KING EDWARD'S HOSPITAL FUND FOR LONDON

The organisation of hospital clinical work

Report of a conference held at the King's Fund Centre

on

18 March 1980

KFC 80/120

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INTRODUCTION

1. The purpose of the conference was to discuss the report of the King's Fund working party on The Organisation of Hospital Clinical Work. (KF Project Paper No. 22). The participants included representatives of organisations and individuals with an interest in the report. (A list of those who were present may be found in Appendix A).

2. The working party had concluded that a severe crisis in medical manpower and organisation was imminent. The primary cause was past failure to analyse fully the need for medical posts from the service or patient perspective and to provide for a properly balanced medical career structure.

3. The principal recommendation of the working party was that medical work should be performed by fully-trained doctors. The main implications were:

   (a) A reduction in the proportion of 'junior' hospital doctors;
   (b) A corresponding increase in the numbers of consultants and the introduction of more than one grade of consultant;
   (c) A redistribution of work between hospital-based specialists and general practitioners;
   (d) A redistribution of work between medically qualified and non-medically qualified personnel;
   (e) Better use of women doctors.

4. Mr Graham Cannon, Director of the Centre welcomed participants to the Conference. He expressed his thanks to the Working Party for their work and introduced the chairman for the morning, Professor T J H Clark, Professor of Thoracic Medicine and Sub-Dean, Guy's Hospital Medical School, who had been chairman of the working party.

THE REPORT

5. Professor Clark thanked the Fund for supporting the working party and outlined the background to its work. He said that in 1974-5 the idea to establish such a group had been stimulated by two dominant themes:-

   1. The serious overworking of junior hospital doctors and the acknowledgement of this problem by the constant claims of consultants for more juniors;
   2. A continuing and inappropriate rise in the numbers of junior posts in relation to the career structure, specifically:
      (a) too many in relation to permanent career opportunities;
      (b) over dependence on overseas doctors;
      (c) too much care of patients by those "in training".

   The statistical basis of the view that there were too many juniors for the career structure was compelling. Both the unthinking acceptance of the teaching hospital 'firm', added to the expediency of dealing with the many doctors returning from the war at the very start of the NHS, had helped to lead to this now inappropriate structure and imbalance between training and career grades.

6. The Working Party had recognised early in its thinking that the 'junior' problem was in fact symptomatic of the main issue which was the role and work of Consultants. The real challenge, trying to define the role, status and therefore pay of Consultants was realised by the Working Party to be a highly political issue.

7. The members of the Working Party served not as representatives but as individuals. Their combined role was to facilitate discussion and to act as a catalyst to debate. They expected, as with all catalysts, to be consumed in the course of the provoked dialogue! Professor Clark hoped that the dialogue of this day would not be 'that of the deaf', and encouraged participants to attack the Working Party's conclusions. Hopefully, however, there would be agreement that there is a problem and further worthwhile ideas would emerge during the day.

8. Professor Clark claimed nothing original in the Report. He said that it was essentially a re-cycling of many previous discussions and ideas but from a dispassionate viewpoint. The working party's belief was that the present career structure was in danger of collapsing and the urgent focus must be on what action is now required.

9. There were some aspects of the Report which Professor Clark felt merited more detailed attention, for example:

   (a) The effect on the G.P. if the hospital sector changes its career structure;
   (b) The need not simply to reduce the number of junior posts but to improve the training grades as such;
   (c) the whole position of women doctors, in the light of the increasing proportions now coming out of the medical schools;
   (d) the role and nature of Consultant work.

10. Professor Clark stressed one crucial issue. That was whether or not to have a sub-consultant grade ? He said that this had to be decided soon. He hoped that the Conference would at least achieve consensus on this issue.

