The potential for marketing planning in an NHS trust

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This is the eleventh in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson, chief executive, British Association of Medical Managers. A book of the series is now available from the BMJ Bookshop.

No planning procedure can predict the future with complete accuracy. None the less, those managing NHS trusts, like their counterparts in industry and commerce, must somehow try to anticipate it so as to plan appropriately. This is no easy task at the best of times, but during periods of rapid change and uncertainty it is even more difficult. Too much is at stake to rely on good fortune or an irreproachable moral stance as being enough to allow an organisation to win through.

Learning theorists claim that we learn through our mistakes. In general the lessons from industry were expensive when it came to planning ahead. Companies have been slow to adopt a marketing approach, and those that went under paid the ultimate price. NHS trusts can learn from the collective mistakes which have gone before.

This article attempts to remove some of the mystique which surrounds marketing. It will consider some of the marketing tools which are valuable in the preparation of a marketing plan.

What is marketing?

A delegate setting out on one of our courses suggested, to the amusement of his fellow students, that marketing is "the application of jargon to common sense." He was visibly deflated when we tended to agree with him.

As in most professions, practitioners develop a convenient vocabulary which aids communication to insiders, but which is opaque and incomprehensible to everyone else. Marketing, like accounting and medicine, among others, is equally guilty of this charge. As a result, the "common sense" element has become obscured by a combination of mystery, hyperbole, and banter. Let's put the record straight. Marketing is not about selling, nor is it about parting the gullible and unwary from their hard earned money. It is far more mundane and down to earth. Reduced to basics, marketing is the process of matching the resources of the supplying organisation with identified customers' needs, so that both parties achieve their objectives.

Philosophically, this definition does not seem to be very contentious, yet its blandness hides some very important organisational issues. The implications are that the organisation is clear about its customers and their needs (which is often not the case); it actually wants to satisfy customer needs (as opposed to, say, providing the things it finds easiest to provide, or making profits at all costs, regardless of the consequences); it has the appropriate resources and technology to succeed (which, again, is not always the case).

In an imperfect world it is inevitable that this matching process starts off as something of a compromise. However, by making a decision to base the business on the needs of its users, the organisation can develop the necessary skills, products, and services to ensure that it becomes increasingly attractive to its customers, both actual and potential. This in turn earns it the prospect of justifying further investment. Thus, success feeds on success.

Alternatives to the marketing approach

There are many alternative approaches to marketing. Technology is one. The problem is that technology is often not enough. Indeed, in the United Kingdom few should need reminding of the famous technology breakthroughs that have led to bankruptcy.

Another is production efficiency, which focuses on a low cost approach. Alas, this approach eventually fails, because customers become more demanding as choice increases.

Yet another is financial husbandry, which in many ways is similar to production orientation. No one needs reminding of the spectacular failure of once great organisations, deserted by their customers because they failed to pay sufficient attention to their needs.

There seem to be two other alternatives to marketing as a means of moving the organisation forward.

CHARISMATIC LEADERSHIP

Some organisations can be highly successful with a visionary, entrepreneurial figure at their helm. It is the charismatic drive and leadership which inspires those within the organisation, sometimes against great odds, to follow and succeed. Even so, the "business idea" has to resonate with the times in which it is born.

Such an approach can establish the recurring theme for organisations to remain successful for years. Witness the great religions of the world and, more prosaically, many of today's grand companies, which owe their origins to the imagination and singlemindedness of their founders. However, charisma, power, and drive are not always enough. Leadership alone cannot carry an idea that is basically flawed, and too often the original concept is overtaken by events. Commercial examples abound.

INCREMENTALISM

As a counterbalance to the "big picture" option provided by charismatic leadership, there is the "one small step at a time" approach, which typifies incrementalism. If growth was experienced in part of the business at, say, 10% for the past two years, the thinking goes, "Let's assume we can do better and aim for 11% this year." In practice this softly, softly approach at best only limits damage, because the growth experienced by the organisation might be grossly misrepresenting the real growth potential of the market. Incrementalism therefore inhibits the organisation from capitalising on new opportunities and, instead, traps it into reliving its past.

Whereas both of these approaches could be said to appeal to the emotions, the first to "blind faith" and the second to "security," marketing alone brings an analytical and essentially rational dimension to the forward planning conundrum. It is this dimension which sets it apart.

