TALKING POINT

More consultants, fewer juniors

DAVID T JONES, R SAMPANGI RAMAIAH

The Department of Health and Social Security has now issued its guidance¹ to regional health authorities in England on how it wishes them to proceed towards implementing the recommendations in the fourth report of the Social Services Committee of the House of Commons.² This report (the Short Report), which was fully endorsed by the Government,³ recommended that "a much higher proportion of patient care should be provided by fully trained medical staff than at present." It is essential that the radical implications of this recommendation are fully explored and debated before changes are brought about that could have serious adverse consequences for patient care.⁴

The problem is generally stated⁵ to be an imbalance in the ratio of career to training grade posts in the hospital service, with far too many doctors in the "junior" grades—especially at registrar level—chasing too few openings at senior registrar and consultant level. The solution now advocated by the Government is that manpower policy and practice in the NHS is to be directed towards changing the current overall ratio of consultant to junior medical staff, of one to 1.8, to one to one by 1988. Thereafter, the stated intention is to progress towards achieving a complete reversal—that is, 1.8 consultants to every one junior—of the present ratio by 1996.

We have attempted to set this important issue in the context of one "new" district health authority to encourage debate as to how the task of implementing this policy could be approached.

The authority is that of Clwyd in north-east Wales, which has the same geographical boundaries as its predecessor area health authority. It has a resident catchment population of 385 000 and has two district general hospitals, 30 miles apart, each serving about half the total population.

For statistical purposes we have used the following definitions:

Consultant—All consultants (except regional specialties) holding a contract of service with the Clwyd Health Authority, and including those consultants having a sessional commitment but whose contracts are held by other authorities.

Junior medical staff—All hospital medical staff in the grades of senior registrar, registrar, senior house officer, and house officer (preregistration and postregistration) employed by the health authority.

Excluded grades—Medical staff employed in the hospital service in the non-training grades of associate specialist, hospital practitioner, and clinical assistant.

The current ratios in Clwyd are given in the table as an overall ratio and as individual ratios for 21 specialties. Individual ratios vary widely between, at one extreme, specialties such as radiology that employ no junior staff in Clwyd, to accident and emergency medicine, which has the highest number of junior staff to each consultant employed. The overall ratio for Clwyd is one to 1.32, well below the stated DHSS ratio of one to 1.8. This, at first sight, might seem to present the health authority with an encouraging prospect. It overlooks the fact, however, that at

regional level ratios must also reflect the staffing figures for regional specialties, teaching centres, and, of course, other health districts.

The problem and a possible strategy

The classification of specialties put forward here is based on the current overall DHSS ratio of one to 1.8 and the interim target ratio of one to one; thus in specialty category I the current ratio is <1:1, in category II the ratio is 1:1 to 1:8, and in category III the ratio is >1:1.8.

Applying this classification to the ratios in the table results in the following groupings:

Category I—Specialties with ratios below the interim target ratio of one-to-one: child psychiatry, dermatology, orthodontics, radiology, pathology, genitourinary medicine, and mental handicap.

Category II—Specialties placed between the two DHSS ratios quoted above: anaesthetics, chest diseases, ENT surgery, orthopaedic surgery, rheumatology, paediatric medicine, ophthalmology, and psychiatry.

Category III—Specialties with ratios greater than one to 1.8: accident and emergency, general medicine, geriatric medicine, obstetrics and gynaecology, general surgery, and oral surgery.

The following strategy is put forward as a series of observations applicable to each category, which could be taken note of by regions and DHAs when developing their forward manpower, service, and capital planning programmes.

CATEGORY I

So far as the typical non-teaching district general hospital is concerned these specialties have never developed a strong infrastructure of junior medical staff.

Consultant and junior medical staff numbers and ratios by specialty in Clwyd at 31 December 1981*

Specialty	No of consultants	Consultants as wte†	No of junior medical staff	Junior medical staff as wte†	Ratio of consultants to junior medical staff
Accident and emergency	2	1.36	10	10.00	1:5.00
Anaesthetics	12	10.62	13	12.63	1:1.08
Chest diseases	3	3.00	5	5.00	1:1.67
Child psychiatry	6	4.18	2	1.54	1:0.33
Dermatology	2	1.45	1	1.00	1:0.50
ENT surgery	4	2.91	5	5.00	1:1.25
General medicine	6	5.91	17	17.00	1:2.83
General surgery	7	6.55	20	20.00	1:2.86
Geriatric medicine	4	4.00	13	13.00	1:3.25
Obstetrics and gynaecology	6	5.55	12	12.00	1:2.00
Orthopaedic surgery	6	4.72	10	10.00	1:1.67
Pathology	10	8.81	0		
Radiology	8	7.54	0		
Rheumatology	1	0.91	1	1.00	1:1.00
Paediatric medicine	4	4.00	7	7.00	1:1.75
Orthodontics	2	1.54	1	1.00	1:0.50
Oral surgery	2	2.00	4	4.00	1:2.00
Ophthalmology	4	3.00	5	5.00	1:1.25
Psychiatry	10	8.80	13	13.00	1:1.30
Genitourinary medicine	2	0.54	0		
Mental handicap	4	2.00	0		
All specialties	105	89.39	139	138.17	1:1.32

* Excluding regional specialties.

† wte = Whole-time equivalent.

Department of Community Medicine, Clwyd Health Authority, Preswylfa, Hendy Road, Mold, Clwyd CH7 1PZ

DAVID T JONES, FFCM, MRCP, chief administrative medical officer
R SAMPANGI RAMAIAH, MB, BS, senior registrar in community medicine

Thus future expansion in non-teaching health authorities could largely be confined to consultant posts, with additional support being sought from staff appointments in the "excluded" grades.

