TALKING POINT

Thoughts on hospital staffing

I K MATHIE

Obstetricians in the Northern Region have been told that as part of the redistribution scheme for registrars and junior doctors the Department of Health and Social Security will take away three registrars in the next three years and a further two later. This has been opposed by the consultants concerned.¹ In discussions with several colleagues I have discovered that few understand what is happening to hospital staffing. It seems that there is to be a reduction in the total number of registrars and a redistribution—purely on a population basis—throughout the country so that their numbers will be more in line with that required to replace consultant wastage. If carried to its logical conclusion this would result in approximately one registrar to five consultants. But the working of most hospital departments depends on efficient and experienced registrars. If they go someone else must do the work or the work will not be done because in most district general hospitals the consultants are already working at full stretch.

The Department has tacitly assumed in its recent paper, *Medical Manpower, The Next 20 Years*,² that there must be a change in the pyramidal structure of the hospital medical staff. But this should not be imposed on the profession without full agreement with those in the front line. A ballot would force the profession's leaders to be more constructive and to make real proposals for such an alteration in training patterns that many—if not all—consultants believe is needed. Simply to remove a registrar and expect the work to continue as before is neither possible nor sensible. The decisions must be acceptable to the profession, particularly in the sharp end specialties where changes could lead to recruitment difficulties.

Four options

There are at least four options open to the profession. We could continue as we are; the number of consultants could be increased in order to do much of the routine work; a subconsultant grade could be created; we could give a much reduced service.

STATUS QUO

Many consultants and junior doctors feel strongly that there is not much wrong with the present system. It does at least tend, by competition, to improve the quality of the stock of consultants appointed. Further-

more, many of the incumbents will return to their own countries and therefore need not appear in the formula. It is impossible to forecast the effect this will have on hospital staffing. Some junior doctors do not accept this option. So the subject must be studied much more fully. There is a lack of information, as Maynard and Walker have cogently complained in their report to the Royal Commission on the National Health Service.³

MORE CONSULTANTS

The second option of increasing the number of consultants seems to be favoured by the DHSS, and one attraction would be that the patient would always be treated by a fully trained doctor. What would this mean to the people doing the work in a specialty which demands immediate attention to patients? It might mean that the terms and conditions of service would require the doctor to live less than two miles from the hospital. In most hospitals this would not be practicable. The alternative would be for the consultant to live in while on call.

The numbers of consultants would have to be at least doubled immediately, making a much larger number of junior staff in training necessary to produce them. Otherwise the consultant staff of a hospital would have to live in at least twice a week. The effect of wives on the choice of career should not be minimised and eventually severe recruitment problems could develop. General practice seems to be the main career choice at present and it is not difficult to see the reasons. The number in general practice interested in work requiring a 24-hour cover is dwindling. Why should consultants be any different at a time when social attitudes are changing? The human factor is totally ignored in all the papers on this vexed subject.

The financial implications must also be considered. In many parts of the world hospital specialists are doing this type of work but at higher salaries than those paid to NHS consultants. It would be interesting to know what the negotiators are doing about recompensing consultants who have to live in hospital when on duty. In the real world we all know that the DHSS will attempt to procure a fully trained, highly expert, service on the cheap. On present contracts consultants would be forced, albeit by their own professional pride and recognition of the needs of their patients, to do this work for no extra salary at all. How is it that the Joint Consultants Committee and the Central Manpower Committee are attempting to push forward their ideas apparently without due consideration to their secondary effects? An increase in salary for this work might induce consultants to do it without complaints. This might be difficult because to make the disruption in family life worthwhile the payment would

have to be large when the taxation levels render the amount taken home only a tiny proportion of that paid.

If this second option were adopted a consultant would be devalued in status, job satisfaction, and eventually salary. The only real consultants would be in the teaching hospitals and that would be a full circle back to pre-NHS days. Is this what the profession and the public want? It certainly goes directly against the wish of the Department, which is to even out the availability of medical care throughout the country.

SUBCONSULTANT GRADE

The creation of a subconsultant grade may not be as fearsome as it seems. Probably most consultants think that this grade is needed but are very ambivalent about the matter, realising the failure of both the SHMO and the medical assistant grades. There were two main reasons for failure: status—possibly through the dreadful names—and finance, inadequate for their work and responsibility. Perhaps a name such as senior specialist with a salary level higher than any other in the Health Service training grades, equal to GP salaries but less than consultant ones, would be acceptable. This assumes that the consultant should be paid more than the GP. This would be attractive to GPs who wish to work in hospitals, and to many women doctors who do not want the work load or responsibility of the consultant. It could be a satisfying post without making the holder feel like a second-class citizen. It might also help prevent the present movement to general practice of well-trained doctors who cannot pass their higher diploma examinations, and whose first choice of work was in hospital rather than in the community. There would still be the problem of the 24-hour active cover specialties. It would probably be no easier to provide these from a new grade than it would be from the consultant one and for the same reasons.

