Consultants and their future

Twenty-five years ago a Scots physician[1] first drew attention to the imbalances in the hospital staffing system. Since then a series of reports from independent committees,[2-5] the DHSS,[6] the BMA,[7] the HCSA,[8] and the Joint Consultants Committee[9] have identified the same problem—the disparity between the numbers of junior doctors in training posts and the numbers of consultant posts. For 12 years now the policy agreed by the DHSS, the JCC, and the BMA has been that consultant posts should grow at 4% per annum and junior posts at 2·5%. Nothing of the kind has occurred. Last week the House of Commons Social Services Committee added its report[10] to the stack of its predecessors, showing that politicians still rate optimism over experience—for the unanswerable statistics show that between 1968 and 1979 the numbers of hospital junior doctors increased by 62% while consultant numbers grew by only 29%.

What, then, is the reason for this perverse differential growth[10] of so-called training posts when all the heavyweight battalions assert that the NHS needs more consultants and fewer juniors?

The SSC report quotes the BMA as blaming financial restraints and the Hospital Junior Staff Committee as blaming intransigence by consultants. Two former chief medical officers, Sir George Godber and Sir John Brotherston, told the MPs that the main obstacle had been resistance among consultants, especially in peripheral hospitals. This entrenched resistance by so many consultants is seen by the junior doctors as simple self-interest. Consultants who worked long hours as registrars themselves are said to believe that they have earned the right to have junior staff of their own. No 55-year-old surgeon or physician wants to become his own registrar overnight. Another factor repeatedly mentioned in evidence to the committee was private practice: any substantial increase in the numbers of consultants would give each a smaller share of the cake.

In fact consultants' doubts and fears have a wider, more realistic basis. Long experience of NHS "reforms" has taught them that reform is always accompanied by economy. Their natural apprehension is that as senior house officer and registrar posts disappeared the balancing growth of consultant numbers would be too small and too late. In an era of financial restraint, closures, and contractions consultants see the loss of their junior staff as a move to an even gloomier future with bigger clinics, longer operating sessions, and less leisure, and no financial recompence for this increased workload.

Yet—perhaps surprisingly—Mrs Renée Short's committee was convinced that the prospects for change are better now than for many years. Certainly younger doctors seem more than ever aware that they are being swept, like Gadarene swine, towards a cliff—and that the edge is now in sight. Without a determined reform of the career structure many of the newly qualified will face a prospect of unemployment, for the escape routes available to earlier generations of disappointed registrars—emigration and late entry to general practice or a shortage specialty—are being shut. As the numbers of overseas doctors serving a few years in unpopular corners of the NHS diminish they will be replaced (if nothing is done) by British graduates with no Asian or African country as a refuge for their disappointment.

The insular English and the doubting Welsh should, perhaps, look north—where they can see a glimpse of the future and see that it works. For many years the numbers of registrars and senior registrars have been more closely controlled in Scotland than in England, and there are proportionately more consultants and fewer juniors (in England each consultant has 1·5 but in Scotland only 1·3 postregistration juniors). Consultants in Scotland do expect more often to attend personally to emergencies and to see most of their outpatients—so providing the service to patients called for by the Social Services Committee. Clearly such a system can work in an NHS setting. One factor, cynics will argue, may have been the smaller size of the private practice sector in Scotland. Another, equally important, must have been the higher spending on the NHS per head of population; ever since 1948 Scotland has consistently had a greater share of NHS resources than would be justified by population alone.[11]

If the climate of opinion is more favourable and the policy makers are more determined to expand consultant numbers, how should it be done? The Social Services Committee recommends that the General Medical Council and the royal colleges together should enforce strict standards in recognising training posts. Posts that do not meet these standards should be closed down—perpetuating them can serve no one's interests. The Social Services Committee calls for an immediate freeze of senior house officer posts in England and Wales and for the DHSS to ask district health authorities to draw up specific programmes for increasing the numbers of consultants. Another vital recommendation is that academic posts should be made subject to the same manpower controls as NHS posts—for most "research registrars" eventually compete for NHS consultant posts.

The Social Services Committee report makes no proposals for any new central body to oversee the manpower reforms that are so urgently needed. The General Medical Council and the health departments have the necessary powers already: what is needed is their joint determination to act and to convince hospital doctors that the plan is in their best interests. Cutting out the unsatisfactory junior posts will be acceptable locally, however, only if enough new consultant posts are not only created but also filled. What will happen when a consultant vacancy attracts no applicants? In some parts of the country unfilled consultant vacancies in the shortage specialties have been running at 11-12% for some years now. What incentives can be offered to attract good-quality applicants? The answer must be "an attractive contract." Critics of the BMA sometimes allege that it is interested only in money; to which the answer must be that money matters to doctors just as much as to miners or civil servants. At the heart of medical scepticism about the case for expansion of the consultant grade is the belief that more consultants could mean cheaper consultants. DHSS calculations suggest that a 4% annual increase in consultants (with a reduction in junior posts of a corresponding size) would cost £43 million over 10 years. The Social Services Committee heard evidence that consultants are more efficient than junior doctors—they make less use of radiological and pathological services, for example—and so might achieve savings of comparable or even greater magnitude. Probably, however, patient turnover would also increase—with the all-too-familiar NHS paradox of greater efficiency bringing higher costs. The Social Services Committee solves that dilemma by recommending that "the level of growth money for the NHS should be increased sufficiently . . . for the change in the career structure and other high priority areas."

