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

American hospital specialists usually focus on care of patients, not research or teaching

LOUISE OLIGNY/IMPACT PHOTOS

because training positions have far outnumbered the medical graduates to fill them. As a result, specialty training is more predictable, shorter, and probably more humane than in Britain.

Specialty training

For the young person whose sights are set on specialisation the path is predictable. After four years of college and a further four years of medical school the young doctor begins graduate medical education. For those going into primary care the training is usually three years. But for those who want to specialise further—to reach the level of consultants in Britain—the road gets longer. For example, doctors training to specialise in cardiology can expect to add three to four years of cardiology fellowship to their three years of internal medicine residency (table I). In some types of surgery the path may be as long as 12 years after medical school. So, typically by the age of 32 a clinical specialist will have done all the years of training and up to five examinations. He or she may then practise as a fully fledged specialist.

At this point the new specialist faces two barriers. The smaller of these is the recertification examination, which he or she will probably have to go on to take several times as a senior specialist as most specialties demand that their members should be recertified every

TABLE I—Requirements for training and recertification for major specialties in United States¹

Specialty	Training (years)		No of years between recertification examinations
	Initial	Advanced	
Allergy and immunology	3	2	10
Anaesthesiology	1	3	NA
Colon and rectal surgery	5	1	8
Dermatology	1	3	10
Emergency medicine	NA	3	10
Family practice	NA	3	7
Internal medicine	NA	3	10
Medical genetics	2	2	10
Neurological surgery	1	5	NA
Nuclear medicine	1	2	10
Obstetrics and gynaecology	NA	4	10
Ophthalmology	1	3	10
Orthopaedic surgery	NA	5	10
Otolaryngology	1	4	NA
Pathology	NA	3-4	NA
Paediatrics	NA	3	7
Physical medicine and rehabilitation	1	3	10
Plastic surgery	3	2	NA
Preventive medicine	1	2	NA
Psychiatry/neurology	NA	4	10
Radiology	NA	4	NA
General surgery	NA	5	10
Thoracic surgery	5	2	10
Urology	2	3-4	10

NA=not applicable.

seven to 10 years. But the greater challenge is finding a job. By some estimates there are 20-33% too many specialists in the United States³, and for many young specialists, finding a well paid job is growing more difficult. Even keeping a job is difficult in 1995, and several medical schools are meeting a new demand to retrain specialists as primary care doctors.

Academics

Newly certified specialists can stay in academia, where, if they succeed, they will have security, prestige, varied and interesting roles, and less time on night calls than private specialists. But their first years as young faculty members will be especially difficult. Firstly, they have to find a job: many more young specialists want to stay near the academic centres than posts exist to fill. Secondly, academics live or die by the grant, and grants becomes harder to get each year as the number of researchers grows and the number of dollars does not.

Nevertheless, young faculty specialists are senior clinicians. They are responsible for their own patients, and they report to no one else about their patients' care. Although at first they lack job security, if they succeed they will acquire tenure seven to 10 years after completing their training.

American academics have been reluctant to adapt to the marketplace reforms that have swept across America. Numerous observers cite four major reasons for this reluctance. Firstly, most university medical centres are clinical departments that are run separately from other departments, so the university cannot easily offer patients cross disciplinary care.

Secondly, tenure remains entrenched in university centres. Like consultants in Britain, tenured professors in the United States have lifetime job security with almost no oversight or monitoring of activities.

Thirdly, the rise of technology has made the hospital generalist physician almost obsolete. Internal medicine especially has been in contortions trying to redefine itself. Most internal medicine physicians now either practise primary care medicine in adults or have become true subspecialists. When medicine was primarily a diagnostic endeavour doctors could still be generalists, according to professor of infectious diseases Patrick Murphy, who trained in Britain about 30 years ago. "But it is more a therapeutic endeavour in modern times, and therapeutics requires knowledge of more minutiae. And a generalist cannot know everything."

