TALKING POINT

Medical manpower: my crystal ball is clouded

DAVID BELL

Planning medical manpower in the NHS is akin to playing three-dimensional chess and a crystal ball seems a more useful instrument than most for those engaged in the game. Before looking into the future, however, let me sketch the present scene.

Present scene

The Health Service deserves a staffing policy that gives patients a high standard of care, offers doctors career posts that are professionally and financially rewarding, and ensures that doctors have the time, facilities, and teaching to acquire specialist skills. Regrettably, the Health Service has a medical staffing structure which depends on large numbers of "junior" hospital doctors—staff in training—to do the emergency and routine work. This is evident from the adverse reaction of senior staff to one simple suggestion, namely, that the number of juniors be reduced and that of the consultant staff increased. In any case, were this not true then large numbers of young doctors would be sitting around doing little, except, of course, "training," a state of affairs which my own experience tells me is nonsense.

A recent addition to the unbalanced hospital staffing structure in the NHS is the training scheme for general practice. This has been introduced to improve the quality of recruits to general practice. The scheme also enhances the importance of general practice and, in my view, has resulted in part from a long-standing belief, founded by Lord Moran,¹ that GPs were "hospital doctors—failed." While its importance to general practice is obvious the scheme has complicated attempts to achieve a balanced staffing structure.

Finally, the present staffing ratios relate conveniently to an annual medical school output of 1800 doctors or less—remarkably close to the "guesstimates" of the numbers of graduates required to replace career grade posts at present. I accept that doctors are lost

from this 1800 but the manpower equation has remained in some sort of equilibrium because career grade posts have been expanding over the past 10 years and because British hospitals' service needs have been met by the large supply of doctors from overseas who really came here for training. Sadly, too often, they receive too little training.

Prospect of uemployment

Training to be a doctor takes five years in medical school; and, say, another four years in further training for general practice, or, optimistically, 12 years for consultant practice. In practical terms this means that the 1976 entry to medical school—about 3700 students—will enter general practice in 1985 and consultant practice in 1993. I turn now to my crystal ball, with its picture of 1986. By then the annual output of graduates will have risen to 4000. If "wastage" at present levels continues then the crystal ball reveals that 15 000 doctors, who emerged idealistically from medical school, will find that they have nowhere to go. Nevertheless, the crystal ball for the intervening years is somewhat clouded and I fear that long before 1986 the doctors emerging from medical schools in such numbers will revolt. They will undoubtedly be better organised than now and their response to the prospect of unemployment will make present medical discontent look pallid by comparison. Can this threatened wastage of expensive skills be prevented? I believe it could but only if some important changes are effected, in particular changes of attitude.

Possible solutions

Solution of this problem depends, firstly, on the medical profession and its ability to understand what has, is, and is likely to happen; secondly, on recreating trust between politicians, departments, employing authorities

on the one hand, and doctors on the other; thirdly, on accurate, credible figures for the production and movements of doctors; and, finally, on some redefinitions of health care. Let me comment on each of these.

UNITED PROFESSION

If we are to iron out the distortions created by the existing staffing structure and the rapid expansion of medical school places—in terms of the doctor-training time it *has* been rapid—the medical profession must look at the problem collectively. It is dangerous for doctors to split into sectional interests on this subject: it has been well said that it is easy to put the arguments as either "pity the poor junior" or "pity the poor consultant." Perhaps it would be better to view it as "pity the poor Service—or even the patient"? Furthermore, it is a problem which should worry all doctors now. Senior members of the profession whose daughters and sons are, or soon will be, doctors, will take the point.

POLITICAL TRUST

As to the role of politicians, government departments, and employing authorities, if the Service is to emerge from this dilemma without conflict these groups must handle the problems with unprecedented sensitivity. Otherwise doctors will turn their anger and frustrations on them as convenient scapegoats. Agreed and not imposed plans will be required, while proper consultations and not misnamed consultative documents will be prerequisites for any lasting solution.

