TALKING POINT

Registrar substitutes and the district general hospital

TOM MCFARLANE

The need to alter hospital medical staff structures is now generally accepted, though the nature of the alteration remains the subject of debate. The Hospital Junior Staff Committee (HJSC) seeks improved prospects for registrar promotion through reduced registrar numbers with compensatory expansion of the consultant grade, while the Hospital Consultants and Specialists Association (HCSA) will agree to a consultant expansion only with an increase in supporting staff.¹ The British Medical Association is reported to be "split" in a "major row," with a sizable proportion of its consultant members dissenting from its broad agreement with the HJSC's views.²

Many of the proposals made so far are expressions of partisan pressure rather than attempts at comprehensive solutions. The BMA working party's report,³ the Nabarro proposals,⁴ and the Short Committee Report⁵ have all been influenced by the need to adjudicate between rival factions with inevitable detriment.

The registrar grade must be rationalised: it is larger than necessary for the purpose of training consultants. Many posts are of a purely service nature with no training component. The argument that seven or eight registrars are required for each senior registrar opportunity is fallacious. Were such intensity of competition essential to ensure adequate standards in aspirants to consultant status, the maintenance of this standard would require continued testing of the competence and efficiency of the established consultant. It is wrong that well-qualified registrars in their 30s fail to gain promotion after many years of toil in the grade merely because of numerical bottle-necks, particularly when opportunities for the "failed" registrar are rapidly declining.

The altered staff structure should identify the trainee consultant at the earliest possible stage and incorporate him in a proper training programme from which he will emerge as a consultant. This concept has been accepted by Nabarro in the "higher training" (HT) registrar.⁴ The HT registrar grade will be much smaller than the existing grade and therefore restricted to the teaching hospitals and the minority of district general hospitals (DGHs) concerned with rotational training schemes. It should be emphasised that all HT registrar training schemes should have a DGH component as teaching hospitals and DGHs will become even more disparate than they are now.

Options for the DGH

The options for the DGH will be: a permanent subconsultant grade to replace the registrar grade; an expanded consultant grade doing what is now consultant and registrar work; an expanded consultant grade in two tiers, the lower tier being responsible for emergency duties; a service registrar grade as envisaged by Nabarro in his "general training" (GT) registrar; and a new grade of registrar substitutes.

The permanent subconsultant grade has too many inherent defects to be the only option and would be difficult to introduce in the face of violent opposition from the HJSC. Labelled second-rate, the subconsultant would almost inevitably become disaffected in time in a post that would probably have many irksome features, and he would naturally be less able and willing

to cope with the emergency component of registrar work as age took its toll.

The service (GT) registrar option is also non-viable. It would be difficult to find applicants for a grade that leads nowhere and is defined as not providing training. The supply of overseas graduates will decline with the development of local training programmes, and governments will be reluctant to send their trainee specialists to the acknowledged inferiority of the GT registrar post. This grade would also need to be larger than the present grade as the campaign by the HJSC for reduced working hours for junior doctors will certainly succeed.

The popular panacea is the decimation of the registrar grade in the DGH with compensatory expansion of the consultant grade, this having the blessing of the Short Committee,⁵ whose report has now been largely endorsed by the Government.^{5a} A basic knowledge of how the DGH functions and competence in arithmetic less than that of my 10-year-old son suffice to illustrate its inadequacy for most hospitals. Let us look at its effect on the department of general surgery in an average DGH. This has increased its consultant establishment to 12 and abolished registrars. With eight weeks' annual and study leave the consultant would work on average one night (Monday to Friday) each fortnight and one weekend in ten: respectively 7.5 and 4.8 hours a week on average. The consultant would therefore work a minimum of 12.3 hours a week on average as a resident registrar substitute. Consultants would soon abandon their present benevolence in providing on-call services for no reward and insist that these hours be recognised as real work and weighted as "time and a half" or "double time," so that 12.3 would become 18.5 or 24.6. Assume that those who are over 55 or not 100% fit are spared on-call duties and the figure rises to 25 to 30 hours a week for those undertaking resident duties. To exacerbate matters, most departments require at least two trained individuals to be available at all times. This would mean a second consultant being on call so that a consultant with 11 colleagues would work at best a one-in-five on-call rota, with half of the duties being resident. Clearly, this amount of on-call work would have a seriously deleterious effect on the daytime work of the department. To add further disruption, there would have been no expansion of facilities such as operating theatres and outpatient clinics, which would now have to be shared, with loss of efficiency.

This pattern of work would have a disastrous effect on consultant morale. The Review Body's investigation of consultants' working hours⁶ shows that they work substantially longer hours than their contracts stipulate. The pace of work within these hours is determined by the consultant's enthusiasm: damage his morale and the work done in the DGH might well be halved.

Another serious consequence would be the loss of continuity of consultant responsibility. This would have major consequences for the quality of patient care and deprive the patient of the ability to identify with one consultant. It would also damage the consultant's sense of commitment, for this originates in the patients who "belong" to the consultant and are felt to be his responsibility. Remove this and it will not be replaced by notions of responsibility to the hospital or the NHS or a concept of the greater good—it will simply encourage a "clock-on, clock-off" mentality and the view that the problems of waiting lists, etc, are nothing to do with the consultant.

Vast expansion of the consultant grade and removal of the registrar grade mean more time spent in specialist rather than

Stepping Hill Hospital, Stockport, Cheshire SK2 7JE

TOM MCFARLANE, BSC, MRCOG, consultant gynaecologist

consultant work. This dilution of experience will have dire consequences for the skills of the consultant: the learning process continues at consultant level and experience has no substitute.