Marketing planning

Again, stripped of its obfuscating jargon, marketing planning is a fairly straightforward, four stage process involving the determination of the strategic context; the situation review; formulation of marketing strategy; and resource allocation and monitoring (box).

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Components of marketing planning

The strategic context:	Specifying what the organisation wants to be and what it wants to be achieving at some time in the future
The situation review:	Understanding the factors both within and outside the organisation which are going to help or hinder in attaining its ambitions
Marketing strategy formulation:	Establishing the best mix of products and services to meet the strategic and situational scenario
Resource allocation and monitoring:	Ensuring that resources are allocated in ways that make the greatest contribution, and checking that this actually happens

The output of this process, the strategic marketing plan, covering a period of about three years, is a shortish document (probably of no more than 25 pages) that spells out certain criteria:

- The organisation's mission
- A financial summary
- A market summary
- SWOT (strengths, weaknesses, opportunities, and threats) analyses on key elements of the market
- A summary of the SWOTs
- Overall assumptions
- Overall marketing objectives and strategies
- Budget details

ESTABLISHING THE STRATEGIC CONTEXT

The first consideration is to define the organisation so that its sense of purpose and direction is clear to everyone who has a stake in it. For a trust, this means its staff, fundholders, the immediate medical infrastructure, and the community it plans to serve. Such a definition is encapsulated in the mission statement. Ideally this will not exceed one A4 page and will include the following.

Role—There should be a vision of the role towards which the trust is striving—for example, to be a centre of excellence, to be the obvious first choice of anyone in its catchment area, to attract the brightest and best medical staff, etc.

Business definition—This should clarify the benefits that the trust provides and the needs it satisfies.

Distinctive competences—These are the skills on which any success to date has been founded.

Indications for the future—Here the values of the trust are made explicit in terms of what type of work it will, might, and will never undertake.

It is only in the past decade that the value of such a mission statement has become recognised, for, when tackled seriously, it provides a touchstone which can help decision making at all levels. For example, making the choice between two equally valid options can be simplified by considering which is most consistent with the mission statement.

Thus, the mission, business philosophy, statement of intent (call it what you will) should say something unique about the trust which is unlikely to be applicable to any other organisation (box). Those missions which are mere "window dressing," full of platitudes and pious hopes, serve no real purpose and certainly never engage the hearts and minds of those to whom they are addressed.

Once a sense of personal identity has been established, the next element of the strategic context phase of the marketing plan is to determine what the organisation should actually be achieving some years

hence. In industry a three year planning window is widely accepted for quite pragmatic reasons. A longer period is beset with greater uncertainty; a shorter period is not normally adequate to achieve a major strategic shift. In practice the time frame for the strategic marketing plan has to be chosen to be compatible with the nature of the business. For example, three years would be ludicrously short for a company engaged in long term capital projects like the aerospace industry.

For a trust, these corporate objectives will specify the level of funding it will need to be successful. They will also hone the mission statement into clearer business boundaries, covering:

- Which services and customer groups (marketing)
- What kind of facilities (logistics)
- The size and character of the workforce (personnel)
- The image the trust wishes to project (to the community, fundholders, its staff, and so on).

	1991-2	92-3	93-4	94-5
Outpatient attendances	14 100	14 250	14 450	14 850
Inpatient episodes	350	220	140	100
Day cases	380	380	420	470

FIG 1—How a trust can earn its income. This three year business plan shows a 5.3% increase in outpatient activity; 26% increase in day cases; 71% decline in inpatient episodes

Under the new system of purchasers and providers, income flows will tend to be in proportion to the number of procedures carried out over the planning period. Some might regret this change of emphasis by putting money at the heart of what the trust can and cannot do, but realists will recognise that this has always been the case. What is different is that the trust can plan to "earn" its income, rather than relying on receiving an annual injection of government funding, the level of which often bears more relation to the political exigencies of the moment rather than to the needs of the situation. How the Midtown Hospital endocrine and metabolic unit tackled this is shown in figure 1.

Mission statement endocrine and metabolic unit, Midtown Hospital

To provide treatment of, advice on, and prevention of complications, for a wide range of endocrine and metabolic diseases for the local population. Also to take advantage of the ease of access afforded by the location of the hospital, to attract patient referrals which would otherwise go to hospital further afield.

To perform relevant clinical research and training for professional staff, in particular to meet the increased training needs of general practitioners as "shared care" for diabetic patients becomes more popular.

