TALKING POINT

Who cares about "juniors"?

JAMES OWEN DRIFE

The profession's attitude to junior hospital doctors badly needs bringing up to date. Thirty years ago, Simon Sparrow accepted long periods of incarceration in miserable residencies for little money, partly because it was the route to affluence and prestige as a consultant, but more because it was his natural place in society. Britain has changed since then, but time has not altered the public's view of non-consultant doctors. The patronising term "junior" has perpetuated a comic undergraduate image, but the reality is that these doctors deal with nearly all emergency admissions to hospital, with most outpatient follow-up consultations, and with a large part of NHS inpatient care. The proportion of junior doctors born overseas has now fallen to 32% and the proportion of women has risen to 25%. Those who manage to become consultants will finally lose their "junior" status at an average age of 37.

The Review Body on Doctors' and Dentists' Remuneration has just published a survey¹ of work load in the "training grades." The latter term seems another misnomer: according to the survey over 70% of trainees' clinical work is unsupervised and they spend only 3% of their time attending teaching sessions. They do, however, work hard—at least in the acute specialties.² For example, 45% of trainee surgeons are on duty for more than 110 hours a week and 17% spend more than 80 hours actually working. What purpose is served by such a Dickensian work pattern? A trainee must spend time on call to gain experience, but sleep deprivation and excessive stress are the techniques of brainwashing rather than education. The BMA reminded³ the Review Body that consumerism, the increasing use of advanced techniques, and an aging population have all increased the consultants' work load recently, and the same applies to trainees. In 1982 the 100-hour week is more than a social anachronism: it is an unacceptable danger to patients.

Recognising this, the Review Body has urgently asked doctors to discuss how trainees' excessive work loads may be reduced. There are four ways of doing this. One—reducing the standards of patient care—is unacceptable. The second is to appoint more trainees. This is unsatisfactory because career prospects in the worst-affected specialties are already grim, and to train more specialists without providing jobs at the end of training is, to say the least, illogical. The third possibility is outside help, either from a subconsultant career grade (which is rightly rejected by the profession⁴ whenever it is suggested) or from general practitioners, nurses,⁵ or paramedics⁶—who would probably be unable to offer substantial assistance. The fourth option is that consultants should undertake some of the work traditionally done by trainees. This idea is attractive: more consultant participation in clinical care should benefit patients—who, as consumerism

grows, are going to demand it anyway. It will also please the Government (which is already proposing to double consultant numbers by 1990), and it should increase consultants' job satisfaction. Trainees often hear consultants complaining about excessive administrative duties, and consultants in private practice maintain that total patient care keeps clinical skills well honed.

Nevertheless, the change will be resisted by many doctors—even by trainees themselves, who cope with their sometimes intolerable work load by looking forward to the day when they can shed work on to trainees of their own. Some consultants will be unhappy, believing that their job is to be "consulted" not by patients but by less experienced colleagues, and having taken on heavy commitments to administration, college affairs, private practice—or all three. Though the Short Report⁷ and the Central Committee for Hospital Medical Services⁸ have rejected the concept, older consultants for whom routine clinical work becomes arduous or uninteresting could be protected by a "senior consultant" grade, as suggested by a King's Fund report.⁹ The most important argument against change is its possible adverse effect on training. The royal colleges should examine this carefully and ask whether working solo beyond the point of exhaustion may not be the only way for a specialist to learn his craft. It may not even be the best way, since easing the work load would allow trainees to think about what they do, instead of having to concentrate on surviving.

The main problem about increasing the number of consultants is that the Health Departments have said¹⁰ that they will not pay for it. What the Government is asking for is a minor revolution in NHS practice to make it begin to resemble private practice, but trying to achieve this without increased funding shows touching naivety. The likely result of this attitude is that discussions will quickly reach an impasse. Government pressure will, however, produce a slow but steady rise in the numbers of consultants—all expecting the system to continue as at present—and trainees (whose numbers will, if anything, fall)¹¹ will be working even harder with even less time for learning.

Trainees have limited political muscle and little control over their environment, while the Health Departments seem to have little conception of their job insecurity. The Review Body has—not unreasonably—declined to increase overtime payments indiscriminately to underwrite a system that is dangerous to patients. Trainees' work load is determined ultimately by consultants—who all too often think that young people ought to endure the miseries that they themselves endured, and who select for promotion those who can take it on the chin. With rising medical unemployment,¹² trainees no longer have the option to get out—yet the Review Body implies that real action will be taken only when jobs remain unfilled or when recruits to the acute specialties are demonstrably incompetent. Anyone who talks to medical students knows that they are repelled by conditions in the

---

Bristol Maternity Hospital, Bristol BS2 8EG

JAMES OWEN DRIFE, MRCOG, FRCS, lecturer in obstetrics and gynaecology

continued on page 1894

Scottish Council

Short Report discussed

The Scottish Council met on 25 May with Dr Samuel McKechnie in the chair.

Since the last meeting of the council the Government's response to the Short Report on medical education had been published (6 February, p 427) and the Scottish Home and Health Department had issued a circular (NHS 1982 (GEN)4) on medical education and training, which developed those proposals in the Government's response that related to Scotland.

