lems? Similarly, would the young doctor seeking collateral life assurance to guarantee his house purchase loan wish to pay more because those of us who have hypertension are not to have it revealed?

To sum up, if an individual wants something—whether it be a job, insurance cover, or a pension—invariably there are conditions; and in many cases one's state of health and future prognosis constitutes one condition to be fulfilled before the transaction can be equitably completed. We all see the grounds for Dr Howe's concern, but if consent to disclosure, however reluctant, prevents a hypertensive from being a steeplejack are not both his interests and those of his mates better served?

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Negotiating for doctors

SIR,—Dr John Havard's reply (7 November, p 1268) to my letter on the status of the craft committees (p 1268) makes a number of questionable points. Firstly, he accuses me of neglecting the facts and then sets out exactly the facts on which I based my letter. Secondly, he says that there is no link between the question of recognition of the craft committees and their universal franchise status, even though the universal franchise status is the main argument that has been repeatedly used against recognition of other organisations. Thirdly, he refutes the argument that other unions participate in the craft committees as organisations, and says that my letter will fool very few people on that point. Indeed it won't, for I made no such claim. My letter quite deliberately avoided this issue by claiming only a right for *members* of other unions to participate, without getting drawn into the question of whether that amounted to participation by the organisation itself.

The BMA and the Medical Practitioners' Union (MPU) have different views of the status of the craft committees, each of which is internally consistent and consistent with all the facts. The BMA's view is that since the craft committees have the legal status of BMA committees they are merely part of the BMA. The seats on the Medical and Dental Whitley Council, which are vested in the craft committees, are therefore BMA seats, and since these constitute the whole of that council the BMA has sole negotiating rights and is in possession of the medical and dental seats on the General Whitley Council. The seats held by the MPU on the General Medical Services Committee (GMSC) is an arrangement that is quite common in industrial relations and is known as an "agreement to protect," whereby a recognised union makes a concession to an unrecognised union of allowing it access to the machinery of the recognised union. The right for non-members to participate in the craft committees is conferred by the BMA out of the goodness of its heart.

The MPU's view is that the legal status of the craft committees is merely an unimportant concession to the BMA. The status which really matters, because it is the status from which they derive their negotiating rights, is the status which they are recognised as having by the employer. The seats on the Medical and Dental Whitley Council are held by the craft committees in their own name—the only instance in the Whitley system where they are vested in a specified committee rather than in a union per se. The craft committees are recognised as "representatives of the profession" and they have claimed, and defended, that status quite explicitly on the basis that they are elected by universal franchise. The participation of non-members of the BMA is therefore a right which could be withdrawn only at the risk of losing the status of the sole representatives of the profession.

MPU members, co-ordinated and guided by the union, have participated in the committees and influenced their policies. On some issues, such as the Family Doctors' Charter and the problems of women doctors, that influence has been important. The MPU views this as being activity which the union can take some credit for. We see ourselves as exercising our right to use the representative machinery by fielding candidates. The BMA, however, views our members simply as individuals and sees our co-ordination of their activities simply as an organised lobby of the BMA, such as any medical organisation could mount.

The facts bear both interpretations equally well because they were intended to. The essence of the craft committee system is that all doctors can participate in it, and if they see its relationship to the BMA rather differently then that does not matter so much as the fact that they can work within it. It would be important to work through to a conclusion the issues raised by this correspondence only if there were a desire to break up the craft committee system. Dr Havard has assured the profession in his reply to my letter that the BMA has no such intention, and I have written to him assuring him that the MPU has no such intention either. Indeed, the only medical organisation which seems to want to abandon the system is the Hospital Consultants and Specialists Association, so perhaps we can leave them on the sidelines gnashing their gums while the rest of us get on with the task of representing doctors. There is no point in discussing philosophical legalisms of no practical importance to the functioning of the representative machinery.

The reason that I wrote my original letter was because I interpreted Dr Havard's letter to district health authority chairmen as an attempt to shift power from local medical committees and district hospital junior staff committees to BMA place-of-work accredited representatives, who are elected not by universal franchise but only by BMA members. I was writing to point out that such a shift would be unacceptable and that the status quo would be defended. I believe that my point of view commanded quite broad support within the profession, although many of those who supported it saw it as a dispute *within* the BMA rather than *with* it, since they viewed the craft committees in the BMA light. I now gather that Dr Havard did not actually intend his letter to have such consequences and therefore the issues which I raised can safely sink back into the mists of deliberate ambiguity, where they have rested comfortably for over 20 years.

STEPHEN J WATKINS
National co-ordinator,
Medical Practitioners' Union

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**The Secretary writes: "Dr Watkins seems determined to continue to misrepresent the position of the craft committees of the BMA. They have two main roles. They are standing committees of the Council of the BMA and they are executive committees of their own national craft conferences. With the exception of the Conference of Local Medical Committees the craft conferences have only recently emerged as representative bodies and their decisions are not constitutionally binding on their craft committees, although for obvious reasons they are nearly always adopted as craft committee policy. This arrangement works well. It is one of the reasons why we have managed to avoid the fragmentation of representation of doctors which is characteristic of most other European countries, and which Stephen Watkins seems determined to achieve in this country. The vast majority of doctors have the good sense to realise that this arrangement is in the best interests of the profession as a whole, and the good will to ensure that it works.

