TALKING POINT

Progress of a cohort of trainee anaesthetists

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The excessive number and consequently poor career prospects of registrars in training have recently been the subject of comment.¹ Even in a shortage specialty such as anaesthesia suitably qualified registrars have had difficulty in obtaining promotion to the senior registrar grade for higher professional training² and expanding the grade would improve the registrars' chances of promotion.

Are enough senior registrars being trained to fill the vacancies that occur in the consultant grade? If no senior registrars voluntarily left their specialty or the United Kingdom matching the number of their posts to that of consultant vacancies would be simple. If wastage of senior registrars does occur it must be allowed for in planning the establishment of posts for higher professional training. We studied the progress of a group of senior registrars in anaesthesia to see if any were lost.

Method

There were 49 senior registrars (37 men and 12 women) in anaesthesia in the North-west Thames Region in April 1976—over one-fifth of all such senior registrars in the UK. We followed them for three years. During this period all would

TABLE 1—Senior registrars, registrars, and senior house officers in anaesthesia in North-west Thames RHA, March 1976

	UK graduates	Primary FFARCS	Final FFARCS
Senior registrars			
Establishment 50;			
1 vacancy	49	35	45
Registrars			
Establishment 86;			
1 vacancy	29	19	8
Teaching	18	8	3
Postgraduate	38	4	2
District general hospital	85	31	13
Senior house officers			
Establishment 68;			
2 vacancies	22	19	3
Teaching	10	4	5
Postgraduate	34	7	1
District general hospital	66	30	9

have been expected to have completed their higher professional training and moved into consultant posts. At the end of the study only half (20 men and five women) had become consultants in the UK. A quarter (eight men and four women) were still in the senior registrar grade and another 12 were lost to anaesthesia here. Eight of these (all men) were practising anaesthesia abroad, four of them having returned to their home to do so.

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Of the four who emigrated, two went to Australia and one each to Canada and the United States. Of course, some of these emigrations may prove to be temporary but three of the four had been abroad for two years or more by the end of the study. Three other senior registrars went abroad during the study but

TABLE 2—Registrar and SHO career progression

	Teaching	Postgraduate	DGH
Registrars			
Initial sample ..	85	29	18
Remain in post ..	9	2	1
Left ..	76	27	17
Senior registrar ..	21 (25%)	14	6
Other registrar ..	22 (25%)	4	1
Left UK (home) ..	21 (7) (25%)	7 (3)	5 (4)
Left anaesthesia ..	9 (10%)	2	5 (7)
Unknown ..	3	0	3
Senior house officers			
Initial sample ..	66	22	10
Still in post one year later	5	1	0
Left ..	61	21	10
Registrar ..	27	9	6
Other SHO ..	11	2	0
Left UK (home) ..	6 (5)	2	2
Left specialty ..	14	8	1
Unknown ..	3	0	1

all returned after a year and now hold consultant posts here. Of the four who abandoned anaesthesia, one died and two were unemployed, one after her marriage. The last, also recently married, was engaged in part-time welfare work.

Discussion

The failure of half the senior registrars to obtain consultant posts in the time expected is not due to an insufficiency of consultant posts. The Department of Health and Social Security has estimated³ that there are 120 vacancies in the consultant grade in the specialty. It has also been estimated that, allowing for retirements and a 4% increase in the number of consultants, the approximate requirement for consultant anaesthetists in the United Kingdom is 100 a year.⁴ If we assume that a senior registrar spends three years in post then there is a national requirement for 300 senior registrars if no allowance is made for wastage but at 30 September 1974 there were only 234. The number of senior registrars does not seem to have increased appreciably since then. If the wastage of a quarter found in this survey is typical expansion of the senior registrar grade would be appropriate. From these results consultant posts would seem to be not sufficiently attractive to tempt all eligible senior registrars to apply for them. This may be related to the fact that, with overtime payments, many senior registrars are paid appreciably more than many consultants.

During the first two years of the survey, 36 of the 85 registrars in anaesthesia in the North-west Thames Region obtained the FFARCS diploma, which is the necessary qualification for entry to the senior registrar grade. Only 21 of them, however, obtained senior registrar posts. Some reduction in the number

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General Medical Council

Disciplinary Committee

The Disciplinary Committee of the General Medical Council met this month.

The committee decided that Dr Abul Bashir Mohammad Nazem's name should be erased from the Register for drug offences. Dr Mohammad had issued numerous private prescriptions for drugs to several people in the course of bona fide treatment.

