TALKING POINT

Staffing in thoracic medicine

K M CITRON, D R LEWIS, A J NUNN

An imbalance between trainee and consultant posts often occurs in medicine and surgery. This leads either to a shortage of adequately trained doctors to fill consultant vacancies or to poor career prospects for senior registrars when there are too many of them. Accurate surveys of staffing would prevent these imbalances and help in the proper planning of staffing for the future needs of the NHS. In the past thoracic medicine has lacked accurate information about current staffing, future consultant retirements, and staffing needs. Concern about this prompted the present survey, which was sponsored jointly by the Thoracic Committee of the Royal College of Physicians, the British Thoracic Association, and the Thoracic Society.

Methods

A questionnaire was sent to all consultant physicians practising thoracic medicine in England and Wales. The physicians were identified from the Chest Clinic Directory of the British Thoracic Association; the hospital section of *The Medical Directory*; information from physicians in thoracic medicine about others practising the specialty in their regions; and from the Medical Research Council's survey of tuberculosis notifications. We believe that our list is almost complete; we had a 98% response rate. The staff reported here are those in post during March 1979.

Results

CONSULTANTS

Three hundred and ninety-three physicians were identified. Of these, 229 (58%) were general physicians with an interest in thoracic medicine who were undertaking general medical work including emergencies as well as practising in thoracic medicine; 164 doctors practised in thoracic medicine only; 188 (48%) of all the consultants were responsible for the running of a pulmonary function laboratory. Of the 393 consultants, 266 were full time (11 notional half days); the remainder worked part time, their sessions amounting to an additional 99 whole-time equivalents. It was not possible to apportion accurately sessions between general medicine and thoracic medicine for the doctors who worked in both disciplines. The most remarkable feature of the survey was the age distribution of the consultants.

Table I shows the number of doctors in each decade from the ages of 35 to 64, including 18 who were still in post after the age of 65. They recorded on the questionnaire the year in which they expected to retire. From these data we found that 205 (52% of the total) are expected to retire in the next 10 years and 122 (31% of the total) in the next five years. During the next 10 years an average of about 20 retirements annually may be

expected. After 1989 the proportions are different. The average annual retirements are expected to be five during 1989-93, six during 1994-8, and nine during 1999-2003.

Table II shows the percentage of consultants aged 60 or more in England and Wales. As would be expected, regions with several teaching hospitals, such as the Thames regions, have

TABLE I—Age structure

Age	No of physicians	%
Under 35	25	6
35-44	101	26
45-54	62	16
55-59	84	21
60-64	103	26
65 or more	18	5
Total	393	100

TABLE II—Percentage of consultants aged 60 or more

Region	Total No of consultants	Aged 60 or more (%)	Consultants per million of the population
England:			
South-east Thames	37	57	10.4
Mersey	19	42	7.7
Wessex	21	38	7.8
West Midlands	29	38	5.6
North-west Thames	46	37	13.2
Northern	24	33	7.7
South-west Thames	24	33	8.1
Yorkshire	22	32	6.2
East Anglia	10	30	5.4
Trent	25	24	5.5
South-western	20	20	6.6
North-east Thames	42	17	11.4
Oxford	15	13	6.7
North-western	27	4	6.6
Wales	32	31	11.6

more consultants. Eighty-two doctors had university appointments and 106 were recorded as having appointments in specialised thoracic centres. There was a striking contrast between the ages of doctors practising in thoracic medicine only and those undertaking general medicine with a special interest in thoracic medicine, 52% of the former but only 15% of the latter being aged 60 or more.

SENIOR REGISTRARS

There were 32 senior registrars in posts approved by the Joint Committee for Higher Medical Training. Some of these posts were in a rotational scheme with general medicine so that there were 42 doctors in approved training posts. In addition there were 11 other posts comprising lectureships, research, and honorary appointments in university hospitals, also approved as senior registrar training posts. We understand that the DHSS has agreed to establish a further six posts, making a projected total of 59.

