not rise at all), we will end up with greater than 80% more economically active UK graduated doctors than we have at present.

(*ii*) For the foreseeable future, the economic circumstances of the country will preclude any great increase of expenditure on the Health Service.[4] In this situation, the training and employment of a substantial increase in the number of doctors should not be feasible on financial grounds.

(*iii*) Unless action is taken immediately medical unemployment is inevitable.

Recommendations

(4.1) That the annual output of medical graduates should be reduced to 2600§ by an immediate reduction in medical school intake. This will allow the UK to become self-sufficient in doctors, will allow for a small growth in potentially employable doctors and assumes we have about as many doctors as we need now. This would also produce a saving in training costs and salaries over the next five years of about £132 million (appendix 2). In addition, the employment of one doctor at present engenders the employment of additional staff and the provision of extra capital equipment and buildings.

(4.2) That there be an annual review of medical manpower, with particular reference to medical student intake, and involving all interests.

§2600 graduates pa with 32 years' service is $2600 \times 32 = 83\,200$ potentially employable doctors. Allow 20% "wastage" and that is $83\,200 \times \frac{80}{100} = 66\,560$ economically active UK graduated doctors.
(Compare 52 000 UK graduated doctors and 65 000 doctors overall at present.)

References

1 Royal Commission on Medical Education 1965-8, *Report*, Cmnd 3569. London, HMSO, 1968.
2 General Medical Council, *Annual Report for 1972*. GMC, London, 1973.
3 World Health Organisation, *Health Services in Europe*, 2nd edn, 1975.
4 DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.

Appendix I

Accurate figures of "wastage" are difficult to come by for obvious reasons. Nevertheless, it is estimated that the present average wastage rate is about 15%.

Wastage of graduate medical staff is of two types:

(*i*) Complete wastage: means people who emigrate permanently, cease medical work for family or business reasons, or who are employed in some other profession—for example, drama or politics.

The present rate of permanent as opposed to temporary emigration is about 12%. This is an average and emigration in some specialties, for example radiology, is much higher.

(*ii*) Long-term wastage: results from long-term but not permanent inability to practise. Many women fall into this category and their unemployment is substantial: 3/15 doing no work; 5/15 working part time.

Therefore less than half the medically qualified women are working full time. This is one reason why it is thought that the wastage rate will rise (3.2) as the proportion of female graduates rises.

Appendix II: financial savings

Hold medical graduate output at 2600 (1976 level).

Saving of graduates

Year	Saving
1977	200
1978	400
1979	600
1980	800
1981	1000
	3000

Training cost per doctor = £40 000.
Therefore saving on training = £120 million.
Saving of salary is 3000 doctor/years.
Annual salary averages £4000 (with As and Bs).
Therefore saving on salary = £12 million (1982-6 inclusive).
Therefore total saving = £132 million, at 1976 pounds.

From the HJSC

- *Complaints procedure*
- *Hospital practitioner grade*
- *Royal Commission*

Disquiet about new contract implementation

When he opened the meeting of the Hospital Junior Staffs Committee on 10 February Dr D F H Guèret Wardle told the committee that he intended to retire from the chairmanship but was prepared to continue in office until the SRM on the Royal Commission on the NHS on 9 March. A ballot was held and Dr R Milsted was appointed chairman-elect.

Complaints procedure

The committee was concerned at the possibility that the hospital complaints procedure might be extended to clinical matters. A House of Commons Select Committee is looking at the procedure and the committee decided to form a small working party. The reason why people wanted clinical matters included was that at present a consultant was not accountable to anybody, Dr J A K Davies pointed out.

The chairman reminded the committee that it was its policy to support the concept of medical self-audit and Mr K Mayer agreed that a formalised system should be introduced as soon as possible. Dr P O'Connor did not think any type of audit would change matters and Mr J N Johnson said that if machinery was introduced whereby the profession investigated complaints against itself it might be used as "a try on" in the courts.

Hospital practitioner grade

There was a short debate on the hospital practitioner grade and the following resolution of the Scottish HJSC was endorsed: "In the belief that the hospital career structure is already unsatisfactory, SHJSC notes with dismay the recommendation of the CCHMS (18 December, p 1518) to broaden the definition of the hospital practitioner grade. Because of the inherent dangers of the eventual creation of a subconsultant grade therein SHJSC believes that this is contrary to resolution 58 of the ARM 1976. Furthermore, this matter clearly lies within the remit of the HJSC as well as the CCHMS."

(Resolution 58 reads: "That this meeting instructs the Council to: (1) examine the problems involved in the interpretation of the hospital practitioner grade, including the lack of definition of the responsibilities of the grade; (2) negotiate a part-time grade offering equivalent opportunities and remuneration for doctors of similar experience and qualifications who are not principals in general practice (avoiding the danger of a permanent subconsultant grade); (3) secure that a proper relativity in remuneration be established between consultants who carry ultimate clinical responsibility and other members of their team who do not.")

Royal Commission evidence

Dr Wardle thought that the seriousness of the medical manpower problems was still underestimated: medical school output was being doubled, while few new posts were being created. Many consultant and senior registrar posts were being frozen and the

Dr R Milsted, chairman-elect.

money used to fund preregistration jobs for graduates. The BMA's evidence to the Royal Commission was not strong enough. So far as staffing structure was concerned this would not be altered as the HJSC would like to see it until there was a strong financial incentive to consultants to change their pattern of work, much of which was being done by juniors.