To rationalise services that are currently offered so as to provide better value for money.

The marketing plan is concerned with establishing the best mix of health services for the relevant target population served by the trust. In this sense it greatly simplifies the forward planning process by eliminating many complications and distractions which are clearly the remit of other functional areas such as accounts or personnel.

THE SITUATION REVIEW

The objective of this phase of the marketing planning process is to identify the key factors, both within and outside the trust, which will have a bearing on its fortunes. In an article like this it is impossible to go into detail regarding what should be investigated. However, in general terms the trust should be concerned with factors likely to make an impact on it. It is often convenient to group these under four broad headings: the business environment; the market; the competition; the organisation (box).

The information generated by the situation review does not appear in the marketing plan. Instead it is summarised in the form of a "market" summary, which should be no more than three or four pages long. The purpose is to make it clear to anyone concerned with the plan what the real trends are in the market served by the trust.

The next step is to distil this situation review even more by doing a SWOT analysis (strengths, weaknesses, opportunities, and threats) on each of the principal components of the market.

An example of one SWOT analysis from Midtown Hospital endocrine and metabolic unit is shown in table I. The numerical values in the SWOT analysis can be established by using independent market research, and techniques are available for establishing what these are. Otherwise, great care is needed to avoid bias. However, it is important to be clear about how "strengths" and "weaknesses" are interpreted, for marketers are more concerned about comparatives than about absolutes. So a trust is strong if it can outscore a rival on any critical success factor regardless of whether it still has far to go before it could be deemed to be excellent in this area. Its weaknesses must be gauged in a similar way. The completed SWOT analysis provides the input to the next phase of the marketing plan.

TABLE I—SWOT analysis of infertility treatment

Critical success factors	Weighting factor	Hospital		
		Midtown	Albry	Nearest teaching hospital
Location	10	100	50	50
Ultrasound	10	80	70	70
Facilities (privacy)	20	200	160	120
Success rate (research)	60	480	360	300
Total weighted score	100	860	640	540

SETTING MARKETING OBJECTIVES AND STRATEGIES (MARKETING STRATEGY FORMULATION)

Because the essence of marketing is getting products and services to customers, it follows that marketing objectives can fall only into the categories illustrated in table II:

- A—Providing existing services to existing customers
- B—Providing new services to existing customers
- C—Providing existing services to new customers
- D—Providing new services to new customers.

It is box A which provides the basis for the marketing planner; all others introduce an element of the unknown—that is to say, risk. Box D is clearly the most risky option of all.

A technique known as gap analysis can be used to determine the nature of the chosen marketing objectives. Gap analysis allows the user to set the

Impact factors

Business environment

- The general economic situation
- Political/legislative changes
- Social/cultural issues
- Technological advances

Market

- Total market and "market share"
- Developments and trends, such as changing demography
- Market characteristics, such as principal services in the past, volume of demand, patterns of take up
- Pricing arrangements—normal practice, regulations, etc
- Channels—how patients are reached, purchasing, patterns of fundholders, etc
- Communications—principal methods of communication, such as direct mail, open days, public relations
- Current best practice, trends, and changes

Competition

- The impact of other trusts which could be construed as being in competition
- Distinctive competences, business approaches, etc, of other trusts
- Pricing policies, efficiency, facilities, etc, of other trusts
- New entrants, mergers, and acquisitions

Organisation

- Staffing—levels, location, demographic make up, staff turnover, etc
- Skills and special competences
- Structure or administrative issues
- Bottlenecks and underused facilities
- Patients', staff's, and general practitioners' perception of the trust

required objective for a future time period, project the likely outcome (given current policies), and then attempt to fill the gap by means of one or more of the following: productivity improvements; better results from current activities; or new activities (either from new services provided, from new users, or from a combination of these). Figure 2 illustrates this theory and figure 3 illustrates how this operated in an example from Midtown Hospital.

There was a 17.7% increase in productivity over one year (1990-1) due to more efficient management of the clinics. With this efficiency drive expected to continue and a reduction in the number of non-attenders (currently 21% of clinic appointments), it was anticipated that a further 10% increase in productivity could be achieved over the next three years.

FIG 2—Theory of gap analysis

TABLE II—Marketing objectives

	Products and services	
	Existing	New
Customers: Existing	A	B
New	C	D

FIG 3—How gap analysis worked at Midtown Hospital

By 1994-5 the outpatient workload for osteoporosis treatment will be 915 attendances a year. These patients will be largely from the Midtown market.

