TALKING POINTS

A feast in the midst of famine

T J H CLARK

Perceptive medical students must be wondering if they will find a permanent job in the Health Service after qualification. Yet we appear to be chronically short of doctors and have come to rely increasingly on those qualified overseas to staff our hospitals. In hospitals more junior doctors are employed than are required to replace consultants and general practitioners who die or retire. This excess of young doctors is deemed insufficient by many consultants, and according to one estimation an additional 17 500 junior posts are necessary to staff hospitals properly. This would about double the number of junior doctors when less than half of the present total are likely to secure a permanent post in the NHS unless a substantial expansion of career grades materialises.

Medical school output

Medical school output has been increasing and will continue for the rest of the decade. This output is achieved with difficulty and at great cost and has to meet two related but conflicting needs. The number of graduates has to be sufficient to resupply career posts as retirements and deaths take their toll, but graduates also provide the junior staff for hospitals and this latter requirement threatens the former actuarial balancing act. The conflict is made worse by the fact that young doctors need stay in junior hospital posts only a short time for training (even shorter if Merrison is heeded—what will happen to unemployable specialists?) and this produces a bulge of posts far beyond that required for career needs. The bulge could be controlled either by delaying the transfer into a higher training post (remaining four to six years as SHO) or by creating jobs not leading to career posts (a subconsultant grade) but such solutions are apparently unacceptable.

The apparently unsatiable demand for hospital junior doctors leads to them working excessive hours, particularly in understaffed hospitals, which also compromises their training. Reducing the working week results only in a cry for yet more junior doctors, reinforcing the long-term staffing problem if the plea is satisfied and straining the remaining hospital staff if it is not. Could this unfulfilled demand for junior doctors be met in other ways?

Mitigating factors

The excessive number is mitigated at present by several factors. The first is our dependence on doctors qualified abroad. They fill many of the posts in excess of our long-term needs but this serves only to disguise the problem. If foreign countries stopped allowing medical graduates to come here or the Temporary Registration Assessment Board reduced the number eligible for work in the Health Service then our overdependence on this source of junior hospital doctors would be exposed and we would be forced to examine how hospitals could survive with a smaller number of junior doctors. The pressure on career posts is also eased by the fact that there is an increasing proportion of women doctors who spend longer in junior posts and compete less resolutely for whole-time career posts. This state of affairs is undesirable and unlikely to persist.

The imbalance between short-term demands for junior staff and long-term planning needs has also been disguised by an abnormal age distribution of consultants: this has resulted in a bulge of retirements. In addition, consultant expansion is helping to mop up senior registrars so that the pressure on career posts is not as severe as the figures suggest. To this can be added wastage, sorrowfully through emigra-

tion, and manpower planning, which should bring into line job opportunities with potential applicants.

Despite these mitigating factors we are still left with the fact that the demand for junior hospital doctors far exceeds the number for replacing consultants and general practitioners. Increasing our medical schools' output to meet the short-term hospital demand will be grossly wasteful unless we solve our present manpower problems. Somehow we have to bridge the gap between the demand for over 30 000 junior doctors and the career need of 5-10 000 posts.

Imbalance between training and service needs

The excess jobs result from many factors and include the need to staff small and uneconomic hospitals inherited from the past. An important factor, however, is the notion that all junior posts are for training and arises from the fact that while in post junior doctors carry out routine service tasks and this has been considered part of their training. Once this is understood then the fact that all junior posts are said to be for training falls into perspective; training and service have become inextricably intertwined. The fact that not all jobs can serve as training posts for a permanent job is ignored: the myth is sustained because it is convenient for all parties. It enables nonteaching hospitals to attract staff, as few would apply for a purely service job, and it allows junior doctors to think they all have a chance for promotion. If we are to solve our present predicament this myth must go.

The present career structure forces on us the need for a smaller number of junior training posts than career opportunities and in part arises from the lack of a hierarchy within our permanent posts. Occupancy of a permanent post takes about 30 years compared with less than 10 years in training and this means that most doctors have to be in permanent career posts with a minority in training. If the number of junior doctors both actual and requested were reduced accordingly either by agreement or by TRAB then the work they do would have to be done by other staff—medical and paramedical.

Hospital service needs

If junior staff posts were to be reduced radically we have to consider how hospitals could survive and who would do routine clinical tasks. What are hospital service needs? It will always be necessary to have someone instantly available to provide emergency cover and to deal with technical matters such as care of intravenous administration of fluids and drugs and the care of patients being treated in specialist units. Junior doctors have traditionally supervised certain nursing duties and written up patient records as well as looking after the administration of the patient's stay in hospital. This administrative role extends to follow up of inpatients and outpatients, making sure that medical care is being translated into effective practice. There is, however, more argument on the role of junior doctors in performing operations and pursuing a more definitive clinical role as part of their training. In view of this it may be more sensible and economical to concentrate our efforts on defining what is specifically required for training.

