SUPPLEMENT

TALKING POINT

First things first: Patients before career structures

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Manpower is one of the "in" words at present but it is fast falling into disrepute. Since the central and regional manpower committees were formed and plans devised for the "reallocation of manpower" (RAWP) to meet the clinical needs of the Health Service we have been assaulted with numbers, percentages, regional norms, population statistics, and papers from everyone interested in planning how other people work. Attacking our other flank, like a war-time pincer movement, with a different set of numbers and statistics have been the proponents of the growth industries of the postgraduate training schemes. These have now proliferated to include every facet of medicine and become so fixed in their ideas of what a proper training should be that it will soon be impossible for a trainee to change course at a junior level without adding four or five years to his training.

These two prongs of bureaucracy not only assault us. They also attack each other for the demands of manpower and the demands of training are different. The result of this endless harassment is indecision by the medical managers and utter despair in the breasts of all the hospital doctors attempting to practise medicine in the Health Service.

The reason for these problems are obvious, yet no one will give the profession the sustained leadership it needs to solve them. In the paragraphs above the word patient does not appear. But patients are what the hospital service is all about. We have only one job that matters: to look after the sick. None of the studies on manpower or training have discussed how we should do this. But things have changed in the last 50 years from private medicine to a health service, from a preantibiotic era to a period of complex medical technology, and from supportive bedside care to demanding intervention techniques. Furthermore, the total number of doctors has increased at all levels without much thought of career prospects. Current clinical practice has developed through the chance influence of factors which have been concerned primarily with the development of medical technology. This was inevitable and essential but does not mean that the resulting staffing structure is the best one for looking after patients or for giving the young doctor a reasonable chance of planning his career. The conflict between manpower and training and the numerous publications on these topics confirm that the present structure is wrong. Many suggestions have been made to put it right but they start by asking the wrong question. There is no point in beginning by defining a career ladder or by stating that we agree or disagree in principle with particular grades. There is only one place to start—with the patient. And there is only one question to ask:

how can we best look after our hospital patients? Once we have defined the best method we can then try to arrange manpower availability and career structures to fit it.

Two patterns of care

There seem to be two basic patterns of patient care, with a variety of compromise systems between them. Firstly, there is our present scheme of a team of doctors at different levels of training led by a consultant. This allows the consultant to advise on and supervise the care of many patients and is an efficient way of getting the widest possible use of the consultant's expertise. For a few patients this works well but inevitably most patients and all the minor complaints are looked after and managed by the junior members of the team. Mistakes are made and the patients do not always get the best possible care.

The opposite to the team system is a one-to-one arrangement in which one doctor, of consultant status, looks after all the needs of a few patients without the help of junior staff. This theoretically gives the patient better care because he is not exposed to the junior in training. But it can only work if the consultant has a small number of patients, has sufficient time to look after them, is prepared to be on call at all times, and is willing to keep up to date in all aspects of medical care. The last is an impossible task. The recent explosion of knowledge means that junior staff frequently know much more about some aspects of medical care than their consultants and the juniors play an important part in educating their seniors.

Doctors are best able to judge which type of care they would like. Every time I have discussed the subject with colleagues I have found that they want the best of both systems. They want the consultant to take all the major decisions and visit sufficiently often to be able to detect and to deal with any of the usual complications and problems that might arise—for example, they want close personal care from the consultant. But at the same time they accept that the consultant cannot be at the bedside for 24 hours each day, so to cope with sudden unexpected problems they want a capable resident physician. No one would dispute that such a system gives the best standard of patient care and that it is close to what we would have now if all the hospital staffing establishments were properly filled.

Close consultant supervision with a resident junior backup—if that is our view of the way we wish to look after patients then we must reconcile this objective with the problems of manpower and training. On the one hand a legion of consultants with no junior staff is not good for patient care, on the other a hierarchy where every consultant expects a bevy of juniors in his team—one at each level—is incompatible with a good career structure. I said that we must ask the right question—how do we want to look after our patients? So it would be foolish not to suggest a

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solution especially as it seems that there is only one solution which the profession must be prepared to face.

One consultant: one house officer

If we want individual consultant care plus junior resident care there must be enough consultants and a drastic revision of our ideas about the numbers of patients that a single consultant can look after at any one time. That is a simple exercise and not too costly. Next we must ensure that enough medical students qualify each year to fill the primary resident posts—the house officers—so that each consultant has his own resident house officer. This pair must become the basis of the clinical team. What goes in between must be put there to enable aspiring consultants to train and to provide more expert help for the consultant.