REACTIONS TO THE REPORT

11. A number of speakers with an interest in the subject who were not members of the working party had been asked to give their first reactions to the report: These were:-

Mr David Bolt FRCS	Consultant Surgeon, West and South Middlesex Hospitals, Chairman of The Central Committee for Hospital Medical Services, The British Medical Association.
Dr John Horder OBE FRCGP FRCP	General Practitioner, London, President, The Royal College of General Practitioners.
Dr Pamela Ashurst MRCPsych	Consultant Psychotherapist, Southampton.
Dr Richard Coffey MA MB BChir MRCP DCH	Registrar in Paediatrics, St. George's Hospital, Tooting Chairman, The Hospital Doctors' Association.
Mr Alan Maynard BA BPhil	Senior Lecturer, Department of Economics, The University of York.

12. DR HORDER said that he was impressed with the Report because he felt that it faced difficult questions courageously and tried to take account of what patients need to have done, why doctors exist and what their work tried to achieve. The intentions of the Working Party were good, but in his view, not completely successfully fulfilled. The Working Party had looked at the organisation of hospital medical work and not of health care in toto, so they were concerned only with the needs of half the doctors, that is those in hospitals. He agreed with the view that patients need to see a fully trained consultant when they go to hospital.

13. DR HORDER questioned whether GPs wanted to work in hospitals. This used to be true when doctors thought all the real work was done in hospitals. He referred to the strength of feelings against the view put to their College 4 years ago by Sir Cyril Clarke (then President of the Royal College of Physicians) that GPs would really 'prefer to work in hospitals'.

14. DR HORDER questioned what this 'working in hospitals' might mean. Possibly looking after their own patients in Cottage Hospitals, which seemed to work well in many places. When beds were made available to GPs in the District General Hospitals, practice had shown a low bed occupancy and a low take-up. He suggested there was no proof that vocational training encouraged demand by GPs for hospital work as intimated in the Report. He also queried the belief that this sort of experience would help GPs to do better. This had not been validated.

15. DR HORDER felt that:

    1. GPs needed more time in their own practices. He gave a comparison of a mean consultation time of 6-7 minutes in the UK to that of 13 minutes in France and longer in the USA;

    2. GPs should be concentrating on keeping patients out of hospital and on the multiple problems of each unique individual, and as a member of a family. The key issues were therefore prevention and health promotion, early treatment, treatment at home and at work;

    3. The most important aspect for patients were the GP's role in prevention and emphasis on psycho-social problems and their encouragement in self-care and mutual aid.

16. Dr Horder then presented some of the opposite arguments to those in which he believed:

    1. From the GP's point of view

    Many older doctors resented their exclusion from Hospitals in 1948. Many GPs still miss the problems met in hospital work, the better diagnostic facilities and dealing with the serious illnesses met there, feeling this experience makes them better GPs. Some find a great deal of job satisfaction in work in Cottage Hospitals.

16. ...../

2. From the Patient's point of view

(a) The loss of contact with the GP when a patient enters hospital can be very important and has been described very well by a number of authors.

(b) We need more hospital beds under the control of GPs:
Dr Horder referred to Dr London's estimate that 1/5 to 1/3 of hospital patients do not require specialist care.

17. DR HORDER reflected that this Conference was only the beginning of a lot of debate. The Working Party's brief had been only hospital clinical work and he posed a few questions not fully explored in the Report:

1. Will the numbers of doctors be allowed to increase ?
2. Will GPs increase their responsibility for personal care, continuity and prevention ?
3. Will these proposals succeed in reality when the Central manpower agencies had failed despite having the same aims ?
4. What should be our approach to the role of women doctors ?

18. Questions to Dr Horder

Participants, including Mr da Costa (Shotley Bridge) and Mr L P Harvey (Rugby), raised various points, in particular:-

1. Continuity of care: within both (a) the Hospital, where Consultants increasingly co-ordinated the care of the patient due to high turnover of juniors, and (b) in Group Practices.
Dr Horder admitted that Group Practice brought many problems and was a threat to continuity of personal care.
Professor Clark stressed the importance of the issue of continuity and clinical responsibility.
2. Independent Doctors working together using common facilities:
Dr Horder felt this was not a great difficulty but Professor Clark said Consultants would need to learn to work together in a similar way e.g. in shared Outpatient Departments.