Dr Mohammed Abdul Bari, Dr Peter Nigel Aldridge Holden, and Dr Ian Thomas Williams were admonished and their cases concluded. Dr Williams had made false claims in applications that he held the qualification FRCS (Glasgow). The case of Dr Philip James Doust was concluded.

Dr Bimal Kumar Ghose and Dr Bryan Sandford-Hill were unsuccessful in their application to have their names restored to the Register. The name of Dr Madhusudan Harishchandra Shivadikar was restored to the Register.

The registration of Dr Noel Patrick Burns was suspended for 12 months. The registration of Dr Paul Eruno Davies, Dr John Cotton

Gregg, and Dr Eifion Phillips was suspended for a further 12 months, and that of Dr Aylmer James Crompton and Dr Geoffrey Bowerbank Hayle for a further nine months.

Judgment was postponed for 12 months in the cases of Dr James Michael Bristow, Dr

Sankar Chaudhury, Dr Ewen Mochrie Clark, Dr Bejoy Bhusan Mukherjee, and Dr Nal-lasivam Thiru. The cases of Dr Robert Joseph Carroll, Dr Jegarajasegaram Eliatamby, and Dr Naval Kishore Ghai will be heard at the next session.

Clegg and professions supplementary to medicine

In its fourth report (Cmnd 7850) the Standing Commission on Pay Comparability (the Clegg Commission) has made recommendations on the pay of professions supplementary to medicine. The group includes chiropractors, dietitians, occupational therapists, orthoptists, physiotherapists, radiographers, remedial gymnasts, and speech therapists. The recommendations complete a pay settlement which was effective from 1 April 1979. This provided for increases to salary scales of around 9% and for a payment of £1 per week to the end of July 1979 in anticipation of the commission's findings. The report has recommended average

increases ranging from 16.7% for the basic grade to 10.3% for the most senior management grade and 10% for the most senior teaching grade. The overall average increase is 15.4%. The commission expects the cost of implementing its recommendations will be £19.6m in a full year or 14.2% of the total pay bill.

Both sides of the Whitley Council agreed in advance to accept the commission's recommendations but the staff side is disappointed at the outcome, with the Association of Scientific Technical and Managerial Staffs strongly condemning the report.

Letter from a Junior—continued

revolution. It is reminiscent of the politician who assured us that devaluation of the pound would not detract from the value of the pound in our pockets.

Problems of immigrant doctors

The number of registrars in training already greatly exceeds that required to provide replacements for existing consultants and cope with the foreseeable expansion of consultants.⁴ The system works because a majority of registrars are foreign. Many wish to return to their country of origin and so will not be competing for senior registrar posts. For those who wish to stay the battle is not only uphill but almost vertical. In a recent survey,⁵ 60% of doctors whose country of origin was the United Kingdom or Eire believed Asian doctors to be less competent than white British doctors. (Interestingly, 16% of Asian doctors agreed.) Add racial prejudice, which in my view is as common among doctors as among lay people, and the promotion prospects for the coloured foreign doctor are bad. The survey also found that 85% of foreign doctors and 86% of British-qualified doctors believed that selection committees would discriminate in favour of the British-trained doctor competing with a coloured, overseas-trained doctor who was otherwise comparable. Why have we digressed from PM(79)3 to the problems of the coloured immigrant doctor? Because

they are real and worthy of regular publicity, and because the increasing medical school output will lead to native graduates displacing them from their inferior training programmes and experiencing their reduced career prospects.

Without expansion of the number of consultants there is little point in increasing part-time training for women. It will merely add to competition, which will be intolerable when the increased medical school output percolates through to the registrar grade. Or could PM(79)3 be a feeder mechanism for a subconsultant grade?

Reluctant to finish on so dismal a note, I offer a prize to the individual who can identify the greatest number of defects in

the formula $x = \frac{w}{z} (p \div \frac{y}{z})$.

References

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- 3 Department of Health and Social Security. *Medical manpower—the next twenty years*. London: HMSO, 1978.
- 4 British Medical Association. *Medical manpower, staffing and training requirements*. *Br Med J* 1979;i:1365-76.
- 5 Smith DJ. *Overseas doctors in the National Health Service*. London: Policy Studies Institute, 1980.

Trainee anaesthetists—continued

of registrar posts will be necessary if all the holders are to have a reasonable chance of promotion. The number at present obtaining the necessary qualifications in anaesthesia could probably be accommodated in the slightly expanded senior registrar grade proposed if progress through this grade were a little more rapid.

References

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- 4 Sykes MK. A symposium on staffing and training in anaesthesia: the staffing problem and its situations. *Anaesthesia* 1973;28:364-72.

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