SUPPLEMENT

Talking Point

The career structure—an indication for major surgery?

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The medical career structure in National Health Service hospitals has been a source of anxiety to the profession and to health planners for longer than some of us care to remember. Untold hours have been expended discussing the problem in BMA House, the Elephant and Castle, and elsewhere, and countless columns in this journal have reported the rhetoric and the recommendations. Even if all those recommendations had been implemented in full the problem would largely remain with us. It is as though the basic (and archaic) structure of the hospital medical hierarchy was seen as some kind of ancient monument to be preserved, within which were permitted only minor, tasteful adaptations to fit the edifice to its present day purpose. When will someone dare to ponder whether the mason's trowel should give place to the bulldozer?

It is said that a problem clearly stated is part way to being solved—so what is the problem? This question is best answered from two view points—those of the doctor and of the health planner.

Doctor's problem

A newly qualified doctor deciding to seek a career in the hospital service is confronted by a prospect of a decade—more or less—of moving from one short tenure job to another. During that time the one thing that is certain is that he will have no place on a payroll one, two, or five years later unless meanwhile he has been successful in competing for another post. He might present himself for interview on a couple of dozen occasions or more, the prize being not merely advancement but survival. The culmination of this nightmare is that at some time in his mid-30s the doctor will (with luck) convince an advisory appointments committee that he is worthy of appointment to a consultant post. Only then will he have permanence of tenure of appointment; only then will he receive a salary befitting a professional man at the peak of his energies; and only then will he be able to look the world in the face and say, "I have succeeded." It is an all or nothing gamble: either you reach the summit of the pyramid or you fall by the wayside.

The practical effects of this unseemly obstacle race are that general professional and specialist training are undergone against a background of insecurity, and there is an inherent incentive to minimise the timelag before consultant appointment, to the detriment of breadth of experience at the general professional training stage. A further consequence is, perhaps, an enhanced sensitivity on the part of young doctors to any perceived failure of the health authorities to create and maintain the right number and proportion of posts in the respective grades to permit career progression, given that such progression is totally dependent on the availability of posts in the market place.

Planner's problem

From the health planner's standpoint the difficulty is that all the whole time grades below consultant (leaving aside associate specialist) are training grades. Their location and numbers are, quite properly, dictated by educational and manpower considerations and controlled by the bodies concerned with these matters. Thus they are not (and should not be) available for the planner to deploy to meet service needs. Hence the only posts that can be created in response to service requirements are consultant posts. These are the top jobs, whose occupants have preconceived ideas about the kind of duties that they will or will not undertake. This means that on recognising a need for medical input at other than consultant level there is no legitimate and satisfactory way that a health authority can respond. Instead, authorities are asked to pursue medical staffing policies which a lay member might suspect are geared towards ensuring satisfactory prospects for doctors. And so they are—within a career framework which is seriously flawed and ill matched to the realities of the NHS in the 1980s.

The outstanding fault is the total lack of a main core grade in hospital medicine—a grade between the trainees and the top brass. Let us not call it a permanent subconsultant grade (even though that is literally what it would be) in view of the connotations that this term has acquired. Those connotations stem from the concept of a consultant post as being the only respectable career objective in hospital medicine. It is that concept, as well as the career structure, which needs to be changed. Without such an intermediate grade health authorities (at least in districts not recognised for higher specialist training) are presented

with a problem analogous to that of an education authority attempting to run its schools using only probationer teachers and headmasters.

All that I have said so far is fairly obvious—or at least the first part is obvious to young doctors and the second to health planners. Most people shrink from taking the logical next step of proposing an effective solution to the conundrum, either from political and medico-political caution or from a natural disinclination to overturn hallowed institutions. Setting such inhibitions aside, I shall proceed to raise some eyebrows.

