TALKING POINTS

A subconsultant grade in surgery

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In 1948, before publishing the recommendations of the Spens Committee on hospital medical staffing, the Health Departments introduced what was to be a permanent subconsultant grade, the SHMO.¹ This grade has been approved by each of the five official committees set up since 1955 to advise the Departments on staffing.² In 1968 the Royal Commission on Medical Education added their approval.³ Between 1969 and 1973 the medical journals published numerous individual statements supporting the Health Departments' opinion. This professional backing was sporadic and unorganised. In 1974, however, the position changed. In its report on hospital medical staffing, the Hospital Consultants and Specialists Association included a permanent subconsultant grade as one of the main recommendations.

The BMA and its autonomous committees have always opposed such a grade and, in the form of the medical assistant grade, it was formally rejected by the Annual Representative Meeting in 1968.⁴

In practice the SHMO grade was a failure. It was closed in 1964. It would be disastrous if the profession allowed this mistake to be repeated.

Lesson of SHMO grade

The SHMO grade failed because no one had defined how an SHMO's work differed from that of a consultant. In 1948 the Departments made the ambiguous statement that an SHMO was to perform work of limited scope, of lower responsibility, and requiring less skill than a consultant. Thirteen years later in 1961 the evidence submitted to the Platt Committee showed that the scope and responsibility of the SHMO's clinical work overlapped the work of the consultant to such an extent that in many instances the two grades were indistinguishable. Because of this fusion it was recommended that the SHMO grade should be discontinued.¹

The HCSA has made a similar mistake. Its report lacks a clear definition of subconsultant work. It stops at another ambiguous statement: this time to the effect that the new subconsultant grade shall undertake work "at the level which is at present assigned to doctors in the grade of registrar and in the early year of senior registrar."⁵ The fate of the SHMO grade suggests that if there is a large overlap between the clinical work of the registrar grade and that of the consultants a similar result can be expected. Ultimately the two grades will fuse.

Measurement of overlap

In the surgical specialties the hospital records show which operations the consultant

does and which are done by a registrar. If a particular operation is always carried out by a consultant then the amount of overlap is zero; if an operation is never performed by a consultant but always by a registrar, again the overlap is zero. If, however, there is an equal chance of the operator's being either a consultant or a registrar the overlap is total. From this analysis a simple method of measuring the size of the overlap for each operation can be deduced.

To illustrate this method I have used the 7373 operations in general surgery performed at the Bromsgrove General Hospital from 1971 to 1975. Firstly, the number of each type of operation in the five years was added up; secondly, the percentage of cases where the registrar did the operation was calculated. So the overlap of the subconsultant's operative work on the consultant's can be measured as a percentage (see table).

Overlap of operative work of subconsultant and consultant

Percentage of operations performed by registrars	Operations
0-10 51-75	Appendicectomy, acute and list; repair groin hernias; varicose veins; benign lesions of the male external genitalia at all ages; excision of benign tumours of epidermal and mesodermal origin; biopsies of glands and solid tumours; digital amputations; drainage of abscesses
26-50	Cholecystectomy and choledochostomy; laparotomy with and without appendicectomy or liver or other biopsy; repair of ventral hernias; local mastectomy for cancer of breast; excision of benign neoplasms of the breast, cysts, wedge resections, and biopsies; all operations for benign anorectal conditions and pilonidal sinus; major lower limb amputations; the establishment of a colostomy
11-25	Truncal vagotomy and drainage; vasectomy; operation on the salivary glands and their ducts; urological endoscopies
0-10	Open prostatectomy; partial thyroidectomy; partial colectomy; operations on the stomach, cardia, and hiatus; the removal of renal neoplasms and calculi (the remaining eight operations were never done by a registrar)

In the series as a whole 40% of the operations were done by a registrar. This grade did 2039, or 33%, of all list cases, and 75% of the 1187 emergency operations.

The degree of overlap in general surgery, however, might differ from that in other surgical specialties. So a larger sample was taken, but over a different five years, 1966-70,

and again from the Bromsgrove General Hospital. The 17 189 operations included orthopaedic, ophthalmic and ENT surgery, gynaecology and obstetrics, in addition to general surgery. The overlap remained virtually identical: the total number of operations performed by a registrar rose from 40% to 40.7% and the number of emergencies fell from 75% to 73.9%.

A final possible source of gross error was that the Bromsgrove General Hospital was not representative of the other hospitals in the West Midlands Region. Fortunately, the health authority had recently carried out a 10% survey of the whole region. The overlap was larger than at Bromsgrove, with registrars doing 48.6% of all the operations. Thus taking Bromsgrove as a sample was to err on the safe side.

A permanent subconsultant grade can only succeed if its clinical tasks and responsibility are sharply defined. In other words an overlap greater than 10% would, in the long run, be fatal. Otherwise, as happened with the SHMO grade, more and more of the subconsultant grade will be able to claim that they are doing consultant work, especially as their skill and experience increases with age and years of service. Therefore it would be a waste of time to introduce a subconsultant grade based on the work of the registrar grade, as the HCSA has proposed, because already the type of operation done by a registrar is frequently the same as that done by a consultant.

Criteria for a subconsultant grade

For a subconsultant grade to survive, the fundamental criterion is the elimination of the overlap. A possible way would be to use the current trend towards specialisation in the practice of regional consultants in general surgery. The Bromsgrove results show that the operations where the subconsultants overlap is 0-10% fall into three groups: urology, arterial surgery, and gastroenterology. Gastroenterology is not such a consultant stronghold as the other two because 27% of the cholecystectomies and 16% of the truncal vagotomies and drainage were performed by registrars; but operations on the oesophagus, gastric cardia, hiatus, pancreas, large bowel, and rectum were rarely delegated. Diagnostic reasons alone insist that these two procedures should be classified as consultant work. This would close gastroenterology as a specialty. The specialist trend has been confirmed at regional and national surgical meetings.