Brompton Hospital, London SW3 6HP

K M CITRON, MD, FRCP, consultant physician
A J NUNN, MSC, statistician

North Derbyshire AHA

D R LEWIS, MB, TDD, consultant chest physician

Discussion

Twenty-five years ago doctors in the specialty were mainly concerned with pulmonary tuberculosis, but their work has changed considerably with the rapid decline of the disease. Debate about the need for consultants in the specialty led the Central Health Services Council to set up a committee of inquiry. The council's report¹ recommended that consultants who had specialised in the treatment of chest disease (thoracic medicine) should provide a service in district general hospitals, the physician trained in thoracic medicine and also in general medicine undertaking a share in general medical work. The Joint Tuberculosis Committee, which reported in 1971, noted a decline in the number of consultants from 631 in 1959 to 494 in 1969. It recommended that the decline should be halted and the number of senior registrars increased to meet the increasing number of consultant retirements.² The Thoracic Medicine Committee of the Royal College of Physicians considered the future of thoracic medicine in 1971³ and proposed that the number of consultants should be 350 and senior registrars 48. No accurate information about staffing in thoracic medicine, however, has been available until the present survey, which showed that there were 393 consultants and 53 senior registrars. This differed considerably from the figures given by the Medical Manpower Division of the DHSS for September 1978—262 consultants and 28 senior registrars. The discrepancy in the number of consultants is likely to be due to the fact that we identified consultants with a major commitment to thoracic medicine. AHAs recorded them under general medicine and they were classified as such in DHSS statistics. The considerable expansion of the specialty which occurred in the 'fifties during the heyday of tuberculosis has resulted in the large number of consultant retirements now imminent. There has been a considerable loss of manpower in thoracic medicine recently. Frequently when a full-time consultant in thoracic medicine has retired he has been replaced by a doctor who spends part of his time in general medicine. Alternatively, the vacancy may have been amalgamated with another in thoracic medicine, or the consultant may not have been replaced and the post has fallen into abeyance, or he has been replaced by a consultant in another specialty.

Future

A consultant staffing target for the future is necessary to plan a sufficient number of senior registrar training posts to maintain the consultant establishment. The Thoracic Committee of the Royal College of Physicians, together with representatives of the DHSS, have made estimates for future staffing in thoracic medicine in the light of the data provided by this survey. Three hundred consultant posts have been proposed—200 of these would be required to staff the projected number of district general hospitals in England and Wales and another 100 for teaching hospitals and regional thoracic centres in England and Wales. The establishment of 300 consultants would result in about 15 retirements annually, given that 5% retire annually. A senior registrar establishment of about 55 would be required to supply this need. The precise number, however, would best be

established by a regular survey of consultant retirement dates. A review of senior registrars in Scotland suggests that their number is insufficient to provide a net inflow to fill consultant vacancies in England and Wales. This survey shows that there are currently 53 senior registrars with a further six one-holder posts to be established to provide for the greater number of retirements which will occur during the next 10 years. One-holder senior registrar posts will enable gradual reduction of the senior registrar establishment when the bulge of consultant retirements ends.

Accurate surveys of staffing in thoracic medicine and the stimulus of professional bodies in monitoring trends are necessary to maintain standards in the specialty and to establish the correct number of properly trained doctors to fill consultant vacancies. But these activities in themselves are not enough. There are already areas such as the north-east and East Anglia where there is a serious lack of physicians in thoracic medicine. Physicians at district, regional, and area levels must ensure that when consultants in thoracic medicine retire appropriate replacements are made to maintain an adequate standard of service for patients suffering from respiratory disease. Regional thoracic societies could play an important part in this exercise.

References

- 1 Central Health Services Council. *Future of the chest services*. London: HMSO, 1968.
- 2 Ridehalgh F. Medical staffing and training in chest diseases. *Br Med J* 1971;i:161-3.
- 3 Royal College of Physicians of London. *Report of the committee on thoracic medicine*. London: Royal College of Physicians of London, 1971.
- 4 Medical Manpower Division, Department of Health and Social Security. *Medical staffing and prospects in the NHS in England and Wales, 1978*. *Health Trends* 1979;11:53-6.

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Community medicine in Scotland

Dr Colin Brough of Edinburgh has been re-elected chairman of the Scottish Committee for Community Medicine, and Dr H B Brown of Dumfries elected vice-chairman. At its meeting on 9 September the committee received the report of the Clark Working Party on Community Health Doctors. The SCCM believes that these doctors should be incorporated into general practice or, for those prepared to undertake suitable training, as members of the hospital paediatric team; in future representatives of community health doctors should become the responsibility of the GMSC or the CCHMS. The committee was pleased to note that there had been a higher percentage of distinction awards in community medicine than in previous years. The Scottish Home and Health Department had proposed an increase in the distant islands allowance (now available to all NHS-employed staff in Orkney, Western Isles, Coll, Tiree, Jura, Colonsay, and Islay) with effect from 1 April 1980. The committee was told that the General Municipal and Workers Union wanted NHS staff to receive the same allowances as local authority staff.