Dr Watkins's attempt to drag the General Whitley Council into the arrangement has misfired badly. The craft committees have never had any constitutional right to nominate members on to the Staff Side. Indeed, two out of the four craft committees to which he refers were not in existence for the first 25 years of the General Whitley Council. The reason why the BMA consults its craft committees about nominations to the Staff Side is that they are the committees which are responsible for negotiating the terms and conditions of service for doctors working in the NHS. Two out of the four BMA representatives on the Staff Side of the General Whitley Council are members of the BMA's staff. The GMSC has expressed itself content that I should look after its interests on the Staff Side, of which I am deputy chairman; and the HJSC is happy that Michael Lowe, as head of our hospitals division, should look after its interests. This is an arrangement of convenience which is in the best interests of the doctors we represent. If it ceased to be in the best interests of the profession we would, of course, make other arrangements.

There is one point, however, on which Stephen Watkins has correctly represented the views of the BMA. We do, indeed, see members of our craft committees as individuals, irrespective of any union to which they may belong. We see their role as that of representing the views of the doctors who elected them. If, as he claims, representatives are fielded by the MPU section of the Association of Scientific, Technical, and Managerial Staffs, and co-ordinated by ASTMS in order to put forward the policies of ASTMS, it is surely important that this should be made quite clear at the time when those candidates are seeking election."—ED, *BMJ*.

Promises are only promises—even for FPCs

SIR,—The attention of my committee has been drawn to Mr William Russell's report in his Letter from Westminster (28 November, p 1481) that "Ministers have been encouraged to discover whether FPCs are prepared to 'wear' some kind of agency arrangement similar to the one that operates at Wembley, where six [sic] FPCs are run through one centre. . . ." At its meeting on 13 January my committee instructed me to make the following points.

(1) Under present law it is the duty of Barnet Family Practitioner Committee (*a*) to arrange with family practitioners for the provision of professional services in the area of its corresponding (area) health authority; and (*b*) to administer those arrangements in accordance with regulations—for example, the NHS (General Medical and Pharmaceutical Services) Regulations 1974.

(2) Barnet FPC has never appointed an agent at Wembley or elsewhere, nor has it any intention of doing so.

(3) In his Fourth Report (session 1979-80, case No W272/78-79) the Health Service Commissioner had this to say about the "agency" arrangements at Wembley: "Registration functions for the area covered by [Enfield and Haringey] FPC and four other Family Practitioner Committees are carried out by the JRD (joint registration department)

whose staff are accountable to [Brent and Harrow] FPC. It is not within the scope of this report for me to comment on these unusual arrangements. But I am in no doubt that the investigation of Mr—'s complaint was delayed as a direct result of the way family practitioner services are organised in the former Middlesex Executive Council area; and it must be a matter for concern to [Enfield and Haringey] FPC that they are legally answerable for an action over which they had no direct control."

(4) Barnet FPC's legal advice is that the present arrangements at Wembley are "unlawful and void"; that the direction made by the Secretary of State in May 1978 (which purported to regularise the Wembley arrangements) is "invalid and ultra vires"; and that the Secretary of State is himself in breach of his general duty to secure the effective provision of family practitioner services in Barnet in accordance with the NHS Act 1977 and the Health Services Act 1980.

(5) Two officers from the central management services branch of the DHSS are currently at Wembley to examine the costs and benefits of establishing administrative arrangements to enable the constituent FPCs in the Wembley Complex *to discharge their statutory duties.*

MICHAEL GLORNEY

Barnet Family Practitioner Committee
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Civil Service medical officers' pay

SIR,—The letter from Drs C J Bolt and W Miller (12 December, p 1614) advocates that the BMA should negotiate on behalf of all Civil Service medical officers. Before committing themselves civil servants may like to consider the pay settlement achieved on "behalf" of those civilian medical practitioners engaged on full-time medical boards with the armed Forces. This must be unparalleled in the history of pay negotiations in that a permanent freeze in salaries was agreed to at a time when inflation was well over 10%.

The BMA undertook negotiations on behalf of this group without, so far as we are aware, asking if they wished the BMA to act on their behalf. At no time during the very protracted negotiations was any indication given that a different settlement for those engaged on medical boards and those engaged on general practitioner duties was being negotiated, and the settlement was accepted by the BMA without any reference to those affected by it.

We are now told that nothing can be done to remedy this at present as the Government has dismantled the machinery for dealing with civil servants' pay, itself a move of doubtful legality.

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The Secretary writes: "It is the lack of a representative organised group which led to the dissatisfaction expressed above, and which the Special Group for Civil Service Medical Officers is designed to overcome. The Government unilaterally abolished the machinery for dealing with the pay of civil servants before setting up the Megaw Inquiry into Civil Service pay."—ED, *BMJ*.

