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Crisis in rheumatology manpower

Most of the current trainees in rheumatology were encouraged to enter what was thought to be an expanding specialty. They now face the prospect of their planned career evaporating before their eyes. There are 95 senior registrar posts, yet fewer than 10 consultants seem likely to be appointed each year in the immediate future—so that either training will last, on average, 10 years or many trained clinical rheumatologists will be forced to leave rheumatology altogether. They face this prospect at a time when moving sideways into another branch of medicine is impossible. If they leave rheumatology they will have to start training from scratch for another career.

The factors which have combined to produce this crisis were not foreseen. The most important has been the failure of the Department of Health and Social Security and regional health authorities to fund the planned expansion of consultant posts in both rheumatology and rehabilitation. In theory expansion continues—over 20 posts have received manpower approval in the past two years—but in practice most remain unadvertised owing to lack of funding. In the light of current government attitudes little change seems likely.

A contributory factor has been the expansion of training posts funded outside the NHS—the research appointments financed partly by “soft money” from charitable or scientific bodies such as the Arthritis and Rheumatism Council and often by the pharmaceutical industry in support of work on a specific product. Though in theory many of these posts do not qualify for career training recognition by the Joint Committee on Higher Medical Training, in practice the incumbents compete in the same career market. Furthermore, a new trend has been apparent at several recent consultant appointments where moves have been made to combine the commitments of general medicine with those of rheumatology. General physicians should be concerned about the threat to their own specialist practice of internal medicine which this trend poses. Rheumatologists, most of whom have not had higher training in general medicine (only 13 recognised training posts exist which are said to combine both specialties), can no more provide comprehensive and up to date skill in internal medicine than can general physicians in rheumatology.

Though some competition for consultant appointments may be healthy, no one can justify the waste of manpower, training facilities, and frustration that will flow from current arrange-

ments. Four steps must be considered by the specialty if it is to make reasonable provisions for the immediate future and honour its commitment to current trainees. Firstly, though senior registrars complete their training in four years they should be allowed to remain in post for up to six years before their future in rheumatology is reviewed. This would allow extra time for current trainees to obtain consultant posts without undue pressure to abandon their career. It would also help direct the competition to the start of training, when alternatives should be considered, rather than at the end. Secondly, every pressure should be brought to bear on regional health authorities to fund approved consultant posts. At the same time current moves in a few areas to allow consultant rheumatology posts to lapse must be strenuously resisted. (Trainees are alarmed to learn that there may even be pressure in some hospitals to sacrifice existing consultant posts for apparent short term benefit.) Thirdly, the balance between training posts and projected consultant vacancies must be improved in the medium term. This implies halving the current senior registrar posts. There are strong arguments for retaining a few academically orientated posts funded by research bodies, but most of those supported by the pharmaceutical industry and some within the NHS would best be abandoned (if necessary by withdrawing training recognition). In some instances two training posts might be replaced by one consultant post—to the advantage of both the service and budget. In filling those training posts to be retained preference should be given to those already committed to rheumatology (who may have spent some time in research based or locum posts), rather than more junior applicants.

Fourthly, and in the longer term, the profession will surely have to adopt the principle that selection for higher training in any specialty should be followed by appointment to consultant when satisfactory training is completed. This principle is contained in the Short report,¹ but fear of indiscriminate conversion of training to consultant posts with inadequate funding has caused some hospital staff to be sceptical. The set up in rheumatology, arising during the course of an agreed expansion stimulated by the recognised needs of patients suffering from rheumatic diseases, provides an opportunity to alter the relation between consultant and training posts rapidly.

The proposals outlined here appear to be the only counter to the growing disillusionment among trainees, not only in rheumatology but also in other specialties. This disillusionment may itself be one of the greatest threats to the continued provision of good health care in Britain.

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¹ 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.)