Given that these three consultant specialties are set up the work load must be considered. In 1975 the hospitals of the West Midlands RHA admitted 98 770 general surgical patients (including urology). From this a sample of

Cure or care: where do we go from here?

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In a remarkably honest letter to the BMA, the Secretary of State said: "Public expectations of the Health and Social Services will frequently outrun supply" (21 January, p 189). He ended by saying "Resources do not meet all needs, and I shall not stop saying so." Most doctors have known this for some time, but it can do no harm if politicians and the profession recognise the fact and then together set about trying to do their best with what is available.

The consultative document, *Priorities for Health and Social Services in England*, and now *The Way Forward*¹ seek to change priorities from curing on the acute side of medicine to caring for the chronic side. In effect, what has happened is that we have gradually reduced the quality of care in both sectors to an unacceptable level, certainly for those exposed to it, in order to keep up the quantity of work done. Yet even this has failed and there are more than half a million people on waiting lists, predominantly for surgery, in many cases for an unacceptable time, and often in misery.

No one doubts that we must devote more money and resources for the care of the mentally ill, the handicapped, the indigent, and the old. No one who has visited some of our long-stay hospitals for these groups could deny this. But at a time when we are working within cash limits, and these are set so that inflation is actually cutting back the real amount we have to spend, this can only be achieved by killing Peter to save Paul. The biggest users of the acute services are the elderly, one of the priority groups we are seeking to protect. Joint replacements, prostatectomies, prolapses, and cataracts are not common in the young. Yet any cutback in the acute services will increase the waiting time, often to years, for those with least years to spare—rendering them in need of care when cure was possible.

This is where *The Way Forward* ducks the real issues. The caring side must have more, but the acute side must also be improved. Without more new money you cannot do both. Where will this extra money come from? Cut back on administration, the drug bill, and increase the social services is the cry. Yet our administrative and pharmaceutical costs are among the lowest in Europe, and under close scrutiny by the Government and the profession. Paradoxically much of the planning envisaged by Mr Ennals will increase the cost of administration, or not get done at all. Pressure on the rates and the rate support grant are likely to make the social services's position even more acute than the NHS's. If realistic sums cannot be saved, can they be found from Central Government sources? Presumably the Cabinet thinks not or it would have done so already.

Improper suggestion?

In its evidence to the Royal Commission the BMA suggested charges to patients, a concept

which an election-conscious Government rejects. Yet Section 64 of the NHS (Consolidation) Act 1977 increases the maximum amount recoverable by hospitals from £16 to £21 per week as a contribution to maintenance by hospital patients going out to paid work. Furthermore, pensions are abated for elderly long-stay patients. Why is it right to charge the old and the handicapped, but wrong to charge those best able to pay, except in terms of dogma or of votes? A recent poll conducted on behalf of the *Daily Mail*² showed that a large majority of the population would be prepared to pay towards better and quicker services. It seems that the public put health care ahead of holidays, betting, and booze, yet their elected leaders do not give them credit for it. Of course, a small and noisy minority will howl "means tests," as if income tax, university grants, and supplementary benefits were based on anything else.

The private sector could make an important contribution, ideally coexisting in NHS hospitals to the advantage of both. As a matter of political reality this is being denied. Could enough private hospitals be built, and where would the capital come from? Industry and the unions could play a part in this; the speedy return to work of key employees could do little to harm the public image or the profitability of industry. Union pension funds would be far better spent providing an important service to their members and earning a realistic rate of interest than in laying down works of art as a hedge against inflation. Manor House Hospital and Benenden Hospital should not be seen as anachronisms but part of "the way forward."

If private and local authority housing can coexist, so can private and public medicine.

The same noisy minority will cry "queue jumping, attracting doctors from the priority areas by the lure of private practice, diverting much needed staff from the NHS." Far from permitting queue jumping, it could in fact reduce queues for all. If the caring sector were properly funded and a work-related contract available to doctors who work in it, it could reverse the flow of manpower. An effective private sector could provide work for a great many nurses and others, particularly married women needing flexible hours and a job near their homes, who are currently unemployed, wasting skills that the State cannot utilise.

These are the alternatives before us: more direct finance from Government, imposition of charges on those who can afford them, private practice, or the collapse of the NHS as we know it altogether. What is needed now is a public debate in which people of all persuasions can discuss credible solutions. For those who are dying on the waiting list the NHS has already collapsed.

References

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- ² *Daily Mail*, 22 November 1977.

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A subconsultant grade in surgery (continued)

81 918 patients was obtained, of whom 58 796 had operations. The 10% rule was then applied to the printout. Urology accounted for 11 925 patients and 8577 operations. To these must be added a large number of diagnostic and check cystoscopies, which being mainly on day patients were ignored by the computer. Arterial surgery (cardiac excluded) amounted to 3763 patients and 2287 operations. For gastroenterology there were 21 373 patients and 11 008 operations, of which 3344 were cholecystectomies, and, strictly speaking, cholecystectomy is a subconsultant operation.

If these three surgical specialties had existed in 1975 it would have reduced the consultant responsibility and work load from 58 796 operations to 21 872. The remaining 36 923 operations would have been classified as general surgery and the work undertaken by the subconsultant grade. Using the figures shown, the ratio of specialist consultant to general subconsultant operations is 1:1.7. Compare this with the HCSA demand that the ratio of consultant to subconsultant ought

to be 1:1.3. By making the distinction consultant/subconsultant coincide with the distinction specialist/general—provided that each type of operation is allotted accordingly, and also provided that the self-respect of the subconsultant grade is supported by full clinical responsibility—such a grade might endure, despite problems in administration and training.

References

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