In the context of the situation review it is possible to calculate the revenue to be derived from providing the current range of services to existing customers. In figure 2 this reaches level 1, which falls short of the corporate objective. By tightening up in various ways, the initial prediction could be revised to point 2, thus closing the original gap through productivity. Even so, the predicted results still fall short of their target and more must be done to close this strategic gap.

Often, the next best choice is to provide new services for existing customers because it is often quicker and easier to introduce new procedures than to find new customers (but this will not always be the case for trusts).

Another implication of introducing this strategy is that the trust has the appropriate skills and resources to provide new services which are required. If not it must pursue the next strategy option of finding new customers for its existing range of services. Finally, a combination of both new services and new customers may be required.

By focusing on opportunities from the SWOT analysis and playing to its strengths, the trust can follow the best options that present themselves, while at the same time achieving its corporate objectives.

Gap analysis is a comparatively simple, yet essential, technique for deciding on a range of marketing objectives (fig 3).

The 80/20 rule

As with other types of business, there will always be some minority products or services which in themselves are not profitable yet which, for various reasons, must still be provided. Is there still room for these in a marketing plan? The short answer is yes, as long as the rest of the business is managed efficiently. The justification for this is that, empirically, 20% of services generate 80% of costs; if management attention focuses on this 20%, costs can be contained and revenues maximised, thereby enabling other minority activities to be undertaken; investment in such minority products or services should be kept to a minimum.

Ideally, it should be known how each product or service contributes to the whole output of the trust. In this way it becomes possible to manage the range of activities as a complete portfolio, rather than as a set of unconnected services.

Portfolio management

Every service or product can be plotted on a "map" and a sense of their direction can be established. The "map", or "directional policy matrix" as it is often referred to, is constructed as shown in table III. It

assumes that any organisation, regardless of its sphere of activity, will not be equally proficient at providing every service it offers, nor will its customer groups all be equally attractive. How the organisation chooses to define these two parameters is a matter of personal choice. For a trust, the various factors could be pertinent (box). By weighing the relative importance of these factors, a procedure can be devised whereby each service or procedure can be "scored" in terms of market attractiveness and its "fit" with organisational strengths.

Each service the trust provides can be plotted on this map by drawing a circle at the intersection of the scores on the vertical and horizontal axes. The circle size should be proportional to the level of funding which that particular service generates. Thus at a glance the relative value and positioning of all services can be accommodated. The reason for doing this will become clear in a moment, when the meaning of each "box" on the matrix (table III) is explained.

Attractiveness	Strengths
Little competition	Highly competent at procedures
Not price sensitive	Compatible with resources
High procedure success rates	Reputation
Few complications	Good relationship with main fundholders
Minimal inpatient content	Quality standards
Growth area (to justify investment)	Calibre of staff, etc

Box A represents the key services and procedures for which the trust is likely to develop a widespread reputation. Not only is the market attractive in the trust's eyes, but the trust is also well matched to provide whatever is required.

Box B represents newer services or procedures which have been introduced because of the higher market attractiveness score, but for which the organisation has yet to develop sufficient strengths.

Box C also reflects a high compatibility with the trust's strengths, but here the attractiveness score is much lower. This means that some of the resources expended on these services might be used more productively on those which feature in box A. Items in this box might represent yesterday's "stars" which have become less attractive.

Box D is clearly a dubious area for any services or procedures, because not only is the market unattractive, but also the trust is using few of its strengths. Ideally, items which are located in the box might be better provided by another trust for whom these could be Box A items—that is, another trust could view the market differently and would certainly have different strengths.

In simple terms a general strategy is identified by each box on the directional policy matrix as follows:

Box A—Promote expertise (invest in resources and communications).

Box B—Develop strengths (therefore invest selectively in personnel and the organisation).

Box C—Do not actively seek new customers or use up too many vital resources (monitor costs).

Box D—Seek to withdraw or subcontract the work elsewhere, or, at least, minimise costs if these are services you must provide.

Figure 4 shows not only how the portfolio of services is perceived today but also how it is planned to be developed at Midtown Hospital. (The new circles indicate future positioning.) This example shows that

TABLE III—Directional policy matrix

	Organisational strengths	
	High	Low
Market attractiveness: High	A	B
Low	C	D

the diabetes market will become more attractive because of increased screening for diabetes. The strengths will be increased with the implementation of the "shared care" model and the diabetes centre. There will be a greater demand for infertility services and the endocrine and metabolic unit will gain market share from its competitors.