Firstly, however, I want to differentiate between two separate meanings of the word "post" (or "appointment" or "job"). On the one hand, it means a place on a payroll, at a salary scale specific to the grade of the post. On the other hand, it is a commitment to do a certain job of work at a given location, coupled (if it is a training post) with an opportunity to undergo training and benefit from experience at a level appropriate to the particular grade. In our present career structure these two notions are firmly linked together, and if the post (in its second sense) is of limited tenure so is the place on the payroll. My thesis is that in an integrated national health service there is no compelling reason why this need be so.

Single salary scale

This leads me to my first bombshell. Taking the word "post" strictly in its first sense—a place on a payroll—I would abolish all the existing grades from senior house officer upwards together with their salary scales and would abandon for ever the idea of a limited tenure post, except solely for overseas doctors coming here for the declared purpose of obtaining postgraduate training. A fully registered doctor wishing to commit himself to a career in the NHS would, on obtaining his first postregistration appointment, enter into a permanent contract of employment with the regional health authority. He would start on the initial point of a single salary scale incorporating about 15 annual increments, running from the bottom of the present senior house officer scale to the top of the present consultant scale. For so long as he elected to make his services available to the NHS, no matter in what way or at what level, he could look forward to receiving a salary commensurate with his experience. This contract would only be terminable on the employer's part in the extraordinary circumstances of disciplinary dis-

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missal or redundancy. Thus the doctor would be able to pursue his general professional and higher specialist training at his chosen pace without ever having to wonder how his next year's bread and butter would be afforded. However he steered his career he would reach the top of his incremental scale at about the age of 40.

Training posts in the second sense—slots within which a doctor would work and be trained—would continue to be limited in tenure, though the duration in each case would be tailored to the particular training programme. On approaching completion of that programme the doctor would apply for whatever training post he would like to move on to. The process of advertisement and appointment would be much as now—the only difference being that the doctor's pay would be unaffected by either success or failure. If he failed to obtain a post he would be liable to be deployed within his region to a location where he could work at whatever level of skill he had attained. Such deployment would follow consultation with the medical postgraduate dean, its combined objectives being to meet service requirements and to provide the doctor with experience relevant to his needs. He would, of course, continue in his quest to obtain an approved training post of his own choosing, and he would continue to enjoy his annual increments of salary.

Within this new found financial security the doctor would be entirely free either to make a headlong bid for specialist training or to diversify his experience, just as he wished. No longer would there be a financial disincentive to his acquiring a broad general professional training. Equally, he could indulge in a late change of career intention without his incremental progression having to "mark time" as under the present regulations for protection of salary. Medical postgraduate deans would keep track of all trainees in their regions to ensure that they were provided with career advice and made aware of the opportunities available to them.

New specialist grade

My second innovation relates to what happens when the doctor completes his higher specialist training. On obtaining specialist accreditation he would immediately cease to be called a senior registrar; he would become a specialist. He would describe himself simply as a physician, anaesthetist, surgeon, or whatever, without any prefix. This would make no difference to his pay, but would affect his status and mode of working. Like a consultant he would accept referrals from general practitioners, admit patients to beds, and exercise clinical independence, though he would work under the overall coordination of a consultant. He could opt for a whole time or maximum part time contract. Unlike a consultant, he would be prepared if need be to undertake duties at any level—menial as well as skilled—and to participate in a first on call rota. He would derive professional satisfaction from providing total medical care for his patients. He would not be eligible for a distinction award.

Specialist posts would not be advertised or competed for; they would be the logical outcome of completion of higher specialist training. The corollary of this, however, is that on attaining specialist status the doctor would be deployed within the region at the discretion

of the regional health authority. He would be given three months' notice of such deployment. Once deployed, he would not be redeployed except by mutual agreement between himself and the regional health authority.

The specialist grade would be seen, both within the profession and outside, as an entirely respectable career end point, just as the consultant grade is now. A specialist need feel under no personal, professional, social, or financial pressure to become a consultant unless he wanted to. The grade would be in no way analogous to the associate specialist grade. It would become the much needed main core grade of the service. If a regional health authority foresaw a need for more specialists it would create more senior registrar posts in the relevant specialty. The specialist grade would be numerically the largest grade in the NHS.