NUMBERS

It is when we consider statistics, present and projected, that the multidimensional chess game starts. Accurate figures of the present and past numbers of medical students, GPs, consultants, hospital junior staff, community physicians, and of doctors in industry are essential. We must also know the numbers in universities, in medical administration (including those in the health departments), the armed forces, and in the overseas development agency. The proportion of women graduates now and in the future, the present and predicted figures for "wastage" and for emigration would be invaluable information. Then there is the ebb and flow of doctors from overseas, which could well be profoundly affected by decisions of other governments. For instance, a comprehensive Government health service in the USA would be an avid consumer of English-speaking doctors, including British doctors. Some of these figures are known, some when available are too out of date to have much value, some are inaccurate, and others can only be guessed.

GMS Committee continued

as after the first report. Secondly, there was no administrator with family practitioner committee experience on the working party. Thirdly, the consultative document *Priorities for Health and Personal Social Services in England* had stated that "it would be difficult to extend close budgetary control to expenditure on the practitioner services. . . . In general it is not proposed to intervene." Nevertheless, the working party had recommended the opposite.

There was no doubt, said Dr Crawford, that the working party thought that the present financing of the family practitioner services was administratively untidy. For example, in paragraph 6.21 it was stated "if the objective

underlying our terms of reference is to be fulfilled, ways need to be found of securing that the resources at present allocated in quite different ways are more closely related." To suggest that "a review of the interaction between the two services from a financial viewpoint would be timely and we recommend that it should be undertaken" appeared to Dr Crawford to be the first shot in the battle to eliminate the independence of the family practitioner services, and eventually the independent contractor status of general practitioners.

The committee approved the comments of the GP subcommittee and agreed that representatives of the GMSC and the Joint Consultants Committee should meet urgently to discuss the report.

Output of medical graduates can be controlled—though the time between decisions on medical student numbers and their effect is long enough to destroy their credibility. The number of Health Service posts can be adjusted relatively quickly but it is the unpredictability of future emigration and immigration which really endangers any carefully constructed manpower scheme. Given that emigration and immigration in Britain are not to be rigidly controlled—as in totalitarian states—an ideal health service, my crystal ball tells me, calls for a cushion or float of doctors to take the strain of changing demands or fluctuations in supply. But how many doctors would be willing to “float”?

CHANGE IN DEFINITIONS WANTED

There is, however, another possible solution: a changed attitude to definitions. There are two major factors, neither of which is new, but both of which might be altered. At present we are hamstrung by assuming too readily that the demand—as opposed to the need—for care is the overriding influence in the NHS. Dare we attempt to redefine the need for medical care? We cannot do this swiftly but the political challenge inherent in the question must be met soon.

From this challenge my second question flows naturally: how many doctors do we need? This can be answered by saying, “as many as we have now,” or, by a formulation “X patients per doctor,” or more sensibly, by defining what doctors should be doing. No doubt Whitehall would pick the first answer: maintaining the status quo is usually the easiest option. In fact, the question has already been largely overtaken by medical school expansion, which cannot easily be reversed. Nevertheless, a Government looking desperately for ways of cutting its expenditure might be amenable to persuasive arguments for reducing the intake of medical students, who now cost around £30 000 each to train.

UK manpower forum

At present there is no forum in which these difficult matters can be discussed. Central and regional manpower committees have been a step in the right direction but they are limited to part of hospital staffing alone. Manpower is to be a major division of the Royal Commission's work and, though Sir Alec Merrison has promised some interim reports on urgent matters, can we afford to wait even for these? I suggest that the BMA convenes soon a professional conference—with representatives from all branches—to define the problem, suggest ways of solving it, and to establish ways of monitoring progress. If agreement could be reached among doctors then perhaps the BMA should sponsor a meeting of all bodies responsible for manpower, with the long-term aim of establishing a permanent independent manpower commission which would present authoritative advice to the DHSS. The Government would find it hard to ignore advice from such an expert body. In my view this idea offers some hope for resolving our medical manpower difficulties.