We know the numbers of consultants and their retirement and mortality rates, so we know how many must be trained each year. But a straight training ladder without competition breeds complacency and lower standards. There must be competition but the number on the final rung of the ladder, the senior registrars, must be exactly tailored to fit the likely number of vacancies. This will produce a small number of senior registrars, approximately one for every 10 consultants. They would have to be spread throughout the Health Service in district general and the teaching hospitals in a manner that ensures their proper education, not the needs of the service, a requirement that inevitably means that most of their time will be spent in the teaching hospitals where they will be exposed to more special interest subjects and expertise.

These few senior registrars will have little or no impact on the provision of patient care and so we are still left with the problem of providing the consultant with some better trained and experienced backup than the one newly qualified resident house officer we have so far given him. There is only one answer to this problem and until the profession faces and accepts it there can be no solution to the conflict between service and training. There must be a permanent career grade of trained men at a subconsultant level. They would be responsible for a proportion of the emergency work and some of the routine care, so allowing the consultant to look after a reasonable number of patients.

This suggestion has been repeatedly rejected by the profession with one hand but accepted with its other when it agreed to the hospital practitioner grade. It is not difficult for a hospital consultant to understand the problems of SHMO grade. No doctor wants to feel that he can never indulge in independent practice and most young consultants would have great difficulty in accepting a senior experienced subconsultant into his team. These problems are so great that I support the view that the permanent full-time subconsultant grade should not be introduced. But the hospital practitioner grade, with modifications, could provide an acceptable compromise. If a consultant had, in addition to his house officer, one or two men who worked in a local practice for half of their time but who worked at registrar level in their local hospital for the remainder of their week we would have the experience and skill required to support the house officer and be able to give first-class 24-hour cover. Such men would need to have trained in their hospital specialty for long enough to obtain a higher diploma and have the broad experience required for general practice. This grade would provide an outlet for those who could not get on to the senior registrar ladder. Thus the middle section of the hospital team would consist of men in training as registrars, a few of whom would become senior registrars, and the majority who would follow the general practitioner/hospital practitioner career. Such a career would provide the hospitals with trained staff but by dividing the man's work between independent general practice and hospital subconsultant team work the psychological pressures and frustrations of the full-time subconsultant post would be avoided.

I can already hear the Royal College of General Practitioners saying that this is degrading and downgrading general practice. I cannot accept this argument. Group practices where each member has a special interest and is often a clinical assistant in the local hospital are successful and can ensure quicker expert consultation than the long wait for a hospital appointment. Furthermore, I cannot accept that general practice is truly a specialty in its own right. The current attempts to restrict the type of training programme followed before going into practice will, like all restrictive practices, do no good. Of course, a diverse training is essential but the system would have to be flexible to allow men to obtain a broad experience and a special expertise to fill the type of post I have described.

Team of three

"How can we best look after our hospital patients?" The answer, tempered by the knowledge of the problems of manpower and training, is simple and singular. Patients are best looked after by a basic team of three doctors. The consultant provides the opinion and experience and controls the whole programme of each individual's care. The house officer provides the hour-to-hour supervision and performs the basic clinical tasks of note keeping, clinical monitoring, and clinical support. Between these two must be a group of doctors whose duties will stretch from helping and training the house officer to deputising for the consultant. The dictates of manpower and training decree that this middle group must consist of two types of doctor, registrars in training and hospital practitioners. A few of the registrars will become senior registrars but most will go on to fill the bulk of this middle grade—the half-time GP/half-time hospital practitioner. Senior registrars are additional to the system and should not be counted as part of the basic team of three.

No other system can provide a good, competitive, but fair training system and permanent job satisfaction, and look after the patients properly. The time has come for us to make a firm decision about the way we want to look after our patients so that the planners and politicians know what has to be done.

Private practice and the unions

COHSE's motion at the Trades Union Congress condemning the growth of private medical care and the Government's proposal to reintroduce private practice into the NHS was carried by a large majority in a show of hands on 4 September. The motion included a proposal that the Manor House Hospital should be reabsorbed into the NHS. Unions which negotiated private medical insurance for their members were criticised and one speaker said that private medical insurance enabled queue jumping and perpetuated privilege. It diverted scarce, highly skilled resources away from those in greatest need.

Mr Eric Hammond of the Electricians' Union, which had negotiated an insurance scheme for its members, said that he had information that in most NHS hospitals NHS staff were given priority and did not have "to wait their turn like ordinary members of the public." This has been borne out by the findings of a survey carried out on behalf of the Joint CCHMS/JCC Subcommittee on Independent Medical Practice, which investigated over 100 hospitals. Consultants reported that members of staff received a measure of priority in obtaining advice or treatment. It was not official hospital policy but was a long-established procedure.