Consultants and their future

SIR,—Dr A B Shrank's satire on the Short Report (9 January, p 120) cannot be allowed to pass unchallenged. Nowhere does the report state that every trainee entering hospital medicine should obtain a consultant post at the end of training. Does Dr Shrank really believe that junior doctors wish to eliminate competition for consultant posts? The reforms proposed would not eliminate competition but lower the "rate-limiting step" of promotion, so that it would be harder to become a registrar but those who did so would reasonably expect to become consultants. Those who did not obtain registrar posts, or who failed to meet the required standard during a probationary registrar year or subsequently, would have to look elsewhere for a career, just as now.

Dr Shrank's statement that "the standard of the consultant post [would be] substantially lowered" if the Short Report were implemented is based on the same fallacy. Certainly this would be true if all trainees were assured of a consultancy, but this is not what the report says. So long as there is adequate competition at some point on the training ladder the standard of entry to the consultant grade will not change. Far more trainees are capable of reaching this standard than can ever become consultants, and the present system is unnecessarily wasteful at a relatively advanced level of training. Many become stuck at an intermediate stage because they lack the opportunity to complete their training to consultant standard, not because they lack the potential to reach that standard.

Dr Shrank assumes that "a sizable number—maybe the majority—of junior doctors . . . want a major's job and not a general's job." Where is the evidence for this? Has Dr Shrank asked his junior colleagues if they want posts that are subordinate, give little clinical independence, and have a lower salary and status than the consultant grade? Undoubtedly a limited number of associate specialist posts are needed for those who feel unable to accept the responsibilities of being a consultant, or who fail to reach the necessary standard at a late stage in training; but a staffing structure based on an expanded associate specialist grade would not be in the best interests of patients.

Dr Shrank's arithmetic on the fate of newly qualified doctors ignores the Government's policy of expanding the consultant grade—a policy accepted in principle by all responsible groups within the profession. It also ignores the certainty of a parallel expansion in general practice. Dr Shrank has forgotten that women doctors—half of new graduates—as a group work only 85% of the extent of their male colleagues. He has ignored the decline in the number of overseas doctors that will inevitably follow the General Medical Council's introduction of stricter controls over registration and has mistakenly confused the admission and graduation figures, thus overestimating the number of new UK doctors by 10%.

Dr Shrank suggests that to reduce working hours the number of junior doctors must rise. There is ample scope, especially in teaching hospitals, for reducing working hours to a reasonable level by rearranging rotas to avoid unnecessary duplication of cover within a unit, by more cross-cover arrangements between units, and by the rationalisation of emergency services. There is undoubtedly scope for more direct participation by consultants in emergency work in certain places, though this need not mean sleeping in the hospital (an argument used to provoke hostility to the report). Consultants often quote their commitment of continuous responsibility for their patients, but on the whole they suffer far less out-of-hours' disruption than do juniors. A recent Office of Manpower Economics survey suggests that 70% of the average junior doctor's overtime is spent actually working. How many consultants can claim that? Will Dr Shrank and his supporters agree to take part in a similar work study?

The puzzling assertion that "the junior doctors" are sponsoring a Bill to reduce their hours of work has already been dealt with fully by Dr M R Rees (23 January, p 276).

Lastly, Dr Shrank implies that the introduction of a shift system into hospital medicine is a fundamental part of the Short Report, and that it is supported by junior doctors. It was no more than a tentative suggestion but has been seized on by some doctors as a stick with which to beat the whole report. They have aroused fears about a threat to continuity of care but hospital and general practice are based on this concept, which will not be changed by implementing the Short Report. Can Dr Shrank identify "the politicians" who wish to introduce shift work?

I hope that Dr Shrank will read the report again for, contrary to his interpretation, the Short Report is about a balanced, steady expansion of the consultant grade in the interests of providing a better service to patients. It is also about a planned and gradual contraction and redistribution of the training grades in the interests of a fairer and less wasteful career structure for young doctors. Understandably, the report has been criticised by those wanting to preserve the status quo, but it is deplorable that emotional interpretations should be used to distort its contents and provoke opposition.

DOUGLAS GENTLEMAN

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BMA Charities Trust Fund

SIR,—Now that Christmas is over I hope that the readers of the *BMJ* will pause for a moment to remember doctors and their dependants who may be facing 1982 with insufficient money and resources. The BMA Charities Trust Fund distributes money as necessary to the charitable funds of the medical profession.

Many members now pay their annual subscription by direct debit. Unfortunately this method makes no allowance for a doctor to contribute a small percentage of his subscription to the medical charities, neither can the Charities Trust send a personal reminder to each member as was possible with the previous yearly subscription form. The money that we are able to distribute is used to help widows and widowers of doctors and to help children of doctors to complete their education, so maintenance of the contribution level is of paramount importance to stabilise their quality of life for the future.

Would 2% or 3% of the annual subscription be too much to ask of each member towards these funds. The gift of money through covenant increases its value considerably and recent changes in the tax law mean that the money has to be convenanted only for a period of four years to enable us to reclaim the tax and thus enhance the value of the contribution to those in need.

Donations to the various charities can be sent either to the BMA Charities Trust Fund or to a specified trust and details of these are available from the Secretariat. I do hope that we shall have a satisfactory and encouraging response to this appeal.

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Chairman, Charities Committee

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