The council was in general agreement with the Short Report, the Government's response, and the SHHD circular but was concerned at some of the proposals. Although the council agreed that there should be an increase in the number of consultants and a decrease in the number of junior doctors, it was aware of the practical implications and problems. Expansion of the consultant establishment to the extent recommended by the House of Commons select committee would result in a basic change in the nature of consultants' work: not only in content but also in time on call. Other facilities and back-up services would not increase and this, together with the reduction in the number of junior staff, would materially alter consultants' work patterns. In addition, many consultants were already on first or second on-call duty and this would undoubtedly become more general.

The council was also concerned about the mechanism for altering the ratio between consultants and junior doctors. Some months previously the council had emphasised to the Scottish Home and Health Department that the alteration in ratio could not be carried out by imposing a blanket formula: it had to be worked out area by area and specialty by specialty. This suggestion had been taken up in the Government's response and the SHHD's circular, and it seemed likely that a body would be set up to conduct this exercise.

Other matters that the council will take up with the SHHD are the effect of the reduction in the junior establishment on posts available for general practitioner vocational training and the recommendations that junior posts be directly replaced by consultant posts (either where registrar posts are discontinued because they have not been educationally approved or

where an additional consultant post is approved on condition that a junior post be relinquished). It was pointed out at the council that direct substitution was unlikely to be appropriate in most cases, since the job content of a junior post was not appropriate for a consultant post. Direct one-for-one substitution was not mathematically possible in view of the difference in the number of hours for which consultants and junior doctors were contracted.

The council had already told the SHHD that if the alteration in ratio between consultants and junior doctors was to be successful there would have to be a redistribution and redefinition of junior posts, and that proper rotational schemes including teaching centres and peripheral areas would have to be set up. The council believed that junior doctors' contracts should be held at area level. Both these points had been taken up in the SHHD's circular. This included a direction to health boards to incorporate, where possible, every registrar post in a rotational programme providing teaching hospital and peripheral experience; and a consultation letter regarding junior contracts had been issued to health boards.

The council disagreed with the Short Report's recommendation that the target figure for medical school intake should not be altered.

Organisation and management of scientific services

The Council was told that negotiations between the Fife Health Board and ASTMS about the terms of the disputes procedure, invoked by the latter 12 months ago, had broken down. The dispute concerned a decision by the board to implement several proposals (fully approved by the BMA) regarding the management of the area laboratory. When it was invoked, management arrangements had reverted to the status quo, and letters of appointment, which had already been issued by the board to heads of departments, were suspended. The BMA was trying to have the status quo agreement redefined to allow heads of departments to be appointed.

CCHMS manpower ballot

The Central Committee for Hospital Medical Services is conducting a ballot on the acceptability of its manpower proposals for general medicine, general surgery, and obstetrics and gynaecology. These were published on 22 May (p 1575). The ballot card will be sent to all consultants on 25 June. Only consultants in the above specialties, including those with a special interest, should complete and return the ballot card. Any consultant who has not received a card should apply as soon as possible to Gary Webb, CCHMS secretary, BMA House, Tavistock Square, London WC1H 9JP (tel 01-387 4499 ext 121). The last date for receipt of ballot cards is 1 September 1982.

Sports medicine

The Lothian Division had prepared a paper drawing attention to the current lack of knowledge and the lack of facilities for, and organisation of, sports medicine. The council agreed that these should be examined, together with the ethical problems relating to the use of drugs and treatment of other doctors' patients, and the absence of agreed standards in training. The chairman's committee has been asked to obtain information and to consider the best method of proceeding with a study.

Effects of cuts in UGC grants

Representatives of the BMA in Scotland have met the Scottish Minister for Health and Social Work to tell him of the BMA's concern about the effects of the UGC cuts on medical schools and on the NHS. The council is keeping a working brief on the position and information is being obtained from the Scottish medical schools. The council was particularly concerned that it may no longer be possible to maintain the long-established analogue of clinical academic salaries with those of the NHS. An approach is to be made to the Scottish Secretary of State on this matter.

Who cares about "juniors"—continued from page 1887

hospital training grades, and it is inevitable that increasing competition for jobs outside hospital will select the most able graduates. The pre-eminence of the acute specialties cannot survive such a drift. Perhaps this threat to standards will persuade consultants to take a greater interest in their trainees' problems, otherwise change may eventually be imposed on the profession by the blunt instrument of legislation.

References

- Review Body on Doctors' and Dentists' Remuneration. *Twelfth report*. Cmd 8550. London: HMSO, 1982:82-95.
- Anonymous. Health Departments' supplementary evidence on junior hospital doctors. *Br Med J* 1982;284:1649.
- Anonymous. Work load of consultants. *Br Med J* 1982;284:1494, 1502.
- Anonymous. The Week in Brighton. *Br Med J* 1981;283:163.
- Anonymous. Doctors and nurses. *Br Med J* 1981;283:683-4.
- Anonymous. Editorial. *Edinburgh Medicine* 1982;14:3.
- Social Services Committee. *Fourth report. Medical education with special reference to the number of doctors and the career structure in hospitals*. London: HMSO, 1981:70. (Short Report).
- Anonymous. Medical manpower: CCHMS's commentary on Short Report. *Br Med J* 1982;284:285-7.
- King's Fund Working Party. *The organisation of hospital clinical work*. London: King's Fund, 1979.
- Anonymous. Health Departments' evidence to Review Body. *Br Med J* 1982;284:1582-4.
- Anonymous. Medicine, surgery, and obstetrics and gynaecology: CCHMS's proposed career structure. *Br Med J* 1982;284:1575.
- Anonymous. Some points from the crafts' evidence to the Review Body: hospital training grades. *Br Med J* 1982;284:1495-6.