If a trainee failed to attain specialist accreditation, or if he simply chose not to, he could of course retrain in another specialty with no financial penalty. Alternatively, he could settle for what we now call the associate specialist grade, though to avoid confusion the word "specialist" should be dropped. As in the case of a specialist, an associate would be deployed at the discretion of the regional health authority, but could not then be redeployed without his agreement. His salary would continue unaffected; indeed, he would enjoy the same earnings as a specialist. But he would serve the NHS in a different capacity and would not have clinical independence. The move to associate status would follow consultation with the medical postgraduate dean, who would wish to ensure that it resulted from either inability or free choice, rather than from exploitation or lack of advice.

Contraction of the consultant grade

The consultant grade would be for the brilliant high flier or for the specialist of long experience. Far from expanding the consultant grade, as we are supposed to be doing at present, it should ultimately contract to the point where there would be one consultant per district in each major specialty, or one consultant covering several districts in the smaller specialties. This adjustment in numbers, however, would have to be phased over a long time; otherwise, a whole generation of specialists would be denied the prospect of promotion. The consultant would coordinate the activities of the specialists to ensure the effective provision of a total service. He would not challenge the individual clinical decisions of the specialists, but would hold them to account for their efficient use of beds, theatre time, and so forth. He would be seen as the manager of his clinical service, and he should be offered special training for that role. He would, of course, pursue a specialist practice of his own, though he would not be first on call. The specialists might well seek his opinion on difficult cases, though they would be under no obligation to do so.

Consultant posts would be advertised and competed for by accredited specialists, the appointments being made in accordance with the statutory instrument as at present. The successful candidate's basic salary would still continue unaffected, but he would in addition automatically receive a "C" distinction award, though it would no longer be so called. If he were still on the incremental part of the salary scale he would go on getting annual

increments until he reached the plateau. There would be no question of enhanced incremental credit at this or any other stage of a doctor's career, other than for mature appointees entering (or returning to) the NHS from outside. The entire salary structure and its operation would be simplified, no doubt to the relief of the finance departments of employing authorities. There is, however, no reason why "B," "A," and "A plus" distinction awards should not continue to be bestowed on the most outstanding consultants.

In summary, I propose permanent appointment to a single salary scale, and a substantial corpus of specialists providing the major part of the service to patients. The specialist should not be viewed as a subconsultant; rather, the consultant would be a super specialist. This scheme would offer the young doctor security of tenure and smooth progression up the salary scale, in return for the acceptance of geographical direction of labour on completion of specialist training and under certain other circumstances. Given that a specialist would be about as likely to achieve consultant status as is a consultant to acquire a "C" award at present, there would be no marked financial penalty overall. The additional cost to the health authorities would not be vast, and they would be much better able to match medical manpower to service needs than they are now.

It would be naive of me to imagine that these proposals will be received with equanimity in all quarters, even assuming that they are taken seriously. Nevertheless, I earnestly commend them for consideration and debate.

Negotiations continue on Griffiths

Health authorities are going ahead with arrangements to appoint general managers at regional and district level in accordance with the recommendations in the health circular (HC(84)13) on implementing the Griffiths proposals on NHS management. At unit level the role of general manager is closely linked with that of the unit medical representative. The BMA's policy is that clinicians appointed as unit medical representatives should be appropriately remunerated. This would be separate from the remuneration attached to the post of unit general manager, though in practice the BMA believes that many individuals could hold both appointments.

Some progress made towards BMA policy

The meeting of the BMA's executive committee of council on 5 September was told that several meetings had been held between the BMA and the Department of Health and Social Security and that some progress had been made towards accepting the BMA's policy. Negotiations are continuing and it has been made clear to the DHSS that the BMA will be unable to recommend doctors to cooperate in the management process at unit level until the question of remuneration has been resolved satisfactorily.