Hospital staffing in the 1980s

SIR,—In your report of the CCHMS's examination of Dr J D N Nabarro's paper (17 May, p 1237) the main objections were (*a*) that to increase the number of consultants would reduce the private practice and the number of domiciliary visits of the established consultants; and (*b*) that without ample junior staff and backup facilities the extra consultants would in fact be subconsultants or glorified registrars. Dr J M Cundy said this "cadre" would therefore become disgruntled and miserable. Neither of these objections is necessarily correct.

To render them invalid the negotiating subcommittee would have to return to the DHSS and negotiate another consultant contract, which would be "whole time"—the standard 10-session contract could stand as the contract held by all established consultants. The clinical content of this additional contract would fit the skill and experience of senior registrars, aged 32-33 years, as soon as they have successfully completed their higher professional training. This contract they would hold until vacancies occurred among the holders of the standard contract by retirement. On the whole advancement from the "whole-time" to the "standard" contract would be automatic, but which individual obtained the vacancy would be decided by competition between those who had worked longest on the whole-time contract—senior registrars would be debarred from applying.

Take general surgery, for example. An analysis of the general surgical work in the West Midlands Region (98 770 patients) showed that the established consultants could properly transfer the ultimate clinical responsibility of 61·9% of all their admissions to a younger consultant of less experience. There are two ways in which this could be done.[1] Whichever way was chosen it would safeguard the private practice, domiciliary visits, and character of work at present enjoyed by the established consultants. As the 61·9% of the work transferred is clinically and technically simple the extra consultants will require few junior staff and little in the way of backup facilities. As the whole-time contract would be held for a limited number of years a "cadre" of disgruntled consultant surgeons would not develop, which answers the second main objection—there would be no need for a subconsultant grade.

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[1] Doran FSA. *Ann R Coll Surg Engl* 1980;**62**:136-41.

Training the trainee

SIR,—Dr W R Fraser (7 June, p 1378) writes of the problems of a GP trainee. One can only hope that his relationship with his own training practice is not as strained as his letter might imply. Being provoked to reply, I find it hard to do so without risking similar implication. None of the following should be read by my own trainers as a blow below the belt.

A GP trainee, it seems to me, finds himself in an anomalous and rather uncomfortable position, as do all newcomers, all juniors, and all temporary members of any group; and he is all three. That his role is closely defined neither by custom nor by statute can only add to his difficulty. Altogether, the temptation to formalise and regulate his standing to reduce this insecurity may be considerable. It is also undoubtedly true that some practices unfairly exploit their trainees, and a trainee is worth about £10 000 a year to his practice, in cash and in kind, if he has any go about him. Yet if he is always supernumary, never an important member of the team, exploited in fact as a useful resource, he is in for a very dreary time.

My own trainers are informal, vague even; perhaps this decribes my own character too—at any rate, we chose each other. I am not on a "scheme." In retrospect, a more structured relationship might have been valuable. I appreciate the force of Dr Fraser's argument for a more strictly specified teaching commitment, but this could never be more than advisory. Ideally, perhaps, practice and trainee ought to be on sufficiently good terms that they can negotiate their own arrangements according to their individual tastes. Guidelines may help, but if there are any serious differences the value of their union must be in some doubt and regulations will not mend matters.

I think we are in some danger at present in general practice of overregulating and overcontrolling, for which the Royal College of General Practitioners must take most of the blame. Few would deny the value of a college, in an educational and representative role: but some of its keener spirits seem so carried away with the novelty of it all as to want to impose their idiosyncrasies on all of us. Perhaps they will come in time to a more tolerant maturity.

General practice is an independent, individualist business. That is much of its appeal. In the past, there has been room within its confines for almost anyone, to the overall benefit of doctor and community alike. There are niches for the unexceptional. It is the last resort of the maverick. By their increasing power to regulate GP training, the Prince's Gate brigade have acquired a means to wield enormous power and influence over the profession as a whole, as they no doubt fully intended. It remains to be seen whether the effects will be beneficial, or whether the college will prove a King Stork. We already have compulsory training and an increasingly compulsory examination, the value of both being debatable. The problems faced by trainees, including those mentioned by Dr Fraser, can indeed only increase now that they are no longer free agents. Despite the attractions, for some, of standardisation and regulation, we should do well to consider the strengths that lie in diversity.

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SIR,—We hope soon to be able to answer Dr W R Fraser's question (7 June, p 1378) about how many GP trainees get value for money in terms of training from their trainers, who now receive £2550 a year for teaching.

This was one of the many questions on the quality of GP training that we sent to more than 3000 trainees throughout the UK. Their views and the results of this questionnaire will be discussed at the fourth national GP trainee conference, which will be held in Exeter from 15 to 17 July. This will be the first opportunity for trainees to consider the implications of the new regulations with those involved in the organisation of vocational training.

In addition, we should like to hear the views of any doctors interested in a future career in general practice.

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Review Body award

SIR,—I refer to the recent correspondence in the *BMJ* suggesting that we ought to forego part of our increase in pay. I strongly disagree with this suggestion. At age 56 and with over 30 years' service to the NHS, I reckon that, for a 40-hour week, I am worth three times what a novice bus driver is worth. But I don't work a 40-hour week. I work at weekends and at night too, so I reckon I am worth *four* times a novice bus driver. But the bus driver does not have to provide his own bus, or to service it and petrol it. Nor does he have to provide his own tools. I have to do all of those things, so I rate *five* times a novice bus driver. And how much does a novice bus driver get for a 40-hour week? £100 per week, or £5200 per annum. At £26 000, I reckon that for what I am and what I do and what I have to provide this is about right. Nor am I ashamed to expect this sort of figure when my daughter is getting £4000 as a secretary.

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Fees for coroners' postmortem examinations

SIR,—I understand that in several parts of the country pathologists are being asked by public auditors and administrators to pay one-third of the fees which they receive for doing coroners' postmortem examinations to the health authority. This is quite contrary to the agreements which have been reached with the Department of Health in the past, and if any pathologists are experiencing a difficulty of this nature the Secretary of the BMA will be pleased to supply them with copies of the official statements.

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Computer-based child health system

SIR,—Both medical and lay readers of your journal will be concerned about the present BMA embargo—at first on ethical and more recently on practical grounds—of field trials of the Child Health Computing Committee's proposed "preschool module." At a meeting on 18 June the committee unequivocally stated its belief that "there is now no remaining ethical issue which would rightly prevent the preschool systems trials taking place."

The Child Health Computing Committee, which represents the NHS and the professions, was set up in March 1977 with the following terms of reference: "To consider proposals for the development of the computer-based child health system for England and Wales and to advise the centre responsible for the development accordingly, and to co-ordinate and monitor such developments as may be considered necessary." Since its inception three