Middle Articles

HOSPITAL TOPICS

Some Problems of Staffing the Hospitals

GEORGE DISCOMBE,* M.D., B.SC., F.C.PATH., F.R.I.C.

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A consultant's expectation of service is about 30 years. A senior registrar serves about four years, a registrar two years, and a senior house-officer one year in each post. Since there are about 7,500 consultants, on an average there will be 250 vacancies a year. It follows that to supply these vacancies we need about 1,000 senior registrars, 500 registrars, and 250 senior house-officers. We must also provide for an increasing number of teachers and research workers, who will leave the general hospital after serving probably a single registrar appointment, though often this appointment will have been earmarked for "research." In addition, we must provide for about 800 new entries annually to general practice, 50 to 100 into administration, and an uncertain entry into industry, commerce, public health, private practice, and services in the underdeveloped countries. This combined entry is unlikely to be much below another 800, so that the minimum need seems to be about 1,900, which leaves little margin for emigration.

We obviously cannot staff the hospitals of this country with an annual intake of 250 doctors—barely one a year for each large hospital. Thirty years ago an arrangement was practicable whereby a consultant had one resident, who, after a year or two, entered general practice in the area served by that hospital. A hospital of 700 to 1,000 beds might have a resident staff of no more than six or eight; and I have been one of four residents in a hospital of over 600 beds. Today this is no longer practicable; patients' lives are saved, but by the expenditure of much more skilled labour, largely medical. Thirty years ago a small cardiothoracic unit could deal with hospital beds and the local chest clinic while employing one senior and two junior doctors; today they would need three consultants, one or two senior registrars, two registrars, and two house-officers—and none of these would be underworked. Today in all departments "consultants" are outnumbered by "supporting staff" in the ratio of 1:2 to 1:3, and occasionally the difference is even larger. When we make allowance for the many small hospitals to which consultants may pay a single visit weekly, but which nevertheless must have resident medical officers, the proportion of supporting staff increases considerably.

Present System

Our system of hospital medical staffing demands a total of 27,000 to 30,000 doctors, of whom barely 8,000 are established and able to plan for the future with any certainty, and a further 1,000 are reasonably certain of a career in the hospital service. Any organization is unsatisfactory in which two-thirds of the employees are unestablished and expect or fear that they will be forced to leave within a year or two. Particularly will it be felt unsatisfactory when the young doctor expects to

exchange the co-operation of hospital for the isolation of general practice, where 44% of vacancies are for practices to be run single-handed or with one partner, and another 45% are in groups of three or four. Group practices large enough to be economically or socially satisfactory are still rare. It is not very surprising if registrars, already specialized but unable to secure established posts in the hospital service, prefer to emigrate to places where their expertise is valued in a large group practice—even though they find that only some of the community can afford their fees. The exercise of technical skill is very satisfying.

The present organization of hospital medical staffing is obsolete. What can we put in its place? The general pattern of a senior specialist in charge, with a supporting team, remains valid, but the supporting team will have to be more permanent than in the past. At present the cardiothoracic unit mentioned above will have 13 or 14 changes in the course of four years; but it would run much better if there were half this number. This implies that many of the posts now labelled "registrar" should be filled by individuals who would be permanent established members of the hospital service, just as, in practice, senior registrars are today. In addition, there would have to be a number of unestablished posts of limited tenure to provide specialized training for temporary immigrants or for those who intend to enter other branches of practice or to emigrate to regions where the doctor has to be a surgical general practitioner. Presumably the future general practitioner would be attracted by such posts in internal medicine, paediatrics, obstetrics, psychiatry, dermatology, and geriatrics; in some countries city practice is permitted only to those who have had postgraduate experience in internal medicine.

Difficult Problems

If we do have such a new type of "established specialist" there will be some very difficult problems to contend with. He will have to undertake many of the duties of a hospital resident. He will usually be married, with young children, and as he ages beyond 30 his body becomes progressively intolerant of loss of sleep. If he is to provide night cover as well as daytime services, and to lead a tolerable family life, then his family must live within or very close to the hospital grounds. Very rarely is it practicable to rent or buy a suitable house in such a position, so it would seem logical for the N.H.S. to provide, within the curtilage of the hospital, residential accommodation suitable for the families of any established staff who are required to provide services at night. For the usual district hospital this implies the provision of between 12 and 20 apartments of between 800 and 1,400 sq. ft. (74 and 130 sq. m.), and provision for between 20 and 60 children of various ages.

* Central Middlesex Hospital, London N.W.10.

