties of clinical assistants.

One tends to wonder when the apparently fairly reasonable treatment meted out to general practitioners will ever be achieved by hospital consultants and it is difficult not to call to mind George Orwell and his "some pigs are more equal than others" when one sees that the Department of Health and Social Security approves of clinical assistants now being paid for "on-call" duties, with further reimbursement if they are actually called out. We, the hospital consultant staff, soldier on, coming in as necessary and sometimes frequently and merely recouping the cost of petrol.

I recall well about 10 years ago being one of many consultants holding evening clinical meetings and lecturing for no fee while those we lectured to were being paid to listen. It was a bit difficult to stomach at the time but eventually it was sorted out, and yet here we are again being far less "equal" and I wonder if it is generally known. Can we have it out in the open and try to achieve some sort of equality? In the meantime, and on a more personal note, I anticipate eagerly my travelling expenses of 74p being paid at the end of next month for the two hours that I spent in the hospital last Sunday afternoon dealing with an emergency.

A P C BACON
Chairman,
Scarborough District Hospitals
Medical Staff Committee

Scarborough Hospital,
Scarborough, N Yorks

****The Secretary writes: "The new consultant contract, at present under negotiation with the Department of Health, as well as including one notional half day in the basic commitment for the consultant's continuing responsibility for patients currently under his care, makes provision for additional on-call responsibility to be recognised by the payment of fees varying with the degree of availability required. There is also provision for the payment of a fee on each occasion on which a consultant is recalled to hospital to deal with an emergency outside normal working hours."—ED, *BMJ*.

General practitioners' pay

SIR,—It seems clear that there will be no pay rise before April 1978 and it is certain that any significant increase at that time will be achieved only by our negotiators demonstrating a realistic set of figures concerning increased productivity in terms of numbers of patients seen or numbers of prescriptions issued. Our negotiators were unable to convince the 1977 Review Body of any real increase in work load which would have enabled the Review Body to recommend significant pay rises within existing legislation. So that this error is not repeated it would be useful for the BMA, or whoever our negotiators may be, to request GPs to keep such figures and indicate how they should be obtained. Why is this not being done?

M J CRITCHLEY

Bexleyheath, Kent

****The Secretary writes: "The problem of monitoring work load in general practice has been studied by the Association on several occasions in the past and it is quite clear that it is an extremely difficult task to obtain any meaningful figures. Nevertheless, in view of the requests by the Review Body for some firm data our economic research unit is now preparing an on-going study of work load. It is hoped that it will be possible for this to start in the very near future."—ED, *BMJ*.

Use of deputising services

SIR,—The rejection by the Secretary of State of the appeal by Dr Maurice Buckley against the decision of the Walsall Family Practitioner Committee not to give him consent to use a deputising service is greatly to be deplored. If Dr Buckley is personally covering a substantial part of the 66 hours of normal time and is doing one-eighth of the remaining 102 hours for an eight-man rota he will be personally responsible for patients' care for about 72 hours per week. This is what the Secretary of State is requiring of Dr Buckley at a time when the national standard working week is 38 hours and when the Government impose restrictions on the working hours of coach and lorry drivers and airline pilots.

However, while absolutely condemning the Secretary of State and the Walsall FPC, it would seem appropriate to remember the part which medical practitioners have played in this matter. Since the Southampton Annual Representative Meeting of the BMA in 1972 I have, through the appropriate constituencies, tabled a series of resolutions relating to the ability of practitioners to use deputising services, and these have been rejected by the ARM on at least two occasions and have not been discussed on other occasions. When they have not been discussed I have invariably provided a memorandum so that they could be considered by the Council of the Association, and the General Medical Services Committee has considered the matter on each of these occasions and has been unable to support any of the proposals.

The profession must accept much of the blame for the situation in which Dr Buckley now finds himself.

DERMOT LYNCH

Hanworth,
Feltham, Middx

Work of community physicians

SIR,—The Central Committee for Community Medicine recently set up a working party to review the work undertaken by community physicians since the reorganisation of the NHS and how it relates to the theoretical assumptions made prior to reorganisation.

The committee is anxious to assemble as much information as possible and invites anyone who has comments or opinions to send them to the secretary of the Working Party on the State of Community Medicine.

G D DUNCAN
Chairman,
Working Party as the
State of Community Medicine

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Changing the FRCS exam

SIR,—Mr P F Jones (25 October, p 1145) is, of course, referring *only* to discussions which have occurred in the Royal College of Surgeons of Edinburgh concerning possible changes in their own FRCS examinations.

During the seven years I have served on Council of the Royal College of Surgeons of England I am happy to report that the primary and final FRCS examinations have been kept under regular review. Changes of a minor character have been made in the primary FRCS examination but there has been no disposition to effect radical changes in the character and/or timing of either our primary or final examinations.

My personal views happen to coincide with those of Professor Roy Calne (8 October, p 952 and in the *Annals of the Royal College of Surgeons of England* (November 1977, p 514)). However, it would be for the Council of the Royal College of Surgeons of England to decide if any alteration should be made in our own examinations and, for the general reassurance of all our Fellows as well as those in training, may I clearly state that we are not at present planning any changes.

REGINALD MURLEY
President,
Royal College of Surgeons of England

London, WC2