RESOURCE ALLOCATION, BUDGETING, AND MONITORING

In many ways the most difficult part of the marketing planning process is stage 3, where high quality conceptual thinking is required to set objectives and formulate strategies. However, this will all be to no avail unless resources are allocated sensibly to allow the organisational thinking to be converted into reality (tables IV, V).

There will be penetration of the Midtown market for the treatment of diabetes and general endocrine, metabolic, infertility, and calcium disorders. For diabetes, this will be achieved through the establishment of a diabetes centre and a "shared care" model, which will be promoted through educational programmes to general practitioners. For calcium disorders, this market penetration will be achieved by repositioning the existing service to include the treatment of osteoporosis. All the services will be promoted to general practitioners in the home market and priced, if allowed, at a discount.

For infertility services, market penetration across all the markets will be achieved by increasing the number of referrals from existing customers and expanding the hospital's customer base in obstetrics and gynaecology hospital departments. Results of the market research work will be distributed to these departments.

There will be a transfer of inpatient treatment to day case treatment. This will follow on from careful analysis of clinical practice.

The spare capacity on the endocrine and metabolic

FIG 4—Portfolio of services as it is seen today and planned to be developed

TABLE IV—Setting qualitative marketing objectives

	Service	
	Existing	New
Market:		
Existing	Market penetration of home market for all services, particularly "shared care" diabetes	Osteoporosis treatment
New	Penetration of all markets for outpatient infertility work	Research facilities

TABLE V—Setting quantitative marketing objectives

Market	1991-2	1992-3	1993-4	1994-5
Diabetes	5 046	5 046	5 046	5 046
Infertility	1 221	1 290	1 410	1 471
Paediatrics	3 261	3 265	3 265	2 800
General endocrine	2 998	2 932	2 866	1 011
Parathyroid/calcium	1 233	1 159	1 085	341
Inborn errors	341	341	341	13 934
Subtotal	14 100	14 033	14 013	916
Osteoporosis		217	937	
Total	14 100	14 250	14 450	14 850
Inpatient episodes:				
Thompson	85	38	25	20
Carroll	45	37	25	17
Creaser	31	21	14	10
O'Neill	42	19	18	15
Scott	155	105	58	38
Total	360	220	140	100
Day cases:				
Thompson	39	43	47	60
Carroll	274	210	180	160
Creaser	21	27	27	35
O'Neill	22	23	28	30
Scott	24	52	78	100
Subtotal	380	355	360	385
Osteoporosis*	0	25	60	85
Total	380	380	420	470

*New work carried out by clinical assistant appointed in 1992-3.

unit will be used for medical research performed by other clinical teams and the bays in wards will be sponsored by pharmaceutical companies.

Financial projections

The major changes in costs are:

1992-3: £5000 for the upgrade of outpatient facilities to produce a diabetes centre. A reduction in medical staff by one senior house officer (£24 780).

1993-4: A reduction in medical staff by one registrar (£27 200) but an increase by one clinical assistant (£25 000).

1994-5: An appointment of one clinical assistant (£25 000).

Sponsorship for the operating costs of the endocrine and metabolic unit could be obtained from the pharmaceutical industry. This will be about £82 000 a year plus any chemical pathology variable costs.

EXTERNAL COMMUNICATIONS

We do not intend to elaborate on the details of strategy here, because we believe that readers will be familiar with what is involved. Having said this, there will be one area for consideration that would be unlikely to feature in other planning approaches. This is the area of external communications. In order to influence markets, it is important to communicate with them. Normally this is achieved in two ways: through personal transactions—face to face, by telephone, or by letter—or by impersonal methods—advertising and public relations.

The objective of any communications programme is to influence members of a target market (fig 5). It cannot necessarily be assumed that everyone automatically knows what the trust is capable of providing most effectively. Therefore, customers must be encouraged to approach the trust for help. Thus an integrated communication "plan" must be devised (with budgets), directed essentially at fundholding general practitioners, purchasing consortia, consultants, and the relevant areas of the local community. Such is the power and potential of communications, it cannot be left to chance, nor starved of resources.