18. ...../

3. G.P. referrals: one participant illustrated an overall change in the pattern of care by the annual drop in new Outpatient Referrals per 1000 population and per GP between 1971-77. Such changes will influence the overall organisation of clinical care.

19. MR BOLT found the Report stimulating even though he had reservations about parts of it. He said he agreed that the majority of patients in hospital should receive care by trained staff and stressed his profound commitment to resolving the problem of frustration of "blocked" juniors.

20. MR BOLT said that the problems were primarily in the 3 specialties of Medicine, Surgery and Obstetrics and Gynaecology. In fact the reverse problem was felt in some specialties with a failure to appoint replacements as Consultants retired. The general problems had been exacerbated by the failure to pay more for more work and the biggest barrier to solving this issue had been the failure of the new Consultants' contract last year.

21. MR BOLT had great reservations on the proposed 'institutionalised arrangements in creating two species of Consultant'. A progressive move to 'higher status' may work but not if staff have to move and be appointed to the higher level. He illustrated the difficulties in details of conditions and pay by asking whether the merit awards would be restricted to the senior level ? He felt that authorities would ensure that most of the service commitment was met by appointing to the lower and cheaper grade. The proposal was not much different from introducing a sub-consultant grade even though it would carry clinical autonomy.

22. MR BOLT said that there were a number of issues which were not in the report which would affect its implementation. These were primarily economic considerations and the attitude of the government. There is no expansion, or likely to be for some time in the 3 specialties named. There are also likely to be further acute problems in the career structure in London if the recent reports on medical education and organisation there are implemented.

22. ...../

Doctors must be aware of the reality that there is only a limited pool for medical manpower. Although he agreed that the nature of Consultant work must change, MR BOLT recognised the reality that if Consultants did more of the less skilled work, then it would be for a lower rate of pay.

23. MR BOLT said that Government have so far accepted that any fundamental changes in the structure of the medical profession must be clearly the work of the profession itself and undertaken by them. Although many previous proposals may have worked, the reason they have never been implemented was because none have ever been sufficiently acceptable to Consultants in post. Mr Bolt felt this to be right and the only way progress will be made is if the present junior staff make changes as they become Consultants i.e. a slow progressive exercise as posts change hands. The only other way to alter fairly the contracts of Consultants in post is by agreement reached through considerable financial inducements.

24. Questions to Mr Bolt.

1. Dr C Godber (Southampton) said that Senior Consultants refused to acknowledge the problems of juniors and the career structure and the profession must take responsibility to do something about it. He challenged Mr Bolt on how he faced the problem of "blocked" juniors. Mr Bolt accepted the position of some juniors as being appalling and gave examples of two of his own staff whose loss to hospital medicine he very much regretted. He stressed however that the way to tackle the problem was by financial inducement or natural means as retirements occurred. Mr Bolt said this recognised the reality of medical views and the fundamental right of those in post not to have their working conditions altered except by agreement.
Another questioner challenged the same adherence to the status quo and also said the problems of blocked posts occurred in other specialties than the 3 named. Mr Bolt did not accept the evidence for this.

24. ...../

2. Mr R T Marcus (Stratford on Avon) said that although the Report dealt with what the patient needed to have done, it was a pity it did not ask whether Consultants need do it ? He estimated that 95% of the needs of his own patients could be met by a Registrar of 2 years' training. He asked what was unacceptable about a Junior Consultant Hospital Practitioner grade ? MR BOLT recognised there would inevitably be a small element of a sub-consultant grade of some sort, depending on the quality of trainees but that no-one capable of being a Consultant should be forced into such a sub-grade.

25. DR ASHURST spoke as a working woman doctor and she used her own personal family experience to illustrate some of the problems of professional wives and mothers.

