another. This has been the cause of the poor building record and the endless shifts of policies. Secondly, the national and rigid salary system suppressed the supply and demand mechanism, and has destroyed the professional labour market in medicine. It is particularly this aspect which has caused staffing problems and mounting grievances and crises.

Unfortunately the incurable economic structure of the NHS is the NHS and the problems will worsen until the system dies of its own contradictions. In this respect BMA activity has been harmful. It is possible that the GP revolt in 1966 would have brought a painless end to the NHS but for the palliative effect of the new contract. The same might be said of the current junior hospital staff negotiations. There is a terrible danger in Dr Fry's suggestion that the GMC should not only "regulate and police" us but also take on the role of negotiator. Experience shows that professional associations dealing with governments soon become instruments of State control.

My own view is that we should do nothing by way of deals or new contracts which prolong the existing system but let nature take its course.

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Plight of the younger consultant surgeon

SIR,—The current gloom that surrounds most branches of the hospital services in the NHS is nowhere more obvious than among young consultants. These young consultants have seen quite spectacular and justifiable gains by the hospital junior staff in relation to pay and conditions while at the same time they have watched a steady deterioration in their own income and professional status within the hospital community. These young consultants represent the future basis for hospital care in Britain, and the increasing frustration they experience in applying their talents—talents gained after many years of intensive training—must inevitably result in a lowering of standards in hospital care for the future.

This present situation must not continue and to this effect we are appealing for support from a selected group—namely, those holding the fellowship of the Royal College of Surgeons of England. For practical purposes we feel that this appeal should be directed to all those who obtained their fellowship between the years 1963 and 1973, since this would probably represent the greater body of young consultants in the surgical specialties or those at an advanced stage of training and likely to achieve consultant status shortly. It is in no way, however, intended that any other fellow of the college should not be included, if he so wishes, in the subsequent discussion that it is hoped this group will be taking part in. In the first instance we would urge all young fellows within this category to attend the Annual General Meeting of the Royal College of Surgeons at Leeds on Friday, 24 September. At this meeting a motion has been put forward that: "The young fellows of the College protest their right to a career in surgery. They earnestly request the president and council to convey to the Royal Commission on the National Health Service their mounting concern at the erosion of their freedom and incentives to practise their profession to the highest standards."

Those who cannot attend this meeting are asked to communicate to either the proposer (PS) or seconder (DS) at the addresses given below (preferably on a geographical basis) so that their views may be presented in absentia. The immediate aim of this proposal before the royal college is to enable the president and council to bring home to the Royal Commission the real dangers of the continued unrest and job dissatisfaction that exists among surgical trainees and young consultants. To this effect the president has kindly agreed to meet separately with representatives of the young fellows to hear their grievances in more detail. It is anticipated that further meetings will be held with other interested bodies, both within and without the profession, in order to broadcast far and wide the opinions of the young surgeons of this country.

It is accepted that many associations are making attempts, particularly through the Royal Commission, to influence Government opinion, but we believe that this loosely defined association of young surgeons will provide the means of delivering a sharp warning to those in authority that unless something is done soon the long-term effects of the present unrest amongst young consultants, and particularly those in the surgical specialties, may prove to have serious consequences for the future of the NHS.

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Medical manpower and hospital staffing

SIR,—I am well aware that Mr J E Woodyard (10 July, p 112) and Mr G I B da Costa (31 July, p 304) believe that a permanent subconsultant grade is essential if the hospitals are to be properly staffed, consultant standards maintained, and the training programme kept in balance. As Dr E Grey-Turner,¹ writing in 1971, reminded the profession, this was the view reached by the Strachan Committee in 1955, the Guillebaud Committee in 1956, the Platt Working Party in 1961, the Brotherton Working Party in 1967, Panel 1 in 1968, and the Royal Commission on Medical Education in 1968. All these important committees recommended a permanent subconsultant grade.

No one, however, has defined what subconsultant work is—until that has been done no one will know how much of it there is and until that is known no one will know how many doctors will be needed to do it. With great respect, I think Mr da Costa missed a great opportunity for solving this problem when he left this point out of the questionnaire he sent to 8000 consultants in England and Wales before publishing the Hospital Consultants and Specialists Association's report on hospital staffing in June 1974.²

Recently I analysed 17189 operations performed in my main hospital in general surgery, orthopaedics, ophthalmic surgery, ENT, and gynaecology and the corresponding anaesthetics. Taken together, the consultants in the four surgical specialties regarded 38.8% of all their operations as subconsultant and

handed them over to a registrar, senior house officer, or clinical assistant. In gynaecology the corresponding figure for subconsultant work was 60.2% of the total. Limiting the examination to list work the figures were 35.0% for the surgical specialties and 54.9% for gynaecology. Turning to emergency operations the surgeons considered 66.6% to be subconsultant and the gynaecologists 87.1%. For the anaesthetists 75.6% of all list work was subconsultant and just over 86% of all emergencies, whether surgical or gynaecological. All this work was left to registrars, SHOs, and clinical assistants.

Obviously the amount of subconsultant work varies between one hospital specialty and another. Worse still there was a large overlap between the consultant and subconsultant work which varied from one consultant to another and varied for one consultant at different times. To me this presents a serious dilemma. No general principle emerged from my survey—subconsultant work seemed to depend on a personal, subjective, arbitrary decision varying from time to time for the same consultant. Perhaps Mr Woodyard and Mr da Costa can help me resolve this dilemma.

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¹ Grey-Turner, E, *British Journal of Hospital Medicine*, 1971, 6, 11.

² Da Costa, G I B, *Hospital Medical Staffing*. Ascot, Hospital Consultants and Specialists Association, 1974.

Prescription charges

SIR,—You should know better than to state that those with chronic disease are exempt from prescription charges (31 July, p 268). Apart from epileptics, diabetics, and those having replacement therapies the chronic sick have no exemption unless they are so disabled that they are unable to leave their homes. Chronic obstructive airways diseases, heart diseases, rheumatic diseases, peptic ulcers, chronic dermatoses, and leg ulcers—none are exempt.

The prescription charges remain a tax on sickness and an obstacle to economical prescribing. The profession should resume its principled opposition to them.

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Consultant's increments

SIR,—Some months ago you kindly published a letter (8 May, p 1149) in which I complained that younger consultants had been unfairly assimilated to the shortened incremental scale to comply with the then wages "norm" and that the freeze on increments was discriminatory against a less well-off group. The result is that a consultant appointed in 1972 is now in his fifth year of service on second-year pay.

It now appears that the same group will experience maximum detriment in the restoration of the incremental scale. For most this will mean an increment in April 1977 and annually until the maximum is reached. But why not the overdue increment on 1 August 1976, when the freeze on rises above £8500 ends, with procession in April 1977 and