A two-tier consultant grade is implied in the above, with younger consultants undertaking most of the emergency work. To formalise this with a senior and a junior consultant acting as a team responsible for a defined group of patients is a possible solution, but a most unhappy one for the junior member of the partnership. It is likely that this, like the subconsultant option, would be bitterly opposed by the HJSC, though not, perhaps, by their seniors.

The only remaining practical option is the registrar substitute. There are many doctors—general practitioners, women raising families, etc—who would welcome the opportunity for part-time specialist practice. The deficiency of the current possibilities, the clinical assistant and hospital practitioner grades, is that they are peripheral to the main life of the unit. A new grade should be established—the hospital practitioner mark 3 (HP3)—in which the individual undertakes a 24-hour resident duty once each fortnight. A prerequisite for the grade would be a minimum of two years' full-time registrar experience in the specialty. This would take place in the GT post of Nabarro and give these posts some purpose. The DGH would then retain at least one GT registrar per specialty and attract good-quality applicants—usually from general practice trainees wishing to qualify for the new grade. With appropriate rostering, a consultant would work with one or, at the most, two HP3 doctors and be responsible for their continuing training. The royal colleges could provide practical examinations like the DObst RCOG to be taken after, perhaps, one year in the GT registrar grade. The grade would have an upper age limit, perhaps 45 or 50, when the doctor would move to a role like the current clinical assistant.

Such a "registrar" would be superior to no registrar at all, as now proposed, and given the long-term nature of the post would be preferable to the present flux of new and untried registrars. A further bonus would be the increased specialist competence at primary care level. Links between general practitioners and their local consultants would also be improved to the benefit of all concerned. With general practitioners

working in hospital for substantial periods, more posts would be needed in general practice, which, with the needed expansion of the consultant grade, would solve the impending problem of medical unemployment.

There can be no single solution. The rural hospital on a single site serving a small population may work well with consultant and senior house officer teams. The busy urban hospital scattered over several sites and serving a huge population has different needs. Staff structures should be decided at district level, with the regional manpower committee vetting the decision. The possibilities are many: HP3 posts, GT registrars, posts split to accommodate women with domestic ties, extra consultant posts, associate specialists, etc. With financial control at unit level a serious proposal, local determination of staff structures is logical. The Central Manpower Committee should oversee the HT training programmes and ensure that consultant numbers do not fall below defined levels but devolve responsibility for junior staffing to regional level.

It is essential that the profession agrees a way to rationalise the registrar grade and the medical staff structure of the DGH. Failure to do so will lead to health authorities implementing the Short Report "by the back door."⁷

References

- ¹ Hospital Consultants and Specialists Association. *Consultant work pattern to change?* HCSA: Ascot, 1981.
- ² Wood N. BMA split in major row over junior doctors' jobs. *The Times Health Supplement* 1982;No 11:2.
- ³ British Medical Association. Medical manpower, staffing, and training requirements. *Br Med J* 1979;i:1365-76.
- ⁴ Nabarro JDN. Hospital staffing in the 1980s. *Br Med J* 1980;280:1238.
- ⁵ 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.)
- ⁶ Department of Health and Social Security. *Government response to the fourth report from the social services committee, 1980-1 session.* Cmnd 8479. London: HMSO, 1982.
- ⁷ Review Body on Doctors' and Dentists' Remuneration. *Report.* Cmnd 7176. London: HMSO, 1978.
- ⁸ Mahady IW, Morewood GA, Sharp DS. Consultants and their future. *Br Med J* 1982;284:201.

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University cuts: BMA's evidence to select committee

The House of Commons Social Services Committee is conducting a brief inquiry into the effect of university cuts on medical services and research (13 February, p 527). In its memorandum of evidence to the committee, which held its first public meeting on the subject on 11 February (p 603), the BMA says: "In clinical medicine . . . the university medical faculties do not stand alone but are part of a closely integrated system of medical education and patient care which also involves the NHS and the medical profession as a whole. This means that the pain inflicted on the university medical faculties would also be referred to the other parts."

The BMA wants to know whether any prior consultation about the cuts took place with Health Ministers, whose legal responsibility it is to provide health care in the teaching hospitals as in the rest of the NHS. The Royal Commission on the NHS recommended "a formal structure at national level to co-ordinate the policies of the health departments, the University Grants Committee, and the universities." The BMA supports this suggestion. The inquiry, the BMA hopes, will "bring home to the general public the extent to which they have been put at risk, something which they have so far been slow to realise, largely because the interdependence of the universities and the NHS is not widely appreciated." For example, a patient admitted to hospital in an acute surgical or medical specialty in Southampton would have a 36% likelihood of being cared for by a member of

the clinical academic staff; for an emergency admission in child health this would increase to a 50% likelihood. The effects on teaching and research are less easy to illustrate, but in Southampton the loss of one lecturer has meant that students in one firm have lost one teaching session per week.

The provision of more NHS staff is unsatisfactory in the long run because of the special contribution of the academic doctor. In his clinical work he is likely to develop innovative techniques and introduce new ideas; in teaching he will be concerned in the development of the teaching programmes and will be expected to show particular research skills, which he will use in the provision of special investigative services.

The BMA believes that the UGC must ensure that the medical schools are adequately funded to provide the necessary services to the NHS. The chairman of the UGC has said that though the committee could not maintain the previous level of funding for medical students, provision was made in the allocation for an increase in medical student numbers. But, whereas other faculties have the option of reducing student numbers to maintain the level of funding, medical student intakes are determined by Government policy. The BMA hopes that the select committee "will be able to envisage better arrangements whereby levels of funding will be determined more openly and in consultation with the health departments and universities concerned."