As a constituent body of the Representative Body, the Chairman of Council pointed out, the HJSC could put forward motions and amendments to the SRM on staffing structure and other matters.

There was no conclusion in the BMA's evidence, according to Dr O'Connor, that medical school output should be geared to the number of doctors in employment. He forecast that in 1982 there would be 60 000 unemployed doctors in Europe.

Several members suggested that the committee's evidence on manpower should be submitted to the Royal Commission as an appendix to the Association's main evidence. The SRM will be asked to agree to this, together with the motion "That the HJSC demands that a balance be struck between the training and established grades so that all trainees can become established within seven years of registration—that is, that general practitioner trainees can become principals in general practice and all those training in the hospital specialties have the opportunity of becoming consultants."

In debate . . .

Complaints procedure

". . . *if the complaints procedure is extended to clinical judgments almost every doctor will start practising defensive medicine* . . ."

DR D F H GUÈRET WARDLE (chairman)

Medical manpower

". . . *in 1959 there were 10 100 consultants and 10 000 juniors; in 1974 there were 11 500 consultants and 19 000 juniors. Since the beginning of the NHS consultant staff has increased by 49% and junior staff by 140%* . . ."

DR P O'CONNOR (Stockport)

HJS contract

". . . *very few area authorities are conforming to the draft model contract and most junior doctors do not have proper job descriptions* . . ."

DR I MCKIM THOMPSON (secretary)

HJS contract

IMPORTANT NOTICE

The Council had agreed to the committee's request that Berkshire Area Health Authority should be included in the Important Notice in the *BMJ* (5 February, p 395). There had been a meeting with officers of the authority, who had considered that the contract was discretionary. The AHA chairman, moreover, had only recently been informed of the dispute and after a letter from the DHSS it was hoped that the AHA would soon conform to BMA policy.

IMPLEMENTATION

The Secretary of the Committee, Dr I McKim Thompson, was disappointed that members of the committee had done so little to see that the proper exchange of contracts and the preappointment procedures, which had been negotiated to avoid exploitation, were being carried out.

The GMS Committee's representative, Dr P F Kielty, suggested that the doctors on AHAs and RHAs should be asked to raise the question of why the model contract was not being used.

Dr O'Connor told the committee that contracts appeal machinery had been set up in the north-west and there had been successful intraprofessional appeals. The contracts worked if members wanted to use them. When they did not work it was because most juniors did not have a clue what the new contract was all about. The BMA should print a booklet explaining to junior doctors what they were entitled to.

EMPLOYMENT PROTECTION ACT

Dr O'Connor referred to three resolutions from the North-west RHJSC on the Employment Protection Act 1975. The first was that no junior doctor should voluntarily vacate his post unless he had found alternative employment. Failure by the employing authority to renew his contract should be pursued by the Association with recourse to an industrial tribunal. The second resolution was that each junior doctor should be informed of the consequences of the Act and that the BMA had been tardy in bringing it to the notice of its members. The third urged the BMA to inform medical assistants that the Act apparently gave security of tenure to all those who had contracted for a 16-hour week or more for two years with an employing authority. Similarly, all medical assistants who had contracted for an eight-hour week or more for five years also had security of tenure. So far as junior doctors were concerned, Dr O'Connor said, failure to renew a fixed term contract was paramount to dismissal and the industrial tribunal had the authority to order an employer to reinstate an employee.

Dr G McCune urged caution before advising junior doctors to invoke the Employment Protection Act. Those who were not suitable for continuing promotion in the NHS would dig their heels in and completely block the career ladder.

The committee agreed that the subject would be suitable for debate at the HJSC conference in July and it set up a small working party to examine the Act as it affected the HJS contract. The members will be Dr P O'Connor, Mr P McNally, and Dr H Gordon

In brief . . .

Fees for doctors assisting local authorities in Scotland

Agreement has been reached for local authorities in Scotland to pay doctors undertaking work for them in connection with education, social services, and public health. These fees are effective from 1 April 1975.

Mileage allowances are payable for such work at the following rates:

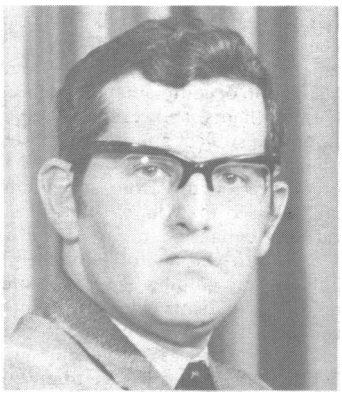
9·4p per mile	from 1 April 1975
10·8p per mile	from 1 April 1976
11·0p per mile	from 1 December 1976

Members are invited to apply to the Scottish Office for information about the fees payable.

Mileage allowances for part-time work

The mileage allowances payable to doctors undertaking part-time work in the community health services (Circular DS 258/75, 31 July 1975) and for local authorities and police authorities (Circular DC 1 and PSSC No 8, 29 July 1975) have been increased from 9·4p per mile to 10·8p per mile with effect from 1 April 1976 and to 11p per mile from 1 December 1976.

These increases also apply to doctors undertaking family planning sessional work at FPA rates (Advance letter MD 11/75).



The committee endorsed a resolution from the West Midlands which noted that the secretary of the committee, Dr I McKim Thompson, had been appointed BMA recruitment secretary. It continued: "We wish him every success in his future post but record our regrets that he will soon be leaving the HJSC. . . ."