REDUCED SERVICE

Giving a reduced service to the patient is an inescapable consequence of present policies. To prevent this more consultants or more staff in career grades might be appointed now to replace the lost registrars. This is impossible. When the new job descriptions are available will it be easier to get good applicants? In order to become consultants young doctors are willing to work hard to learn their specialty, but the inference that they would then be willing, or able, to do this type of work for the rest of their lives is open to doubt.

The current practice in hospital is that the consultant is always available. If he is up all night he is still expected to continue with his operating list the next morning so as not to

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From the GMS Committee

Changes in complaints procedures opposed

Meeting strongly critical of DHSS's proposals

The committee opposed virtually all the DHSS's modified proposals (7 October, p 1037) for revising service committee procedures. It decided this at its routine meeting on 19 November, with Dr R A Keable-Elliott in the chair (25 November, p 1508). GPs could play a greater part in accident and emergency services but only if this work were separate from the normal range of GP services and paid for separately. The GMS Committee is asking LMCs for up-to-date figures on recent closures of GP maternity units, as well as on newly opened ones or any in the planning stage. Home confinements should primarily be the responsibility of the GP and not the midwife. The DHSS is being asked to reimburse directly locum costs to single-handed GPs attending approved postgraduate courses. On a majority vote, the committee supported a proposed publicity campaign to educate the public about the value of deputising services.

Some of the chairman's opening comments to the meeting were published last week (25 November, p 1508). Among other items he reported on were ancillary staff pensions, seniority payments, part-time hospital work, obstetric criteria, and health centres. Agreement had been reached, he said, on changes in the seniority rules from 1 April 1979. The changes would bring the requirements for years of service as a principal (so far as spacing is concerned) into line with the requirements for periods of inclusion in the medical register. Furthermore, full-time assistantships before 1966 would count on the basis of two years as an assistant being equivalent to one

year as a principal. The present wording of the statement about previous service in HM Forces would also be clarified. There had been confusion about the reference to service as a "senior medical officer." It was the nature of the work which was important; where full general medical services had been provided to servicemen's families this should be counted. The DHSS had also been asked to include time in the colonial medical service.

The committee had received further advice from Counsel about ancillary staff pensions negotiations. As a result a meeting had been arranged with DHSS officials. He understood that they hoped to tell the committee what decision they had reached on the question of appeals by GPs against unfavourable FPC decisions on direct reimbursement of pension contributions already received by DHSS.

A second meeting had been held on remuneration for GPs working part time in the hospital service. Some progress was being made and it was hoped to finalise proposals for structural changes by the end of this year. These would then go forward to the Review Body for pricing. It had been made abundantly clear to the DHSS that this must be new money. It could not be funded from money already available for general medical services. A meeting on health centre policy had been held on 9 November with DHSS officials. The profession's views on licences and leases and the role of FPCs and AHAs had been carefully explained. The DHSS was considering further these aspects, together with the question of improving arrangements for dealing

with day-to-day problems in the health centres. The department had been told that special inducements to help health centre doctors were unacceptable unless these were also available to other doctors in the area.

Dr W B Whowell, chairman of the Statutes and Regulations Subcommittee, explained his subcommittee's detailed criticisms of the DHSS's proposals for changing service committee procedures.

Representatives of the GMSC, the DHSS, the RCOG, the RCGP, and the CPME had met on 25 October to discuss obstetric training for general practice, the chairman reported. While there was general agreement on the need to maintain high standards, the GMSC representatives declared that flexible arrangements for existing general practitioners to gain admission to the obstetric list would still be needed. Dr Keable-Elliott hoped that some progress might be made on preparing rules for deciding on "equivalent experience" arrangements which could be made on an individual basis.

Proposed changes in complaints procedures

In September 1976 a DHSS consultation paper had asked for comments on proposed changes to the procedures for investigating complaints against family practitioners. Some 180 bodies had commented and in the light of these ministers had proposed certain major changes. The Statutes and Regulations Subcommittee had considered the modified proposals and had prepared detailed comments for the GMSC to discuss.

The chairman said that several LMCs—most of which had commented adversely—seemed to have the impression that the GMSC

Talking Point—continued

inconvenience patients. This tradition would inevitably change and the problems of the common waiting list in its widest sense would have to be faced.

Much has been written recently about the increase in numbers of doctors. The DHSS's current estimate is an increase of 1.5% per year in order to service the increasing and increasingly demanding population. Alongside this growth there are undoubtedly going to be changes in patterns of medical care and training. The Department's paper suggests that factors such as greater medical productivity, better use of technology, and the use of non-medical staff for certain tasks must be studied and this is right. If we started by studying carefully the needs of the patient and equating those to a work pattern a sensible

and acceptable policy could be evolved. But to inflict such a change of reduction and redistribution on the profession without any proper consultation is dangerous. It can only lead to a total loss of confidence by the peripheral consultants in those who are allegedly leading them.

References

- ¹ *Lancet*, 1978, 2 531.
- ² DHSS, *Medical Manpower, The Next 20 Years*. London, HMSO, 1978.
- ³ Maynard, A, and Walker, A, *Doctor Manpower 1975-2000: Alternative Forecasts and their Resource Implications*. London, HMSO, 1978.

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