FIG 5—The communication chain

Key point summary

- If a business is based on the needs of customers it can develop the necessary skills, products, and services, justifying further investment during the process
- Marketing planning is a four stage process involving the determination of strategic context, situation review, formulation of marketing strategy, and resource allocation
- An integrated communication plan (with budgets) will effectively "market" services to general practitioners, purchasing consortia, and the local community
- It can take up to three years before a strategic marketing system is fully implemented

Conclusions

Regardless of the political dimension of the recent changes in the NHS and the speed of their introduction, health provision has always been subject to the laws of supply and demand. In the past supply dominated, but now the new approach purports to put demand in the forefront. Just how far the NHS becomes customer driven remains to be seen. However, it is clear that those in management positions in self determining trusts must learn more about marketing planning if their organisations are to succeed.

If our experience in industry is anything to go by it is

not easy for an organisation to switch suddenly to a marketing oriented culture, especially when marketing itself is viewed as the equivalent of the golden horde of Gengis Khan battering at the frontiers of Christendom. We have found that it can take up to three years before a strategic marketing system can be fully implemented, because what might seem glaringly obvious is fraught with practical problems.

First, as we have indicated, it is a matter of engendering the right attitudes throughout the trust. Then, information systems need to be devised to provide the right inputs. Then a suitable plan for introducing the planning has to be developed. Who does what has to be established, and so on, and all this has to be done against a background of the normal and busy work routine.

Not least of the problems is that top management often pays lip service to marketing planning without ever being fully committed. Their "semidetached" stance inevitably causes a cynical antimarketing undercurrent in the organisation, which is ultimately the death knell to any meaningful initiative. Thus marketing planning is more than a cognitive process, for it profoundly and irreversibly affects the organisational infrastructure. To become customer focused or driven is not a new piece of management jargon, but a statement of intent. It is a declaration that the organisation will stop contemplating its own navel and, instead, learn how to enter into a mutually beneficial relationship with the community it chooses to serve.

Rethinking Consultants

Specialists in the United States: what lessons?

John Roberts

Several pressures are forcing a rethink of the way that consultants in Britain work. Perhaps the most acute pressures come from the current moves to reduce junior doctors' working hours and the Calman proposals for more structured and shorter specialty training programmes. Together these will mean fewer juniors available to do service work within the NHS and a greater load on the consultants who have to teach them. But patients and purchasers are also demanding that more clinical work should be done by fully trained doctors, not trainees, and the requirements of the new NHS require consultants to take part in auditing, contracting, and managing the service. Last week (11 March, p 673) the BMA council heard consultants' anxieties that the numbers of consultants were not growing in line with the demands of the Calman implementation plan. There is a feeling that something will have to give, and the BMA fears the proliferation of subconsultant grades (staff who are not trainees but do not have full clinical autonomy) to fill the growing gap between the work to be done and doctors available to do it. Also, on 6 April the Central Consultants and Specialists Committee of the BMA is holding a conference to discuss consultants' career development in the face of these changes.

We have commissioned four articles to contribute to this debate about how consultants should organise themselves and their work in future. In the first of these our North American editor, John Roberts, outlines the effect of similar pressures on the way that specialists in the United States organise their work, and how their working practices are changing.

The American specialist and the British consultant travel separate but often parallel roads. Both have recently been buffeted by the same storms: privatisation and competition; demands for account-

ability; problems of supply; and disgruntled juniors.

America's chaotic system of specialties grew out of two world wars. During the first world war the United States army found that over half the country's ophthalmologists were incompetent.¹ As a result, each specialty set up its own specialty board. The second world war accelerated the need for specialists, and the revolution in medical technology after the war further increased the growth of specialty medicine. There are now 25 major specialties and 73 recognised subspecialties.²

Certification

Certification of specialists has been a politically delicate issue. When the American Medical Association tried after the first world war to insist on certification its general practitioners balked at it, fearing that they would lose hospital privileges.¹ So certification remains voluntary. Any doctor may call himself or herself a specialist, and, once licensed, any doctor may theoretically practise all areas of medicine. But about 75% of doctors who call themselves specialists have been certified by the specialty boards.² They have sought certification for several reasons. Firstly, hospitals want to employ certified specialists to maintain their reputations; secondly, medical insurers can attract clients by claiming that they use only certified specialists; thirdly, other doctors, especially in primary care, want to refer their patients to the best specialists, and certification provides at least some measure of quality.

Specialty training in the United States is a marketplace. And since the 1950s it has been a buyer's market