An expanded consultant grade could and should mean a

better NHS; and that would mean a more expensive NHS. Even the DHSS admits[12] that "without more resources or more intensive use of those that exist there must be considerable doubt about whether those parts of the acute sector most affected by demographic change will be able to meet the demands made on them." More money has to be found if the service is not to continue to decline; some of that money must be earmarked for expanding the consultant grades.

Unfilled consultant vacancies reflect the unattractiveness of the prospects in many hospitals. Junior hospital doctors may be able to face the prospect of two or three years working in oppressive, unsatisfactory surroundings. Even with medical unemployment potential consultants will be less inclined to commit themselves for life unless the whole package—job satisfaction, life style, and pay—is acceptable. The Social Services Committee has recommended that consultants should not have a "work-sensitive" contract. They must, however, be given some confidence in their future if they are to agree to the new balance in the hospital service.

[1] Scottish Committee for Hospital Medical Services. *Medical education and hospital career structure*. Edinburgh: British Medical Association, 1954. (Hamilton Report.)

[2] Ministry of Health/Department of Health for Scotland. *Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service*. London: HMSO, 1961. (Platt Report.)

[3] Scottish Home and Health Department. *Medical staffing structure in Scottish hospitals*. London: HMSO, 1964. (Wright Report.)

[4] Department of Health and Social Security/Department of Health for Scotland. *Report of the Working Party on the Responsibilities of the Consultant Grade*. London: HMSO, 1969. (Godber Report.)

[5] King Edward's Fund for London Working Party. *The organisation of hospital clinical work*. London: King's Fund Centre, 1979.

[6] Health Departments/Joint Consultants Committee. Hospital staffing structure (medical and dental). 1st progress report, *Br Med J* 1969;iv, suppl:53-6; 2nd progress report, 1971;iii, suppl:119-21; 3rd progress report, 1972;iii, suppl: 143-6.

[7] Anonymous. Medical manpower, staffing, and training requirements. Report of a BMA Council working party. *Br Med J* 1979;i:1365-74.

[8] Hospital Staffing Subcommittee. The future pattern of hospital staffing. Ascot: Hospital Consultants and Specialists Association, 1979. (Morrison Report.)

[9] Joint Consultants Committee. *Hospital staffing in the '80s*. London: Joint Consultants Committee, 1980. (Nabarro Report.)

[10] Social Services Committee. *Fourth report. Medical education with special reference to the number of doctors and the career structure in hospitals*. London: HMSO, 1981. (Short Report.)

[11] Butler JR. Scottish paradox: more doctors, worse health? *Br Med J* 1979; ii:809-10.

[12] Department of Health and Social Security. *Report of a study of the acute hospital sector*. London: HMSO, 1981.

Regular Review

Pathogenesis and treatment of myasthenia gravis

GLENIS K SCADDING, C W H HAVARD

Myasthenia gravis has an incidence of about 1 in 30 000, so it is not a common disease—but it is important, for two reasons. Firstly, awareness of the disease will encourage early diagnosis any may prevent months or even years of misdiagnosis. The average time taken to make the diagnosis is two years: when the muscle weakness affects limb girdles, distal limbs, and trunk muscles there may be no physical signs, and a wrong diagnosis of psychiatric illness is commonly made. Secondly, the pathogenesis of myasthenia gravis is characteristic of autoimmune disease, and, indeed, is an archetypal example.

Myasthenia gravis is a disorder of neuromuscular function due to a reduction of available acetylcholine receptors at the neuromuscular junction. Typically, the muscle weakness is worse after effort and improved by rest and has a characteristic distribution, affecting the extraocular, bulbar, neck, limb girdle, distal limb, and trunk muscles, in that order. The myasthenia responds to treatment with cholinesterase inhibitors, which prolong the action of acetylcholine at the neuromuscular junction. The quick-acting anticholinesterase edrophonium (Tensilon) provides a useful diagnostic test for myasthenia gravis. The diagnosis is not difficult so long as the possibility is kept in mind.

Two-thirds of myasthenic patients are women, with a peak age of onset in the 20s. Men tend to develop the disease later in life, and most patients presenting over the age of 50 are male. Spontaneous remissions occur in a quarter of the patients, but these rarely last more than two years and are not usually repeated. If myasthenia remains confined to the extraocular muscles for over a year the symptoms rarely become generalised. The several varieties of myasthenia gravis have different clinical, immunological, therapeutic, and HLA characteristics.[1]

Clinical patterns

Generalised myasthenia has three clinical patterns. Firstly, it may be associated with thymoma, when there is no clear HLA association. Patients have a high titre of antibodies to acetylcholine receptors and usually also have circulating antibodies to skeletal muscle. Secondly, it may be associated with thymitis in patients under the age of 40, and in this group there is an association with HLA-B8 or DRW3 or both. These patients have other associated autoimmune diseases but do not usually possess antibodies to striated muscle. Such patients do well after thymectomy. Thirdly, it may be associated with thymitis in patients over the age of 40. These patients have a high incidence of HLA-A3 and B7 or DRW2, or both. They also have the lowest titres of antibodies to acetylcholine receptors of patients with generalised myasthenia.

In ocular myasthenia the muscular weakness is confined to the extraocular muscles. Such patients do not benefit from thymectomy but usually respond to corticosteroids. They have