TALKING POINT

Revised career structure: first priority

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In the evolving relationship between the profession and the DHSS we have reached the point when we must tackle with greater determination the problems of the career structure for doctors and the hospital staffing structure. The redeployment of registrars has been agreed as policy, though its implementation has caused greater difficulties than originally expected. Overall manpower decisions are being debated, there are already increased student numbers, and a new consultant contract is in the making. Yet without agreement on career structure any plans for the future will be incomplete. For many years it has been recognised that our present system, with disproportionate numbers in training grades in relation to career posts, is inappropriate and perhaps impracticable for the future. Changes are inevitable.

It would be deplorable, however, if these changes were seen as a threat to the present consultant body or as a sinister device to deprive trainees of their justifiable expectations. They should be regarded as an opportunity to create a hospital staffing pattern for doctors that will provide reasonable security without unduly limiting mobility or flexibility in regard to specialty and to foster innovation in the Health Services. The prospect is of a profession which will be on average younger than it has been recently. Most of the members will have been educated in Britain and will, therefore, have a lively understanding of the needs and defects of the system. Such a prospect should stimulate Health Service planners.

Present disproportion

The most obvious and easily quantifiable element of the training grades disproportion is the number of registrars (6567 in 1977) in relation to senior registrars (3017 in 1977). Some of the registrars are doctors born overseas who wish to return home after training. For them the absence of promotion prospects is less important, though without senior registrar experience they will leave Britain, under our present educational system, without any certificate of higher specialist training. For most, however, the disproportion means that the doctor will spend much longer in the registrar grade than any of our training schemes requires or that he will continue indefinitely to provide a subconsultant service for emergencies and for routine problems in smaller hospitals, with only peripheral contact with teaching centres.

The priority in changing the staffing structure must therefore be the reduction of registrar numbers and the adjustment of the time spent in this grade to trainee requirements rather than to service needs. At this level there should be an opportunity to change from one discipline to another as the chances of obtaining a career post in the future become clarified. Here, too, a prospective clinician should have the opportunity to do a period

of research without losing his place on the promotion ladder.

At present senior registrar numbers are believed to be well adjusted to consultant vacancies, but the need in the long term to vary the capacity of training grades as alterations occur in the consultant requirements has not been adequately debated. A small specialty which has undergone a rapid expansion and taken on, within a few years, many young consultants may need to reduce the number of senior registrars. By contrast, if the reduction of registrar posts in general medicine and surgery is to be achieved and the services provided by more consultants, a temporary but sizable increase in the number of senior registrar posts will be called for.

A less well-recognised disproportion lies in the numbers of medical assistants in relation to consultants. Medical assistants form rather a miscellaneous body. The grade is sometimes used to accommodate a doctor who is undertaking responsible work in a limited sphere and perhaps part time, who is no longer in training, but who will have difficulty in obtaining consultant status. Appointments in this grade have often been administratively easier to achieve for special cases and may have been made without thought to the long-term effects.

Subconsultant career grade

Almost all proposals for revising staffing structure have foundered on the rock of the subconsultant career post. Though such a grade has obvious advantages as an expedient for expanding the service without disturbing the *modus vivendi* of the present consultant body, it has never found favour with the profession. Rejection of these proposals is sometimes castigated as obstinate or trade unionist. But the opposition is reasonably based on the sorry history of the SHMO grade and on the impossibility of defining in acceptable terms the differing responsibilities of the consultant and the hypothetical subconsultant. The consultant is recognised as having an independent responsibility for the clinical care of hospital patients or for the conduct of investigative procedures which may determine the direction of such care. The introduction of the multidisciplinary team to clinical management may blur the responsibility for individual decision making but it cannot eliminate the ultimate responsibility which consultants feel.

In almost all projected schemes the doctor permanently employed in a subconsultant grade would effectively have the same responsibilities, though perhaps more limited ones. The burden of decision is perhaps less in a small physiotherapy department than in a cardiothoracic unit, but in each case the doctor has a direct obligation to provide for the patient the best that his specialty can afford or refer him to a specialist in another discipline. The supervision of routine bacteriology may be less arduous than advanced haematology but the responsibilities of the pathologist to staff and ultimately to patients for ensuring the correctness of results and opinions are not qualitatively different in the two cases. Thus all doctors who have passed through the training grades and achieved a position of effective responsibility should be recognised as consultants and accept the obligation which that status implies. I hope that

the new consultant contract will make adequate provision for a varying work load between one consultant and the next.

