people's desire for medical advice may be acute, and with nearly nine tenths of households having a telephone in 1990 (up from three quarters in 1981),¹ advice is becoming more accessible. The trend to early retirement may create expectations of good health, and greater unemployment is accompanied by increased levels of ill health. This may raise call rates, both generally and at night. Other new incentives to call have arisen, such as the prospect of meningococcal infection in a child with fever and headache—a fear more intense at night.

General practitioners' thresholds for visiting are probably lower for patients on lists that they cover than for their own patients. With the growth in the size of practices and better practice organisation the likelihood of general practitioners covering many other patients increases.⁶

With no disincentives for patients to request night visits and incentives for general practitioners to visit, can we expect the increased level of activity to yield health or welfare benefits or avoid costs elsewhere in the system? Some people believe that it helps in a night consultation to see a doctor you recognise. Taylor long ago argued that the advantages emerged over several years of contact and that in an emergency most experienced doctors could successfully manage their patient's problem.⁷ Others, especially those with an interest in the psychodynamics of the doctor-patient relationship, have argued that such situations present diagnostic opportunities fully exploitable only by doctors aware of their patients' relationships with those about them, and their previous behaviour and reactions.^{8,9} As for patients, most are satisfied by all aspects of emergency consultations with deputising service doctors, most of whom they do not know.¹⁰

Although there is evidence to the contrary,¹¹ another benefit attributed to general practitioners undertaking their own visits is that, through their familiarity with the situation, they are more selective in referring patients to hospital, and

hospital costs are therefore reduced.¹² It will be important to know whether the trend in nocturnal hospital admissions has changed since the new contract was introduced.

General practitioners are experiencing more stress, less job satisfaction, and poorer mental health with the new contract than before.¹³ The opportunity to enhance income through night visits may soften less agreeable effects of practice with the contract. Paradoxically, most general practitioners think that opting out of the responsibility for out of hours care altogether should be made possible.¹⁴

There has been an explosion of night visiting. Whether this has resulted in better clinical decision making, patient satisfaction, or use of resources is as yet unknown.

BRIAN T WILLIAMS
Director

Department of Public Health Medicine,
University of Sheffield Medical School,
Sheffield S10 2RX

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Role models and patronage

Greater awareness needed of their capacity for harm

In a more rational world some of the central processes of medical education and career development would be less mysterious—or at least more subject to rational scrutiny. No one who has gone through medical school would deny the influence of role models, and no one who has pursued a career in medicine, particularly hospital medicine, would discount the part played by patronage. Both are pervasive and powerful. Both are underdocumented.

Compared with other university courses, clinical medicine is distinguished by the contribution of teachers who are themselves practitioners of what they teach. As role models these teachers do more than they know, and they start early. Medical students in prolonged contact with junior doctors learn attitudes by example, for better or for worse. Though less in contact with students, the more senior and perhaps more influential members of the clinical teaching staff also offer a wide range of role models, which students may choose to emulate or reject. Although such little attention as has been paid to the role of the role model emphasises the positive, the sometimes dramatic impact and value of the negative should be recognised too. Students may choose quite early which behaviours to avoid for ever—or try to.

Teachers are probably more conscious of teaching know-

ledge and skills than they are of passing on attitudes, yet if, as former medical students themselves, they were to identify ideals in teaching the chances are that those ideals would be closely associated with one or two of their own teachers whose attitudes and behaviour made the most favourable impression at an impressionable age. We try to follow where such teachers led, but the accumulation of cynicism as students progress through the course is well recognised. Perhaps we teach what we are.

On an important topic where anecdotes far outnumber studies, a 1988 conference report from Indiana¹ at least provides a concise distillation of local—apparently anecdotally derived—wisdom, noting that role modelling is inseparable from teaching and may do harm as well as good. The report goes on to recommend that role modelling should itself be the subject of teaching so that its functions may become more explicit and better recognised. Even if we are not quite ready for that, we should as teachers at least attempt to promote our exemplar role to the realms of awareness and practise as conscious role models, because whether we like it or not that is how we function.

