TALKING POINT

Cycle of gloom over manpower

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Progress in solving the unsatisfactory hospital career structure remains lamentably slow. The Joint Working Party on Hospital Medical Staffing Structure between the Joint Consultants Committee and the Department of Health and Social Security has not met for a year. The present limited initiative to persuade the Minister for Health to encourage regional health authorities to expand the consultant grade in the popular specialties has met with little response, and regional health authorities deem it inappropriate to channel scarce resources into specialties which they see as already (relatively) generously provided for. Regional priorities rarely extend to expansion of general surgery posts, and regions are quite unwilling to bend their priorities to sort out what they perceive to be largely an internal medical problem. In addition, consultant expansion is demand led from the periphery, and although consultants in the periphery concede that a moderate increase in their numbers could be accommodated within existing facilities, there are in practice few bids for additional consultant surgeons. Those that are made are accorded low priority by district health authorities.

Nevertheless, there is evidence that the long standing controls on registrar and senior registrar expansion exercised with some success by the Central Manpower Committee, together with the more recent senior house officer freeze, are at last having a small but definite effect. The ratio of junior doctors to consultants has now entered a plateau and is even beginning to fall (table). Though it would take several decades at present rates to make a real change in the career structure, a discernible trend is emerging.[1]

Ratio of junior to consultant staff

Year	Junior staff	Consultant staff
1980	1·76	1
1981	1·77	1
1982	1·76	1
1983	1·75	1
1984	1·69	1

There is also evidence of a growing sense of frustration, particularly among hospital consultants in the periphery, at the difficulty in increasing the levels of junior staff. Between 1980 and 1984 the numbers of consultants rose by 9·8%, while the numbers of junior staff went up by only 5·4%. This has prompted fresh demands for a subconsultant grade or, alternatively, for the easing of restrictions on existing grades such as that of associate specialist. A regional committee for hospital medical services recently called for the introduction of such a grade and the 1985 annual conference of senior hospital medical staffs voted for the open advertisement of associate specialist posts.[2] Although this motion failed to obtain the two thirds majority required to change existing policy, the simple majority that it did receive shows a recent and fundamental change in consultants' attitudes to the subconsultant grade.

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Frustration among health authorities

The National Association of Health Authorities recently published a report that provides an interesting view on manpower from the other side of the fence.[3] Health authorities are, it seems, also frustrated, believing that they have "insufficient influence upon decisions about medical staffing." In common with others who have criticised the medical career structure they note the "adverse effect on the delivery of services" of having too many doctors in training and too few in the career grades.

The solution of the National Association of Health Authorities is strikingly simple. It is unlikely, the association argues, that "ensuring that a higher proportion of patient care is provided by fully trained doctors . . . can be achieved with the present career structure. The question of creating a graded career structure with at least two grades of fully trained staff (both of which have full clinical responsibility for patients but those at the lower level would be subject managerially to a 'senior specialist' or 'head of service') needs urgent consideration by all concerned."

In other words the association is firmly committed to a subconsultant grade. But this is no sudden rush of blood to the head. For some time several regional and district medical officers and specialists in community medicine with responsibility for medical staffing have stated privately and sometimes publicly that they see no prospect of correcting the career imbalance along the lines suggested in all the major solutions put forward since the First Progress Report of 1969.[4] In their view the solution of "more consultants and fewer doctors" is simply not attainable in terms of practical politics. Once this conclusion has been reached a subconsultant grade is the only other avenue to explore. There is no alternative.

This year's hospital junior staff conference also debated the proposal for a subconsultant grade and, perhaps not surprisingly, rejected it.[5] In desperation at the lack of any visible progress on the career structure problem the conference did, however, call on the chairman of the NHS Management Board, Mr Victor Paige, to impose a solution on the medical profession. The BMA's annual representative meeting debated this resolution in Plymouth and rejected it.[6] Nevertheless, the Hospital Junior Staff Committee has delegated powers of autonomy and may well decide to approach Mr Paige to ask him to intervene in the impasse over the staffing structure.

Knuckles rapped for lack of progress

In June the House of Commons Social Services Committee published a follow up report to its 1981 report on medical education.[1] This fiercely criticised the lack of progress on the career structure problem. *"In view of the government's commitment in 1982 to a radical change in the ratio of consultants to junior doctors, we cannot but deplore the plain fact that little has happened to change that ratio over the past three years"* (the committee's italics).

The committee goes on to make the following proposal. "We recommend that, based on evaluation of the recently received strategic medical manpower plans, the NHS Management Board now issue to regions unambiguous guidance as to how they are to

fulfil government policies on medical manpower, and on how they are to deal with the financial consequences."

This suggestion, coming as it does from an influential parliamentary committee and taken together with the expressed view of the junior doctors, may be all that is needed to persuade ministers to remove the problem from the hands of the profession and impose a solution. When it comes, however, it may not be to the liking of consultants or indeed of junior doctors. The profession has always stated confidently that a solution could never be imposed on a reluctant consultant body. There is little evidence, however, to back up this assumption and 1985 has seen much impotent protestation from a profession suddenly at the receiving end of edicts from the Department of Health and Social Security. The limited list controversy has surely pointed the way for doubters in regions and in the DHSS who thought that doctors could only be cajoled and nudged along by consent.