The Review Body's recommendation of a "common extended scale" might be applied to the established specialist, and lead in due course to the top of the medical assistant scale, which is regarded as a career level. There are some anomalies which should also be considered. Most professional men do much of their saving between the ages of 30 and 50 by buying a house on mortgage, and obtaining income-tax remission, which may be as much as £200 per annum. Hospitals are often in relatively unattractive areas, owing to local industry, poor schools, poor housing, or lack of open spaces, so that a specialist required to live within the curtilage of the hospital might well expect some compensation for loss of amenity. It seems reasonable to suggest that the rents payable to the N.H.S. by such established specialists should take note of these factors. Since domestic architecture is now costing between £4 and £8 per sq. ft. (£43 and £86 per sq. m.), the provision of these residen-

tial facilities would cost between £50,000 and £150,000 per hospital, and economic rents would be between £350 and £800 per annum. The loss of income-tax remission and loss of amenity might justify a reduction in rent by as much as £400 per annum. Most parties would probably be satisfied if the practice were to charge rent as 5 to 7½% of gross salary.

Such a radical overhaul of the organization will obviously raise many problems which cannot be discussed here: how to differentiate between "training" appointments, such as are now classified as senior registrar, and utilitarian appointments such as "medical assistant"; whether anyone should be allowed to spend his whole career within one hospital group; and how much change from one specialty to another should be encouraged. But the advantages are considerable, and I fear that without some such change the hospital services will collapse.

CONTEMPORARY THEMES

Diabetic Children

M. BEARDMORE, S.R.N., S.C.M., H.V.CERT.; J. J. A. REID,* T.D., M.D., B.SC., M.R.C.P., M.R.C.P.E.D., D.P.H.

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According to Henderson (1949) the incidence of diabetes in the age group 5-15 was one per 4,300, and it was therefore concluded that there were some 1,200 such children in England and Wales. A subsequent pilot study in London and Middlesex, reported by Robertson (1960), gave a minimum incidence of one diabetic child per 3,300 schoolchildren between the ages of 5 and 17 years. After that survey the British Diabetic Association initiated further investigations, and in the course of these it was found that the number of diabetic schoolchildren known to the Northamptonshire School Health Service in July 1960 was 14 out of a school population of 45,500, giving an incidence of one in 3,250. This figure, however, subsequently proved to be an underestimate because, as it became known that the county School Health Service was particularly interested in diabetes in children, there was a substantial rise in the reporting of cases by head teachers and by family and hospital doctors, and by the end of 1964 the total number of children between the ages of 2 and 16 known to be diabetic had risen to 43, comprising 20 boys and 23 girls. Of these, 39 were of school age, giving an approximate incidence of one diabetic schoolchild per 1,200 pupils aged 5 to 16, inclusive.

The Investigation

Insulin

All the children were on insulin, which in 37 (86%) cases was insulin zinc suspension. The earliest age at which a child had learned to inject his own insulin was 6 years 9 months, and among those who had become diabetic before reaching 8 years the average age for beginning their own injections was 10 years. Three children over the age of 12 were still unwilling to inject themselves.

* County Medical Officer of Health, Northamptonshire.

Diet

Of the 43 children 38 (88%) were on diets which involved measured carbohydrates, the remaining five being on more lax regimens, with restrictions only in the more concentrated carbohydrates, or with virtually free diets unless tests revealed substantial glycosuria. In order to try to assess the level of understanding of diet among mothers and older children, three questions were asked: (1) What are the three main constituents of food? (to which the expected answer was carbohydrate, protein, and fat); (2) name three high-carbohydrate foods; and (3) name three low-carbohydrate foods.

In the case of the mothers 29 (68%) could name all three constituents, 4 (9%) knew only two, and 10 (23%) could not answer the question. The results of the second question were more encouraging: only 2 (5%) were unable to name any high-carbohydrate food, and 37 (86%) could name three. The answers to the third question, however, were disappointing, with 25 (58%) parents unable to name any of the customary "free" foods listed on the diet sheets used by local hospitals. The level of understanding of diet in different social classes appeared to be approximately the same, with the exception of class V, where there was a lower level of knowledge. A similar investigation among the 30 children over the age of 8 showed, as might have been expected, that they understood diet less well than their mothers.

Of the 39 schoolchildren 12 (31%) had their lunches by special arrangement with the school meals service, being supplied with suitably modified main courses, followed by fresh fruit or biscuits and cheese.

Hypoglycaemia

Only 5 (12%) children had never experienced any symptoms of hypoglycaemia. Of the remainder 4 (9%) had had repeated