Apart from the community physicians in their various roles, most of the other staff were recruited from the hospital services, knew little if anything of community medicine, and did not want to know. Fitted carpets, new furniture, and potted plants became the order of the day for the new administrators, the transferred ex-local authority staff usually being left with their faded lino and furniture dating back to the early days of health departments. Developments in much-needed spheres such as the speech therapy service were curtailed because of financial considerations, while almost daily one saw further deliveries of new furniture and carpets. A plethora of subcommittees, working parties, and other teams appeared, all holding up the possibility of positive action even when there were few financial implications. "Consensus" became stagnation. Fortunately I was able to retire—not to be replaced because of the financial crisis.

C SIMPSON SMITH

Ossett, W Yorks

Consultant contract

SIR,—The paper by Mr D E Bolt (19 June, p 1548) is timely. Many senior hospital doctors are coming to realise that the old-fashioned professional approach to contracts and salaries may not be appropriate in the modern world. Some form of incomes policy may be necessary in the national interest, but it has led to a narrowing of financial differentials and the rigid application of salary ceilings for one of the most highly trained and skilled sections of the community. Furthermore, consultants are now seeing the freedoms and financial benefits which their junior staff have obtained from their new contracts. When they become consultants most juniors will probably wish to carry their new-style contracts forward.

Three years ago the consultants in north-east Scotland were almost unanimously opposed to the 10-session contract, and more particularly to the speed with which an attempt was being made to introduce it. Today attitudes have completely changed. There is a new willingness to consider the whole subject of contracts afresh, in detail and at some length. The Central Committee for Hospital Medical Services wants every consultant in the country to participate in such a debate. To facilitate informed discussion it would be advantageous if a series of short, clear papers could be produced and sent to all consultants, setting out the pros and cons for: (*a*) present contracts, with the "shopping-list" items added and the "substantially the whole of your time" concept removed; (*b*) the 10-session contract; and (*c*) individual defined contract. The effects of a pay policy or other foreseeable restriction on each form of contract might be outlined.

After full discussion at hospital, regional, and national level several types of contract might be devised, one of which would be acceptable to every consultant.

JAMES KYLE

Aberdeen

Plight of the younger consultant

SIR,—How can our negotiators and the Department justify that consultants in the incremental scale are once again to be asked to make a disproportionate sacrifice in the coming year, as seems likely? A pay freeze or pay restraint policy is obviously necessary for the country. However, on appointment to consultant position one surely is offered a contract in which are explicit promises of pay increments, not pay rises. In the last year, because of the pay policy, junior consultants experienced a drop in salary in real terms by the loss of their increments and now, apparently, are to be expected to drop a further increment in the coming 12 months. Part-timers with private practice, which has not developed and under the present circumstances is unlikely to develop quickly, are paying doubly, as their salaries are assessed as whole-time equivalent for the purposes of pay restraint.

Financial commitments such as house purchase, schooling, etc, have no doubt in many cases been based on the assumption that these increments will come in due course. It is difficult enough to find reasons to continue to practise in Britain, with cutbacks in the hospital building programme.

Young consultants who are earning less than their juniors, possibly working in totally inadequate facilities, being pilloried by an unsympathetic Department and by aggressive left-wing unions, find it very difficult to understand why they have been singled out as a group to sacrifice more than their colleagues or countrymen at large. No wonder there is a move among the juniors to try to preserve their contracts when they become consultants. Surely our negotiators can see the injustice of the present position and surely they must see that if the BMA claims to represent these doctors, then they must make strenuous attempts to have these increments restored. These are not annual pay-round rises. These are contractual obligations on the part of our employing authority.

P C REED

Weston-super-Mare,
Avon

SIR,—Inquiries that I have made make it apparent that the present anti-inflation policy is to continue to hit consultants below the maximum salary scale extremely hard. It seems likely that when the new scheme of low pay awards is agreed between the Government and their masters, the trade unions, consultants will continue to be paid at their present salary and no further increments will be allowed. The ludicrous situation then arises in which consultants with at least five or six years' service in that grade will be paid at "second year" rates. The recent Review Body report makes it clear that no help is forthcoming from that direction. Registrars and senior registrars in many instances are already earning more than their senior colleagues.

It is time that all consultants whose earnings would normally have exceeded the £8500 limit, or pro rata for part timers, called "enough" and made it quite plain to the Government, by the strongest industrial action if necessary, that they are unwilling to allow this situation to continue. There should be a greater willingness for all consultants to unite on this matter than on the ill-fated attempt at unity on the issue of private practice. If the BMA is to retain any respect as the spokesman for the profession with the Government it should show some teeth and threaten the Government in the only language that they understand.

If consultants do not, as a united body, insist on the proper and contracted rate of pay—quite regardless of any issue involving a pay award—then it becomes obvious that they are totally unconcerned with their own destiny and "deserve everything they do not get." The loss of differential between junior and senior medical grades in the hospital service is already causing increasing bitterness, frustration, and emigration.

The very least that we must insist on is that each consultant is paid, as from 1 August 1976, the rate for which his years of service qualify him and that his incremental date be reinstated immediately. The further matter of renegotiating consultants' contracts must be recommenced immediately, regardless of any anti-inflation policy.

If these simple points, involving basic justice, are not vigorously pursued, then the future for our patients, for present junior doctors, for ourselves, and for the entire Health Service is very bleak indeed.

MICHAEL J ARMSTRONG

Belfast

Hospital practitioner grade

SIR,—Many criticisms of the proposed hospital practitioner grade have appeared recently in your columns. Some adequately paid grade with security of tenure should, of course, be available to all part-time hospital doctors who are no longer in training. Clearly also such appointments should be subject to proper scrutiny by an appropriate board. But nobody has answered other criticisms which are based on false premises.

The abolition of the SHMO grade left no place for the general practitioner who wished to spend a part of his time working in some specialist capacity in hospital. The clinical assistant grade, when first introduced, was intended to be a teaching grade. It has rarely been such. In practice it has been used to fill gaps in the hospital staffing structure more or less indiscriminately. Thus most clinical assistants have no supervision.[1] Most GP clinical assistants see this work as part of their careers and on average they have 500 or so fewer patients on their lists than other GPs in the same area.[2] I held such a post in anaesthesia for the whole of my NHS service and have just retired—a long time to wait to be regraded by any standard.

With regard to pay, if the grade is to be a career grade—a prime objective in its introduction—some overlap in basic rates of pay with the consultant scale seems only fair and reasonable. Neither can consultants dismiss merit awards from consideration—the fact is that they exist, and over 50% of consultants in clinical posts benefit.

Finally, to suggest that giving appropriate status and security of tenure to a few part-time hospital doctors constitutes a threat to consultants is surely an exaggeration. The number of consultants has doubled since the NHS began, while the number of GPs has remained more or less static.

I suggest that it will be grossly unfair to many doctors if the introduction of this grade is again delayed. A whole career is too long to wait.

E O EVANS

Stratford-upon-Avon

[1] Marshall, M, *British Medical Journal*, 1972, **4**, 42.
[2] Survey by G P Liaison Committee of the Birmingham Regional Hospital Board (unpublished).