26. DR ASHURST felt that the omission of women from the Working Party was a weakness and felt, maybe as a result, the Report did not go far enough, particularly in recognising how substantial a proportion of hospital clinical work is done by women doctors or that nearly half the medical students are now women. The present career structure mitigated against half the workforce and she believed there were vested interests in the present economic climate for keeping it that way. There is already an iceberg of unemployed doctors, but since they are mostly women we see only the tip. The opportunity to practice medicine depends not on the needs of the community nor on skills, but on accidents of geography and timing.

27. DR ASHURST said that the Report assumed that most women doctors will marry and have families and this is incompatible with fulfilling a total career commitment. It was normal to both sexes to want families and the career structure needs revision to accommodate this 'normal' pattern of life. Professional practice for both men and women should be made more compatible with family life and not add to stress and increase the rate of marital breakdowns.

28. DR ASHURST stressed the need for courses of academic excellence and supervised practical experience but which must have an increasing degree of personal responsibility if the trainee is to acquire the experience necessary for satisfactory performance as an independent clinician. DR ASHURST believed that training spread over a long period may frequently be more valuable than intensive and compressed learning. She refuted the rejection by some Consultants of part-time learning as being inappropriate; they often themselves spent much time outside NHS practice in private work, travelling and in politics. Their juniors, who are supposedly in need of whole-time training, are left providing unsupervised cover. A system enabling both men and women doctors to train and work part-time is the only alternative to the prospect of 'wholesale unemployment and disillusion' which faces doctors if the career structure is not reorganised very soon.

29. DR COFFEY despite criticising the omission of Junior Doctors from the Working Party, warmly welcomed the Report. He was particularly impressed by the 'clarity of its analysis and in the wisdom of its propounded solutions'.

30. DR COFFEY said that the "Juniors' Complaint" is twofold:

    1. Juniors perform a disproportionate share of the routine work, especially emergencies, particularly in the peripheral hospitals.
       To those who rate unsupervised experience highly as good training,Dr Coffey offered 2 points in reply:
       (a) this ignores the patients' best interest:
       (b) there is currently a gross imbalance in favour of unsupervised as opposed to supervised training.

    2. Although Juniors carry such heavy, largely unsupervised service commitments, often still on 80-100 hour rotas, many do so with no reasonable expectation of a career post. Dr Coffey said that he hoped he would not hear the comment 'not everyone can become Admiral of the Fleet'. He felt it was a reasonable ambition for doctors to want 'to practice their profession

30. /cont.....2

and to exercise independent clinical responsibility'. This is what Juniors are trained for and it is what the present hospital staffing structure denies to many of them.

31. DR COFFEY compared the King's Fund report with others:

1. BMA WORKING PARTY REPORT OF 1979.

Dr Coffey praised this Report for the statistical evidence that the imbalance was worsening; consultancies increasing at 3% instead of the intended 4% annually and junior posts at 4.5% rather than the 3% intended. He agreed with their recommendations of urgent expansion of the consultant grade and strict control of entry into training grades. Since the expansion of the consultant grade has been agreed, policy between the DHSS and the Profession since 1969 Dr Coffey hoped there is now "consensus that this is at least one part of the required solution." The HDA also believe there should be early selection for specialist training.

The deficiencies of the BMA Report are however:

(a) the expansion of the consultant grade is nowhere quantified (the increase must be small because the report insists that the nature of consultant work must not change and it would necessarily if there were a significant increase in numbers).

(b) figures were hazy too on restructuring of the training grades. Dr Coffey gave his own estimates that around 2000 "training registrar" posts would equate with the 3000 senior registrars, but we have 7000 registrars in post.

The BMA Report gives no answers as to what to do with the remaining 5000. We must abolish them, otherwise they will be filled mainly by overseas doctors. The main problem confronting us today is who will do the work of the 5000 or so registrars whose posts cannot be justified as training-posts with career prospects ?

31. (1) (b) cont.....