Finally, academic specialists wear many hats so clinical practice necessarily becomes a part time endeavour; many see patients only during one session (4-5 hours) a week. Most of the clinical work is carried out by trainees. Such a system is often inefficient, and it has certainly been avoided by large medical insurers that are seeking the best care for the least money.

Private practice

Most American specialists are not academics, however, and the vast majority settle into private practice. Patient care is usually the focus of their work, with teaching, research, and committees playing a smaller part. Incomes are substantially higher than among academics.

The problem of oversupply is perhaps most obvious among private specialists (table II). The recent shift towards prepaid medical care (where practices are paid capitation fees for providing all necessary care for their patients) has reduced the demand for specialists while increasing the demand for primary care doctors. As a result, many young specialists are finding that they cannot practise their specialty at all, and few are able to practise their specialty full time.

TABLE II—Medical staffing at Kaiser Permanente (managed care group) in Portland, Oregon, compared with national supply levels in United States¹

Specialty	Staffing per 100 000 population	
	Kaiser 1992	National supply 1992
Total No of doctors	136.8	180.1
Primary care	56.3	65.7
Family/general practice	15.6	29.3
General internal medicine	26.3	23.3
Paediatrics	11.1	13.1
Medical subspecialties	14.7	17.8
Allergy	1.5	1.1
Cardiology	2.8	4.9
Dermatology	2.4	2.5
Endocrinology	0.8	0.8
Gastroenterology	1.5	2.4
Haematology/oncology	2.2	1.9
Infectious disease	1.1	0.6
Nephrology	0.7	1.1
Pulmonary disease	1.3	1.8
Rheumatology	0.4	0.9
Surgical specialties	33.0	43.8
Obstetrics and gynaecology	10.8	11.4
General surgery	6.5	10.8
Neurosurgery	1.3	1.4
Ophthalmology	2.3	5.6
Orthopaedics	5.5	6.5
Otolaryngology	3.2	2.7
Plastic surgery	0.3	1.7
Thoracic surgery	0.1	0.7
Urology	3.1	3.1
Hospital based specialties	16.5	22.0
Radiology	7.9	8.6
Anaesthesiology	5.5	9.2
Pathology	3.1	4.2
Other	12.3	20.3
Psychiatry	4.8	12.0
Emergency medicine	6.3	5.6
Neurology	1.2	2.7

Perhaps as a result the world of private specialty practice has adapted more readily to recent challenges in the marketplace. One example is the Minneapolis Heart Institute, Minnesota, whose staff include 20 cardiologists, 10 thoracic surgeons, five nuclear radiologists, four anaesthetists, and one internist. While the group is much bigger than the average specialist practice, its members have work patterns that are not unusual (table III). The practice was founded in 1981 by the doctors, most of whom had trained at the University of Minnesota, which was once the busiest heart centre in Minnesota. Today, the university has slipped into third place, behind the Minneapolis Heart Institute and the Mayo Clinic. Unlike the university and the Mayo Clinic, the institute has no training programme for young cardiologists, with senior doctors carrying out virtually all of the clinical work.

Each of the cardiologists at the institute works 60-70 hours a week and is on call in the hospital one night a month and five weekends a year, according to Zach Myers, executive director. On an average day, the group's cardiologists:

- See 80-130 patients on the wards and about 40 patients in their offices at the institute's base hospital, Abbott-Northwestern Hospital, which itself has grown larger than the University Hospital
- See 13 patients on the wards or in the offices at

one of the 28 small hospitals in Minnesota that the cardiologists visit 54 times each month

- Perform 15 diagnostic coronary angiograms and seven percutaneous transluminal coronary angioplasties or other non-surgical coronary artery procedures

- See six patients awaiting open heart surgery, including one patient awaiting transplantation

- Dispatch a mobile diagnostic unit to perform 27 echocardiograms and vascular studies

- Teach internal medicine residents on hospital wards, in conference, and in clinics.

The doctors are well rewarded financially, and, according to some of the doctors, they receive a salary close the median in the United States for cardiologists: about \$125 000 (£83 000). The institute's foundation spends about \$1.2m a year on 35-40 research studies.

