TALKING POINTS

Part-time training

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Introduction

Several schemes are available for the part-time training of doctors who have domestic or other ties which make it difficult for them to accept employment in the service under the usual arrangements.[1-3] Dr N Sterling examined part-time senior registrar posts in the Wessex Region.[4] I have been looking at some aspects of part-time training in the North-western Regional Health Authority (under the arrangements in HM(69)6 and its predecessor the Manchester Regional Hospital Board from 1970 to 1977.

After the initial build-up of the scheme the numbers fluctuated considerably (table I).

TABLE I—*Part-time posts established under HM(69)6 in the North-western RHA*

Year	Grade			
	Senior house officer	Registrar	Senior registrar	Total
1970			1	1
1971			1	1
1972	1	5	3	9
1973	1	8	3	12
1974	1	1	2	4
1975	4	3	11	18
1976	2	1	1	4
1977	4	6	1	11
Total ..	13	24	23	60

There have been no particular problems, such as shortage of money, to account for this, though in the year of NHS reorganisation—1974—only four posts were created. One-fifth of the posts have been established in the SHO grade and the others equally divided between registrars and senior registrars. Table II shows in which specialties the grades have been established. There have been none in surgery.

Some 58% of the doctors remain in the same posts, 5% have moved to a whole-time post in the same grade, 15% have moved to posts in a higher grade, and 22% have left the scheme without having a definite future post. Only nine have moved to a higher grade, though five of these have obtained consultant posts. Three doctors moved from part-time posts to similar posts in a higher training grade. None of those still in post have been there for longer than would generally be considered appropriate, given the specialty, the grade, and the length of their basic working week.

The previous training of those appointed to senior registrar posts was varied. Five had been whole-time senior registrars and another two had held whole-time university or research posts with this grading. Seven had been whole-time registrars and three had been in whole-time posts of roughly this grade. Two had held part-time registrar posts established under HM(69)6 and the remaining four had had sessional work as clinical assistants.

TABLE II—*Part-time posts by grade and specialty, 1970-77*

Specialty	Grade			
	Senior house officer	Registrar	Senior registrar	Total
General medicine ..	7	4	2	13
Paediatrics	2	1	–	3
Geriatric medicine	2	2	–	4
Rheumatism and rehabilitation ..	–	–	1	1
Nuclear medicine ..	–	–	1	1
Gynaecology and obstetrics ..	–	1	–	1
Mental illness (adult)	1	8	3	12
Mental illness (children) ..	–	–	5	5
Mental handicap ..	–	–	1	1
Pathology	–	1	–	1
Histopathology ..	–	1	4	5
Haematology ..	–	–	1	1
Chemical pathology	–	1	1	2
Anaesthetics ..	1	5	3	9
Radiology	–	–	1	1
Total ..	13	24	23	60

Discussion

Only 60 doctors have taken advantage of the scheme, but suitable arrangements can be made to enable doctors to undertake training part time. During the eight years, five senior registrars obtained consultant posts and in the first two months of 1978 they have been joined by two more. The progress in more junior grades is less obvious. The senior registrars had had diverse previous experience, but only a few had been in part-time registrar posts. This may be because the arrangements were not so well developed in their early careers, their domestic responsibilities were less, or only the most persevering can complete their whole training in part-time posts. The comparatively large number of resignations from registrar posts supports the last possibility.

In future, when there will be a higher proportion of women graduating from medical schools, the lack of part-time training in certain specialties, such as surgery, will affect the number of women who become consultants in these specialties. The proportion of female consultants is just below 10%—ranging from 17% in anaesthetics to 2% in surgical specialties as a whole.

This analysis shows the possibilities of this scheme for providing training. It is perhaps most important for senior registrars but the scheme is also needed in the more junior grades. In practical terms part-time training is not provided in some specialties which are currently male dominated and the increasing numbers of young women doctors will require wise career counselling. In a region in which few, if any, proposed posts have been turned down except for educational reasons, the indications are that the demand is low.

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Future of British anaesthetics

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During the past 25 years British non-teaching hospitals have created a wide-based career pyramid in almost every specialty. This is unique in the world. The increasing output of British medical schools will almost certainly transform the career structure within the next 15 years, and, unless there is a miraculous expansion of the NHS, British graduates will flood the training grades. Few will be able to emigrate to the traditional English-speaking countries of North America, Australasia, and southern Africa when they have completed their postgraduate training. These countries either are closing their doors or, as in the last case, have become less desirable. The Empire has vanished and I doubt whether the well-doctored non-English-speaking countries of the EEC will provide a substitute. In any case, many wives will feel lonely and isolated, and few factors discourage permanent emigration quite as convincingly as the sympathetic ear of a mother-in-law. So the demand for permanent rather than training posts will increase, and the part played by junior doctors in non-teaching hospitals will decline.