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Plenary assembly of EEC doctors

Last week we reported briefly on the two-day meeting of the Standing Committee of Doctors of the EEC (27 November, p 1337), its final meeting in the BMA's three-year term as secretariat. Other matters discussed during the plenary assembly are reported here.

Occupational medicine

There was a report from the recent meeting of the Occupational Health Subcommittee which had been looking at further training in occupational medicine. There had been disagreement about the length of training. Belgium, France, and Germany thought that two years was sufficient, whereas the UK, explained Dr R Archibald, favoured three or four years; this would be in-service training. But as a compromise he regarded two years as a start. So the standing committee agreed to recommend to the Advisory Committee on Medical Training that there should be a minimum period of two years. Approval was also given to a draft contract for doctors working in occupational medicine.

Junior doctors

With the first implementation of the directives an important stage of the standing committee's work has been completed and there was a debate on the way it should work in the future. Delegations will consider the different proposals made and a final decision taken at the meeting of the Heads of Delegations in Copenhagen in May 1977.

Mr Lewin has been keen that the representation of junior doctors should be settled. He had asked at the standing committee's last meeting that a junior doctor should be included in the team if possible. If it was not possible to set up a subcommittee of the standing committee he suggested a liaison with the newly created working group of European junior doctors. The secretariat will write to the new group for information, possibly sending a representative to the meeting in Dublin in April and the matter will be raised again at the May meeting of the standing committee. Dr C Cleary (Ireland) emphasised the urgency of establishing a liaison between junior doctors and the standing committee, and Dr Alan Rowe, head of the UK delegation, pointed out that the standing committee rejected younger doctors at its peril as it was their future that was at stake.

Director General Schuster

Mr Schuster, Director General of the Directorate of Research, Science, and Education, attended part of the meeting and answered questions. Monday, 20 December, he said, would be the birthday of a new dimension in the European Community. He accepted that the standing committee would continue to be a partner in European medical developments and the proposed meetings (27 November, p 1337) would be part of this process. The advisory committee and its subgroups should be able to invite experts or observers as necessary and he confirmed that

the directives did not prohibit member states from going ahead with postgraduate training for general practice. In answer to Mr Lewin, who was concerned that the standing committee was not consulted on draft directives for the paramedical professions, Mr Schuster said that when published the directives could be made available in future.

Mr Schuster speaking at the farewell banquet on 19 November. On his left are Mr Walpole Lewin and Mr David Ennals.

Third country qualifications

At his meeting with Dr Recht Mr Lewin had raised the question of those doctors who had become United Kingdom nationals but had acquired their basic qualifications elsewhere, thus prohibiting them from taking advantage of free movement under the Treaty of Rome. In addition, many of the doctors had qualified at medical schools which at the time had been approved by the General Medical Council and they had subsequently obtained higher qualifications in this country. These doctors felt that they were being discriminated against. Mr Lewin had been told that the Brussels authorities considered this was a political matter and he said that he had gained the impression that active measures were not going to be taken. Dr van Nieuwenhuizen pointed out that if concessions were granted for doctors other professions would have to be treated in the same way. Dr Monier from France thought that it was a problem that could not be solved immediately and Dr P Farrelly told the assembly that the Irish Government had no intention of deviating from the Treaty of Rome.

Medical demography

One of the studies being undertaken by the Committee of Senior Officials on Public Health is on the number of doctors in Europe and their disciplines. The president told the meeting that this study was proving very difficult but the committee hoped to complete its task by April 1977. At the same time the Advisory Committee on Medical Training has been looking at the number of medical students in the member states. Dr van Nieuwenhuizen reported that the numbers were stabilising in Italy but there was an increase in the UK. Dr Rowe pointed out that 3276 medical students had entered university in 1973 and that the estimated figures for 1976 and 1980 were 3686 and 3945, respectively.