Patterns of practice

As specialty medicine has grown more competitive, specialists have had to deliver more services for less money. One way that the heart institute and many other specialists do this is by using physician extenders—nurses with advanced training and physician assistants, who have two years of medical training as well as their college training.

Anaesthetists have used nurse anaesthetists for years. Recently surgeons have hired surgical technicians as assistants, and specialists commonly use physician assistants instead of hospital house officers. The United States has about 25 000 physician assistants, whose salaries average £35 000, according to Nancy Hughes, vice president of the American Academy of Physician Assistants. Hughes said that at first doctors worried that physician assistants would erode physicians' clinical power. But the reverse has been the case. Licensing laws have emphasised that they are assistants, and their training is guided largely by doctors' organisations. Hughes said: "We train physician assistants to do tasks, but only physicians have the education to keep the big clinical picture in mind."

Although the Minneapolis Heart Institute is bigger than most specialist groups in the United States, other specialty practices are also increasing in size as competition for patients increases. "The one word that is guiding specialists' practice styles is efficiency," said a spokesperson for the American Group Practice Association. "The challenge of the next few years is to find the best group size, neither too small nor too big." Although most groups are still too small, with most specialists in groups with only one or two others,⁴ a few may be too big, some having as many as 3700 doctors.

Specialty practices are also shifting away from hospitals—which are expensive and governed by non-medical people—to freestanding specialty clinics, where costs can be controlled by the doctors who run the practice. Specialists also spend more time travelling from their base to primary care sites in rural areas and to smaller hospitals. "Today's specialist

TABLE III—Practice patterns and income of doctors in specialties and subspecialties in United States⁴

Weekly activity	Family practice	Internal medicine	Surgery	Paediatrics	Obstetrics and gynaecology	Radiology	Psychiatry	Anaesthesiology	Pathology
Hours spent:									
All professional activities	59.7	61.2	58.7	57.5	64.5	57.2	50.7	64.0	53.0
Care of patients	55.0	55.7	53.1	52.4	60.4	53.3	43.6	58.3	44.3
In office	34.8	26.8	22.7	31.8	29.2				
On hospital rounds	6.6	15.7	7.2	9.5	5.9				
In surgery or performing procedures	1.6	1.4	15.0	1.6	15.8				
No of patients seen	143.0	117.9	107.7	138.1	115.6				
Annual net income (£000s)	60.6	92.7	139.5	66.3	130.0	133.2	70.7	117.4	97.8

realises that he has to go to the marketplace; the marketplace isn't going to come looking for him," said the group practice association's health expert. Patients also travel more. Large American insurers are sending their transplant patients to just a few busy centres that can deliver better outcomes at less cost. The cost of the travel and hotels is still cheaper than the costs of unnecessary complications.

Specialists worry that they are losing control of their practices, but several management experts agree that doctors will maintain most of their power and autonomy. Nevertheless, the old style, independent doctor is an anachronism in the United States today. Like all health care, specialty medicine is growing more team oriented, and the most successful doctors will be those who develop a deep spirit of collegiality with medical and non-medical providers. Indeed, population based medicine and management skills are being added to medical school curriculums.

Specialists also fear the report card. Large insurers and managed care groups are keeping track of specialists' performance, and these may be used to decide who is hired and fired as competition grows more intense. US Healthcare, a huge managed care organisation based on the east coast, keeps records of outcomes on common operations performed by its surgeons. So far, nothing beyond feedback to doctors has been tried, but no one is certain that information on outcomes may not one day be used in a more draconian way. Still, say supporters, it is unfair to withhold such information from patients.

A new trend in health care is the introduction of clinical guidelines (or critical pathways). Many large practices, such as the group of cardiologists in Minneapolis, have found that by standardising the routines of common procedures, such as coronary angiography and coronary artery bypass surgery, patients can be moved through the system more quickly and with fewer complications. "Everything comes down to efficiency," said one expert, summarising the working practice of specialists in the United States.