Consultants and senior consultants

Implicit in these conclusions is a substantial expansion of the consultant cadre so that responsible work is no longer indefinitely undertaken by doctors in inappropriate grades. Equally, however, experience, distinction, and wider responsibility demand recognition above the ordinary. Policy making decisions and supervision of training programmes are areas customarily and reasonably allocated to those with longer experience. Clinical emergencies are often best cared for by the younger members of the team. Thus, in a staffing pattern containing more consultants but fewer registrars it will be proper and convenient to recognise a grade of senior consultants who would have administrative as well as clinical duties but who would have the help of (and the obligation to train) a registrar. In the acute clinical disciplines consultants would be expected to cover their own emergencies with the help of house officers: the senior consultants would have registrars to reduce this load. The latter would receive less remuneration from emergency recall fees but would be entitled to at least a minimum distinction award.

Length of service would be a factor in the attainment of seniority but not the only one. In a specialty where there were two or more members of the staff the junior might be promoted when the senior post was vacated, but it would be open to the health authority to advertise and appoint a senior from outside. This would obviate the log-jam which can sometimes result if several consultants in a department are about the same age; it would also encourage mobility. We have perhaps become too accustomed to a consultant spending his entire career in one place, whereas the services and the individual would benefit considerably at times from the stimulus provided by a new post and a new challenge. Recruitment to busy hospitals in superficially unattractive areas would improve if consultants were not necessarily committing themselves to 30 years in one place. Newly appointed professors would automatically obtain senior consultant status with a distinction award as of right. This should go a little way towards attracting men into academic medicine. In specialties where the consultant worked alone or in which emergency cover was not a problem, promotion to the senior status could be made on a basis similar to that now adopted for distinction awards.

An increased number of consultants would lead to some alteration in hospital practice. Outpatients would be more likely to see the consultant and less likely to face a new doctor at each visit. This would improve the continuity of care and liaison with the general practitioners. Individual clinics and operating sessions would tend to become shorter and more numerous. This trend is already in progress as a result of the restriction of hours of work by nurses and other grades of staff and must be accepted as an inevitable and probably a desirable change. Health authorities should realise however, that this may mean new buildings so that more clinics and more operating sessions can be carried on simultaneously.

Transition

The increase in consultant numbers and the complementary run-down of registrars would demand a temporary expedient. Registrars who had been more than four years in the grade should be offered supernumerary senior registrar posts of strictly limited tenure to enable them to apply for consultant posts. These supernumeraries should not be observers at units with an existing senior registrar programme but should be set up in educationally adequate departments which are currently prevented from employing a senior registrar because of overall manpower limitations. At the end of the transition period such

posts could lapse or be made available to advanced overseas postgraduate doctors, who would be in Britain on a student visa for a strictly limited period and who would not, therefore, be able to compete for consultant posts in this country. Supernumerary senior registrars who fail to obtain career posts within a reasonable period would then be offered retraining in another discipline and on the registrar grade as the only opportunity for further employment in the NHS.

Standards and staffing

The royal colleges and universities have a responsibility for setting the standards which must be achieved by those seeking a career in British medicine. The DHSS is responsible for filling hospital posts and providing the services to the public. The objectives are different, though complementary, and some accommodation is required from both parties. The colleges must ensure that the standards are high and rising as appropriate to the status of a nation with a reputation for expert medical care, but they must not be so high that adequately trained staff cannot be recruited. The DHSS must provide the facilities which will enable doctors to attain the standards set and must not, for reasons of temporary expediency, seek to lower them. It can reasonably expect co-operation from training bodies to fulfil the service needs.

Because of the prolonged period now spent in the registrar grade appointments committees are apt to expect candidates with wide experience. In the future they must expect only what is required by the rules, so that men can reach a position of responsibility at an age when they still have energy and enthusiasm. When no candidate for a post is sufficiently qualified there should be no hesitation in appointing a man subject to his completing the prescribed programme. In this way even late changes of specialty should be possible. When new posts are required outside the recognised specialties or in a strictly limited sphere an unconventional and uncertificated education should not be regarded as a bar to appointment.

If we are to enjoy the advantages of a younger and better educated profession there must be innovation. Neither doctors nor the DHSS can afford to adopt entrenched positions. If we are to obtain any permanent benefit from the present decisions on manpower, redeployment, and the new contract, we must devise a career structure to match without further delay.

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Radiologists Group

The Radiologists Group Committee of the BMA is dissatisfied at the lack of progress on the negotiations on Categories I and II. Revised proposals have been put to the DHSS and at its last meeting (16 December 1978, p 1730) the CCHMS agreed that unless these were accepted the negotiations would be discontinued. The Working Party on Categories I and II would advise the profession on its own interpretation of the relevant paragraphs. Other matters discussed by the group committee at its meeting last month were the length of radiographers' training courses, the necessity for appointing BMA health and safety representatives in all x-ray departments, the assessment of radiologists' work load, and the need for additional central funding for buying whole-body scanners. The committee recommended that the fee for a Category II chest radiograph should be raised to £9.60 in line with recommended government fees. Dr F W Wright (Oxford) and Dr M Goldman (Liverpool) were re-elected chairman and deputy chairman. It was agreed to invite two observers from the Royal College of Radiologists and one from the British Nuclear Medicine Society.