Patronage, by contrast, has always been a conscious activity. Defined as “the encouragement given to an individual

by a patron who favours, protects, and gives influential support," it has a long and generally inglorious history in the development of careers in medicine. Medical students and junior doctors seek it. Their seniors bestow it with increasing effectiveness as their seniority increases. It is informal in operation, by its nature unequal in its distribution, and in practice a means of subverting both unredeemed meritocracy and the more complex goals of equality of opportunity.

Women lose out,² as do ethnic minorities, which renders the effects of patronage both wasteful and unfair. Its principal practitioners and beneficiaries do not, of course, complain, but a BMA document just published expresses grave concerns about current realities and proposes far reaching reforms which, if implemented, would offer a fairer, better deal for all junior doctors (p 798).^{3,4}

The document recognises that informal patronage could be seen as a response to widespread deficiencies in medical education, postgraduate training, appraisal, careers guidance, and appointments procedures. Individual and covert arrangements offer help and guidance to a favoured minority in overcoming a range of obstacles which nevertheless are faced by all. More open, more supportive, and more accountable mechanisms are now proposed. Were they to be realised, patronage might not disappear entirely but it would wither

substantially as a result of being seen as increasingly unnecessary and underhand.

Financial and administrative constraints permitting, the proposed more open and formal systems of careers guidance, support, and appraisal could achieve much, especially if, as proposed, they were reinforced by explicit fairness in appointments procedures from preregistration level upwards and monitored for ethnic and gender neutrality under the auspices of the NHS Management Executive. And if self aware role modelling in medicine were to include a declared abstention from all the quiet words, phone calls, and fixings of the present highly selective mechanisms of patronage then the expectations of medical students and junior doctors, especially women and those from ethnic minorities, could be transformed, perhaps within only a generation or two.

COLIN CURRIE

Honorary consultant in geriatric medicine

University Geriatric Medicine Unit,
City Hospital,
Edinburgh EH10 5SB

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Career grade posts in NHS trusts

Patients will lose out if some trusts continue making unsafe appointments

The procedures used by advisory appointment committees to appoint consultants have long been governed by successive statutory instruments of parliament¹⁻³ for one reason only—to protect the public. The system has proved a remarkably cost effective way of ensuring that people are not appointed to consultant posts unless they have reached appropriate levels of training and experience. The royal colleges have a crucial role in ensuring the maintenance of standards through these procedures. Some other countries have created vastly expensive bureaucratic accrediting agencies to achieve the same ends.

Previously, regional health authorities were responsible for most consultant appointments, but since April 1991 more and more consultants are being employed directly by trusts. Unfortunately, there is increasing evidence that some trusts, particularly those in the "first wave," are trying to circumvent the current statutory instrument by such manoeuvres as appointing locums to non-existent posts or by using temporary consultant appointments.

Similarly, although trusts were reminded just one year ago of their obligation to abide by the manpower approvals procedures relating to non-consultant career grades,⁴ some have established posts clearly intended to be outside the controls incorporated in *Achieving a Balance*. This has ranged from posts being created without manpower approval to trusts inventing their own titles for grades, which results in grave confusion not only from a manpower perspective but also because different titles may imply competence not possessed by the post holder. Furthermore, because of their freedom to set their own terms of service, trusts are able to offer contracts that are potentially exploitative, requiring hours of work beyond those considered acceptable for doctors in the training grades.

Unfortunately, outposts of the NHS Management Executive, which are supposed to monitor trusts, have proved totally ineffectual in taking any action on this matter. But, sooner rather than later, trusts will have to realise that they can ignore neither the law of the land nor agreements to which ministers are cosignatories. The secretary of state has given the Joint Consultants Committee (JCC) an assurance that the Department of Health will deal firmly with specific cases of abuse that are notified to the department, and, indeed, certain trusts have already been made to reverse inappropriate appointments.

It is unlikely that the JCC knows of all the instances in which either advisory appointments committees' procedures have been bypassed or inappropriate non-consultant career grade appointments have been made. Doctors who are aware of such appointments in their hospitals (or plans for them) should notify the JCC's secretariat of the circumstances so that they may be taken up with the department without delay. The anonymity of doctors who provide these details will be guaranteed. If these practices are not stamped out it is the public who will be the ultimate victims.

PADDY ROSS
Chairman

Joint Consultants Committee,
BMA House,
London WC1H 9JP

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