Lessons for Britain

American specialists face unique problems, but their travails may provide lessons and suggestions for British

consultants as they consider their own future. Firstly, providing medical care for a country's people is complex. Attempts at finding one or two solutions have proved unsuccessful in America. Experimentation is now the rule in the United States, and a single remedy may also be premature for Britain.

Secondly, developing the use of physician extenders might be very helpful to a system in which there are too few senior doctors and juniors are overwhelmed. Thirdly, consultants of similar specialties might join together to deliver packages of services to attract referrals from general practitioners (and other specialists), thus using economies of scale. Fourthly, as service requirements ease, the training pathways of juniors should become more predictable—and perhaps shorter. This is certainly what has happened in the United States and is what the Calman proposals are aimed at achieving.

Finally, experts in the United States wonder whether the whole concept of consultancy is appropriate for the 21st century. Many clinicians, even some who trained in the Britain, believe that the era of the generalist physician is long gone and should be discarded. Management experts say that the pyramidal system works to inflate the costs artificially by keeping the supply of doctors tight and waiting lists long. Consultants of the next century, they say, will be more specialised and more expert in their subject, but they will probably be more subject to oversight of their practice and will not have guaranteed job security.

- 1 Starr P. *The social transformation of American medicine*. New York: Basic Books, 1982: 224-5.
- 2 American Board of Medical Specialties. *ABMS directory of board certified medical specialists*. 2nd ed. New Providence, NJ: Reed Reference, 1995.
- 3 Weiner JP. Forecasting the effects of health reform on US physician workforce requirement. *JAMA* 1994;272:222-30.
- 4 AMA Center for Health Policy Research. *Socioeconomic characteristics of medical practice 1990/1991*. Chicago: American Medical Association, 1991.

Correction

Consultants' workload in outpatient clinics

An editorial error occurred in figure 2 of this paper by Drs Armstrong and Nicoll (4 March, pp 581-2). The y axis should have been labelled "1, 2, 3, 4, 5, 6 [not 10, 20, 30, 40, 50, 60]."

A MEMORABLE EVENT

The men from Kos

The following story comes from the recently published memoirs of Mr John Boyd, *Behind a Surgeon's Mask*.

Sir Ian Fraser and I visited BMA House where he was particularly well known, being a past president of that organisation. On our way into this modern looking building Sir Ian was commenting on some of its special features. As we passed through a small courtyard he talked for a short time about a very ordinary looking fish pond which contained some ordinary looking fish. Eventually he spotted something which he had obviously been looking for—a collection of small ordinary looking trees. From amongst this collection he selected one mundane looking specimen. "That," said Sir Ian, "is a very interesting and unique tree." I could not see anything distinctive or interesting about the tree and I said so. However I excused my ignorance by declaring that I was no horticultural expert. In his own inimitable way Sir Ian stroked the foliage with such care and reverence that I almost felt obliged to genuflect on the spot. He continued, "During my term as president I was one morning alone in my office when a knock came to the door. On my invitation two bronzed young men entered. They then proceeded to inform me that they had been sent by the citizens of the island of Kos."

The visitors went on to explain that the people of Kos (the birthplace of Hippocrates) would deem it a great honour if their two ambassadors were permitted to plant a tree in the grounds of the relatively new BMA establishment. Sir Ian naturally thought that the idea was an excellent one and immediately set about arranging a planting ceremony. On an agreed time and date the two men arrived accompanied by a man with a spade and a photographer.

Sir Ian then appeared with a party of top BMA officials, all dressed in morning suits and bowler hats. As the small tree was lowered ceremoniously into a prepared hole the BMA deputation doffed their bowlers to the accompaniment of clicking cameras. Then with that whimsical Fraserian smile Sir Ian continued, "We are not sure where those gentlemen came from, but we are now sure that they did not come from Kos and we strongly suspect that there are now, somewhere in the world, a few doctors who as medical students fooled their superiors. They got away with a set of valuable and embarrassing photographs while we are left with that very ordinary tree which was probably stolen from a public park."—JOHN BOYD is a retired consultant surgeon in Ardglass, County Down