CATEGORY II

It would be feasible to bring this group of specialties to a one-to-one ratio by linking additional consultant appointments to the existing levels of junior medical staff establishment.

Indeed, trends such as increasingly community-oriented hospital paediatric medicine and the diversification of anaesthetic practice away from the operating theatre will lead to an expansion of the consultant grade and should be encouraged.

CATEGORY III

It is difficult to envisage how the present ratios in these specialties could be much changed without postulating a reduction in the current DGH establishments in the training grades.

Such reductions would probably be opposed because of the serious implications for changing consultants' work patterns.

The first line of approach should therefore be to appreciate that the current recommendations for consultant to junior ratios are intended to be averages that allow for considerable variation from one specialty to another—that is, category I specialty figures could serve to offset or "protect" junior establishments in category III specialties.

In the longer term, accompanying shifts in the organisation of practice, as described below, could contribute significantly towards enabling the Health Service to come to terms with these radical proposals:

(i) Junior grade staff should be concentrated on single DGH sites, or, put another way, individual specialties would not be able to have their junior staff deployed at two or more locations—for example, paediatric staff being "posted out" to support consultant obstetric units separated from their associated DGH.

(ii) Greater emphasis should be placed on developing patterns of health care provision that reduce, so far as possible, the need for hospital inpatient stay—for example, day hospitals, day surgery units, programmed investigation units, and five-day wards.

(iii) The resources of the primary care sector should be considerably expanded in parallel with the developments listed in (ii) above. In this context, the community hospital movement, which we regard as "extended primary care," needs to be more actively encouraged than now.

Two general observations seem relevant to us and are directed at medical schools and teaching hospitals:

(i) Medical undergraduates and young qualified doctors should be more vigorously encouraged to seek careers in the so-called "shortage" specialties.

(ii) Most consultants will spend their professional careers working in non-teaching DGHs, so a reasonable proportion of senior registrar and registrar posts must be retained in these hospitals.

Conclusions

The views in this paper represent an attempt to resolve the inconsistencies in manpower from a district health authority standpoint. We recognise that in England non-teaching DHAs do not hold the contracts of consultants; nevertheless, this does not affect the nature of the local problem.

The approach that we have advocated is based on our observations and experience of Health Service provision in a large semi-rural county, and, quite clearly, it would be nonsense to suggest that the position in large urban areas, including deprived inner cities, could be dealt with in the same way. If, however, the NHS is to respond flexibly and sensitively to these differing circumstances these target ratios must be regarded as regional averages only, so as to allow as much variation as possible between districts, specialties within districts, and the same specialties in different districts.

Indeed, in our view, the DHSS and RHAs should understand that if this radical change in the staffing structure of the hospital service is to occur without adversely affecting patients local health authorities, with their clinicians and professional planners, must together study the local position and make sensible, practical, and achievable proposals on a time scale that they can influence.

This paper expresses our views and not necessarily the views of the Clwyd Health Authority or of the medical profession locally.

References

- 1 Department of Health and Social Security. *Health services management. Hospital medical staff: career structure and training*. HC(82)4. London: DHSS, 1982.
- 2 Social Services Committee. *Fourth report. Medical education with special reference to the number of doctors and the career structure in hospitals*. London: HMSO, 1981. (Short Report.)
- 3 Department of Health and Social Security. *Government response to the fourth report from the social services committee, 1980-1 session*. Cmnd 8479. London: HMSO, 1982.
- 4 Appleyard WJ. Medical manpower mismanagement: mirage or miracle? *Br Med J* 1982;284:1351-5.
- 5 Department of Health and Social Security. *Medical manpower—the next twenty years*. London: HMSO, 1978.

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General Medical Services Committee

At its first meeting of the session on 16 July the General Medical Services Committee re-elected Dr J G Ball as chairman for a second year of office. Much of the day was spent electing subcommittees and representatives on other BMA committees and outside organisations.

Negotiating team

The following members were elected to serve on the negotiating team and to represent the committee on the Review Body Evidence Committee for the 1982-3 session: Dr J G Ball (ex officio), Dr P J Enoch (Ilkeston, Derbyshire), Dr J A Riddell (Glasgow), Dr W C A Riddle (Gateshead), and Dr M A Wilson (Huntington, York).

General Purposes Subcommittee

In the election to the General Purposes Subcommittee the following members were successful: Dr B L Alexander, Dr Simon Jenkins, Dr S E Josse, Dr P F Kilty, Dr Lionel Kopelowitz, Dr R J R Lewis, and Dr D E Pickersgill.

Microcomputers for GPs

The committee was concerned about the views that had been expressed at the LMC Conference and in the paramedical press about the Department of Industry's "Micros for GPs" scheme (19 June, p 1884). At the meeting on 16 July the meeting considered a paper by two members, Dr J W Chisholm and Dr D M

Wilks, who were particularly concerned with the development of computers in general practice. The GMSC believes that the rationale of the scheme is generally acceptable, though in the profession's earlier discussions with the DHSS the committee had expressed its anxiety about the restricted number of systems that were to be made available—the original proposal was that only one company would be involved. Furthermore, the scheme had not been extended to FPCs. These had now been included and the funds available increased. The GMSC would have preferred a wider choice of hardware but it has accepted that there had to be some limitation to ensure that the doctors' investment was protected by adequate and reliable backup and that the conclusions drawn from the project were valid. In its debate on the scheme the committee decided that the scheme did not pose a threat to companies that were excluded and that it was unlikely that some of the smaller firms would have the resources to participate on a national basis.