The North East Thames Regional Health Authority has got the message, for its regional strategic plan has proposed that in the next decade the authority will cut around 250 registrar and 45 senior registrar posts, while creating 67 new consultant posts. The alarm that this proposal has caused provides evidence of the profession's dislike for imposed solutions, but the outcome of this scheme may well set a pattern for the rest of the country.

The history of attempts to change the hospital career structure since the mid-1960s consists of a cycle in which increasing and publicly expressed dissatisfaction among the junior grades succeeds in recruiting outside support until, eventually, senior staff are forced to negotiate. The negotiations invariably lead to satisfactory proposals—the First Progress Report,[4] the report of the BMA council working party,[7] Nabarro I,[8] Nabarro II,[9] and so on. The problem really begins when attempts are made to implement the proposals. The attempts fail, enthusiasm wanes, and the gloomy cycle is repeated. The negotiations are by and large conducted in good faith by the senior members of the profession on all sides—the HJSC, the Central Committee for Hospital Medical Services, the royal colleges, and the DHSS. The trouble is that opposition to the basic concept of "more consultants and fewer juniors" is greatest among consultants working in busy district general hospitals a long way from the well staffed teaching centres. These doctors regard the emanations from committees in Tavistock Square, Lincoln's Inn Fields, Regent's Park, Edinburgh, or the Elephant and Castle as demonstrating that the medicopoliticians and the civil servants are quite out of touch with the day to day practice of medicine and surgery in a district general hospital. They have no intention, and say so openly, of encouraging, let alone assisting with, the dismantling of their junior staff. Furthermore, if health authorities or professional committees did start to take away their juniors they might view the idea of a subconsultant grade as not so bad after all.

Time for a volte face

This summer has seen the simultaneous conclusion by several bodies that all progress on resolving the log jam in manpower has ceased and that the time has come for a change of tack. Two major views have emerged, each in some strength. The advocates of a subconsultant grade have come out of the closet, while those with no stomach for that solution have asked for the imposition of previously agreed solutions—hoping for a benign dictatorship from a Minister for Health whose record so far as doctors are concerned is far from benign.

Unless the profession moves quickly it may once again find itself mounting a defensive campaign against another set of government edicts introduced without consultation. The doctors will have to decide whether to continue to support the correction of the present career structure or to contemplate a more radical solution: to think the unthinkable and go for a subconsultant grade. To do the latter would require an unparalleled medicopolitical volte face. I believe that such an about turn is unlikely. Nevertheless, what is even more important now is that any preferred solution has to be implemented and be seen to be implemented. The dilemma over manpower has been steadily worsening for the past 20 years while doctors argued with themselves and with the politicians. Nineteen eighty five may well be the profession's last opportunity to put its own house in order.

References

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7 British Medical Association. *Medical manpower, staffing, and training requirements*. London: BMA, 1979.
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Armed forces doctors' pay

The Review Body on Armed Forces Pay has announced its recommendations for doctors and dentists in the armed forces.[1] As in previous years the review body has recommended rates of pay that reflect what will actually be paid to general medical practitioners in the National Health Service. The government deferred the implementation of the recommendations of the Review Body on Doctors' and Dentists' Remuneration until 1 June and the Armed Forces Review Body has followed suit.

The recommendations are for increases from 4·9% to 8·4% over the levels that have been in existence since 1 November 1984. The review body says that an important factor that complicates direct comparison with the NHS is that salaries of service officers have to be compatible with the military rank structure. This structure sometimes hinders the adjustment of pay levels to meet particular manning problems as there is no direct link between pay and professional expertise.

The new scales range from £5810 for a cadet on appointment to £31 000 for a brigadier. A pre-registration service doctor will receive £11 928. On appointment a captain's salary will be £15 312; a major's £18 852; a lieutenant colonel's £23 820; and a colonel's £27 244. After eight years in post a colonel will receive £29 645.

The review body has estimated that the additional cost of the recommendations will be £1·69 million.

1 Review Body on Armed Forces Pay. *Service medical and dental officers. Supplement to fourteenth report 1985*. London: HMSO, 1985. (Cmnd 9568.)

Data protection registration starts in November

Computer users who hold information about individuals in their computer systems will have six months from 11 November 1985 to register with the data protection registrar. After 11 May 1986 the holding of personal data by an unregistered person will become a criminal offence. Under the Data Protection Act subjects will be allowed access to computerised data on them and will be allowed to request amendments of any errors. The subject access provisions come into force on 11 November 1987.

As originally drafted the Data Protection Act would not have safeguarded the confidentiality of personal health records. In consultation with the interprofessional working group, which is chaired by Sir Douglas Black, the Department of Health drew up a code of guidance to provide a framework for disclosure of health information in the NHS. Consultations are now taking place on the code. Personal health data held outside the NHS—for example, occupational health services—will be governed by the Home Secretary. The interprofessional working group has sent the Home Office suggested draft regulations, which are drawn from the draft code for the NHS.

General practitioners with computerised patient records will have to register and the General Medical Services Committee will issue guidance on how to register before November.