The effect of change will vary according to specialty and location. Of all the hospital career pyramids, the most vulnerable is anaesthetics. The specialty is unpopular among medical students,[1] yet it needs to recruit a larger percentage of medical graduates than any other specialty outside general practice.[2] Furthermore, shortages of anaesthetists have an unusually dramatic and disruptive effect on curative medicine. On the other hand, there is the long-term threat of redundancy among doctors. This complicates matters immeasurably. A future staffing crisis in anaesthetics would mean much more than a simple shortage of suitably qualified and willing candidates. Bottlenecks in the career pyramid will soon become intolerable and may lead to crippling

shortages in the higher grades. Even now a "wastage" of 80% of anaesthetic registrars is being investigated.[3]

Need for long-term change

If an all-doctor anaesthetic service is to survive in Britain as the envy of the world long-term changes will have to be planned soon. A substantial service commitment, at present carried by the large number of junior staff passing through the training grades but not achieving consultant status, will have to be reallocated to permanent staff. The reallocation should be done in such a way as to improve the status and popularity of anaesthetics. Even so, the present trend is to provide a consultant plus consultant-trainee service. This can continue only with a greatly expanded consultant grade, with no more than a handful of junior staff outside the main teaching centres. Such a service is bound to make the specialty less attractive and certainly less challenging than it is today. Indeed, consultants would be seen to face the tedious prospect of endless "cold" lists on straightforward patients. This would not only be a waste of skill but also contribute to the sort of paranoid neurosis which leads to friction with the surgeons.[4] The rise in the number of women graduates raises the question of the part-time subconsultant specialist grade. This is fraught with political pitfalls, and not only from the feminists. Even if accepted, it is unlikely that sufficient part-time specialists would be available to avoid a staffing crisis.

The only other alternative for an all-doctor service comes from the general practitioners. If they made a major contribution to anaesthetics several problems would be solved. The existing ratio between consultants and "juniors" would be maintained, as would the consultants' status. The image of the specialty would improve as consultants were freed from many routine lists for the more exacting fields of the intensive care units and pain clinics. The GP anaesthetist, restricted to a biweekly list and the odd night "first-on," for example, would find the change in work tempo stimulating and not the drudgery it can be for the full-time anaesthetist. I believe that larger numbers of GP anaesthetists would lead to happier anaesthetic establishments, with an overall improvement in job satisfaction. The larger the number of GPs, the easier it would be to draw up duty rotas which would not clash with general practice commitments. Most hospital departments now benefit from junior staff on GP vocational training schemes. There is no reason why anaesthetic departments in peripheral hospitals should be excluded.

1978 to 1993

I envisage the following change. In 1978 the anaesthetic establishment of a non-teaching district general hospital could be five consultants, one senior registrar, three clinical assistants, three registrars, and five senior house officers. By 1993 this could have evolved to seven consultants, two part-time specialists, eight hospital practitioners, two clinical assistants and one senior house officer (a GP trainee). In 1978 there are 14 full timers, whereas 15 years later there need be only eight. The figures are only a rough guess, as in practice they would vary enormously according to how many sessions each part timer had.

For such a plan to become reality a large number of GP trainees would have to combine their careers with anaesthetics, especially over the next five to 10 years. At present there is little incentive to do so. The clinical assistant grade offers minimal security, and to become a hospital practitioner after 1980 will probably require eight years' postgraduate training (one preregistration, four in anaesthetics, and three as a GP trainee). Amending the recommended academic criterion for the grade from the FFARCS to the DA would reduce the number of formal training years to a manageable five. One of the reasons why the FFA is preferred seems to be related to a hope that those so qualified will one day return to the consultants' fold once the current vogue for general practice has passed. The relative remuneration of GPs and consultants is responsible for this,[5] and nothing in my view could be more short sighted. Remuneration, which can be altered at the stroke of a politician's pen, has no place in long-term planning.

I am convinced that, with adequate publicity and a realistic training programme, sufficient numbers of doctors would combine anaesthetics with general practice to maintain a stable base for the anaesthetic career pyramid and help to prevent catastrophic shortages at the top.

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GP work load

The following figures from Intercontinental Medical Statistics Ltd (IMS Ltd) show a steady rise in the average daily number of patient contacts by general practitioners since 1972.

Year	1st quarter	2nd quarter	3rd quarter	4th quarter	Average
1972	34·3	34·0	33·5	33·4	33·8
1973	35·5	33·5	34·5	34·5	34·5
1974	38·2	36·7	34·9	36·8	36·7
1975	40·8	37·2	36·2	37·9	38·0
1976	41·3	37·7	39·3	40·4	39·7
1977	40·5	39·9	40·2	40·2	40·2

Fees

Public sector fees

Fees for work done for Government departments and local authorities—for example, supervision of medical establishments, reports for social services departments, etc, have not been increased since 1975 despite constant pressure from the BMA. The Government maintains that these fees, normally increased after a Review Body award, are subject to pay policy and not Price Commission controls. They have not been increased for three years because most doctors who receive them have been paid the maximum under phases 1 and 2 of the Government's pay policy. The BMA does not accept the argument that these fees are "pay" when other fees for part-time work have been accepted as "prices." In discussions with representatives of the Civil Service Department and the local authorities the Association is claiming an increase of 32·27% from 1 April 1977 and 25% from 1 April 1978.

Private sector fees

The BMA has increased its Category D (recommended) fees by 25% from 1 April (1 April, p 870). These are for services outside doctors' NHS terms of service such as medical examinations and reports and completion of cremation certificates. It is no longer necessary for the Association to obtain the permission of the Price Commission to increase fees. Negotiations are going on to increase fees for other part-time work paid from non-public sources such as life assurance reports and adoption agency forms. Members of the BMA can obtain full details from the Secretary, BMA House, Tavistock Square, London WC1H 9JP or from regional offices.

Pharmacists approve Clothier Report

The Council of the Pharmaceutical Society has approved the implementation of the recommendations of the Clothier Committee on dispensing in rural areas "as an interim measure" (10 December 1977, p 1559). The National Pharmaceutical Association and the Company Chemists' Association have also given qualified support and the Pharmaceutical Services Negotiating Committee are expected to accept the report. Many pharmacists are dissatisfied at the lack of any acknowledgment in the report that doctors dispensing is a departure from the normal position in which the pharmacist dispenses and the doctor prescribes.

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