Service role staffing

Not all service needs are being met by junior staff. Consultants are increasingly having to take on the clinical supervision of both inpatient and outpatient care.

The nursing staff are also expanding their clinical role, particularly in specialist units. Nurses might now reasonably play a much larger

part in other specialties and in general practice. In geriatrics, for example, nurses might run major parts of the hospital service, calling in a consultant or GP only for specialist medical advice. The increasing interest in this expanded clinical role of a nurse may exacerbate or help the persistent shortage of nurses, but pilot schemes should rapidly resolve this important question.

General practitioners also share the hospital service load and many more are entering hospitals to look after patients who are normally in their care as outpatients and this is reflected in the recently created hospital practitioner grade. Further expansion of this development would integrate the Health Service more effectively than the recent reorganisation.

Future solutions

Our policy concerning medical manpower requires urgent action. At present we can muddle through only by starving many consultants of what they would regard to be their proper junior staff establishment, by the dedication of junior doctors working long hours, and by the grace of overseas doctors who are carrying out many of the tasks of a service doctor or long service SHO but cannot be relied on in the future to bail us out of our present inconsistent policies. Any future policy must take into account the unpalatable statistical fact that the country's medical schools can never produce sufficient graduates to meet our present aspirations for junior hospital staffing on the basis of the present organisation of hospital grades and training programmes. Once this has been firmly grasped a rigorous look must follow at the pattern of service needs and the best way of meeting those from our supply of medical graduates and paramedical staff. Medical schools must also look again at the arguments in favour of increasing their output.

In future consultants, nurses, and GPs will have to assume more of a service role to enable the number of junior staff to be trimmed radically into line with available career posts. There is no case for maintaining too many junior doctors unless British doctors are prepared to accept a permanent subconsultant grade, an enforced stay at SHO level, or a career grade hierarchy. The only realistic alternative to these solutions is a rundown of junior staff.

Such a rundown can be helped by transferring many of those posts to consultant and GP establishments. This would reduce the disparity between the numbers of training and permanent posts and also provide both groups with additional staff to help them take on hospital service tasks. In effect, the number of general practitioners could be considerably increased by such a transfer and this would enable the size of lists to fall and thus free time for hospital duties. The increase in consultants would also have the same effect.

Closing uneconomic hospitals will also be necessary and an expansion of the role of nurses into clinical care will have to be fully explored. The combination of extra consultants, more general practitioners, and newly created nurse clinicians should fill the gap produced by trimming back junior hospital posts to a size sufficient to meet training needs and actuarial imperatives.

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The ideal health centre?

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Priority given to clinical efficiency in the provision of preventive and primary health care ensures maximum administrative and economic efficiency. This paper illustrates this fact, which is repeatedly overlooked by administrators, by describing the cheapest and most efficient health centre encountered during a 12-year peripatetic international career in general practice.

The health centre was a cross between a conventional general practice and a cottage hospital. It served a population of about 10 000 living in an area of 1295 km². The economy was agricultural and industrial—oil and natural gas production.

Facilities and staff

There was a family doctor service backed up by a 24-hour casualty service; 12 beds; an x-ray department capable of handling intravenous pyelograms and cholecystograms in addition to routine views; a laboratory in which the most expensive equipment consisted of a microscope, incubator, and microbalance and which was capable of handling the investigations listed in table I; a pharmacy which, in addition to stocking the usual proprietary preparations, was better equipped than most to compound old but none the less cheap and effective remedies; a minor operating theatre, which was not equipped with an anaesthetic machine, thus placing an effective limit on the pretensions of the unit; and a modern dental surgery and workshop.

A staff of 26 operated the centre. There were a doctor, dentist, nursing sister/matron, two charge nurses (one of whom had the responsibilities of a tutor), a pharmacist, an x-ray/laboratory technician, a lay administrator, four shift nurses, two medical dressers, three medical orderlies, six ward orderlies, and three sanitary orderlies. There was also a recently qualified nurse working as a trainee in the special nursing requirements of the unit.

TABLE I—Available laboratory investigations

Blood
Hb, full blood count, and differential
ESR
Smear for malarial parasites
Group and Rh factor
Widal
Kahn
Sugar (random and GTT)
Urea
Uric acid
Some liver function tests
Sputum
Direct Gram and Ziehl Neelsen stains for AFB
Culture and sensitivity
Urine
Routine analysis and microscopic examination
Culture and sensitivity
Pregnancy test
Stool
Occult blood
Microscopic for parasites
Culture and sensitivity

The centre coped with all of the primary medical care of the community and 99% of the secondary medical care—that is, only 1% of the presenting illnesses were referred to the general hospital 81 km away for specialist investigation and treatment. So the unit prevented expensive general hospital facilities from being abused, leaving its staff free to concentrate on serious illnesses.

Casualty department

The hub of the centre was the casualty department. It was manned by the shift nurses, who also cared for any patients in the wards. They,