Dr Coffey said that the merit of the King's Fund Report is that it states categorically that, for the benefit of the patient and the doctor, this work should be performed by a trained specialist in a career post. There are 3 possible types of such a career post: general practitioners, a specialist grade, or consultants. The King's Fund Report recommends an expanded Hospital Practitioner grade. Dr Coffey was doubtful that GPs could supply the regular second-on-call commitment or receive a sufficient degree of training to take full clinical responsibility for surgical, obstetric or hospitalised medical patients.

2. British Hospital Doctors' Federation Discussion Paper 1978. They put forward the idea of a 'senior doctor' who would be senior in status and salary, either full-time in his specialty or with other commitments to general practice or elsewhere, have had shorter training than a Consultant but still be competent to look after his own patients in a department headed by a Consultant.
This idea had had a mixed reception amongst juniors. Objections centered on:-

(a) salary and status - the belief that they would become "cheap labour";

(b) on-call commitment - would they be second-on-call until retirement while consultant contemporaries were third-on-call ?

(c) could they really be trained to a standard allowing them to undertake independent clinical responsibility ?

Dr Coffey said that their original idea could only be acceptable if these objections were met in full:-

(a) extend salary scale into a consultant range;

(b) bring consultants into on-call rota with some respite for age for all;

(c) adequate training programmes

and all of this "makes the person in question sound remarkably like a consultant ! "

31. 3. The King's Fund Report

Dr Coffey said that the report had the courage to say the gap must be met by an expanded consultant grade and that the significant increase in numbers required means changing the nature of consultant posts. Some of the objections to a waste of the consultant's highly specialised skills on more routine and on-call work are valid and Dr Coffey certainly had no wish to impose second-on-call duties on elderly consultants. However, an impressive number of those just starting their consultant careers think it reasonable to take their share of emergency work for some years at least, and to function with fewer junior staff than is customary. Dr Coffey mentioned the different nature of consultant work already developing in private medicine (doing more routine and on-call work with few juniors), so the precedent may be there for application in the NHS.

32. Dr Coffey said there must be an end to the deception of employing junior doctors in notional training posts but actually to meet service requirements. A programme of reform would go roughly as follows:

1. Officially designate the relatively small number of registrar posts required for consultant training and provide them with the mechanisms of selection, supervision, assessment and advice as laid out in the BMA Report;
2. Abolish remaining registrar posts as rapidly as possible;
3. Replace each abolished post by a career post, either by part-time GPs or others adequately trained in the specialty or create a new consultant post;
4. No further expansion of the SHO grade;
5. Government commitment to funding such reform: the cuts at present are forcing authorities to leave the consultancies vacant. This exacerbates the problems under discussion which the Secretary of State is on record as being concerned to see put right.

33. MR MAYNARD felt that the discussion in the Report was good but it was too supply orientated and did not cover in depth what the demand for services was. Nor did it cost out the proposals to unblock the career structure. He raised a number of other points:

1. Why compensate bad decision makers ? Senior Registrars "blocked' in their posts had made bad choices and the NHS should not compensate them for that.
2. "Fully trained doctors and educational needs" (Recommendation 1. Page 77 of the Report)
   This begs a definition of terms: "fully trained" - to do what ? This will depend on the objectives and on the NHS budget constraints; "educational needs", means the skills needed and ought to depend upon service targets.
3. A reduction in the scale of hospital services is "politically, socially and professionally unacceptable". (Page 72 of the Report).

Mr Maynard felt that this pre-judges a lot. There is a need to cost-evaluate the services (for example, the impact on hospital services compared with a development of community care). He felt that the report ignores this issue. It sounded like 'social security for hospital doctors'.

4. "The Euthanasia of the Junior Hospital Doctor Class".

Who is going to do the work ? The report suggests the following solutions:

1. more consultants (but what sort and how many ?)
2. more GPs in hospitals (even if they don't want to ?)
3. more nurses (substitution)
4. greater use of ("flexibility") of women doctors.

Mr Maynard asked what will be the mix of these alternatives, what will it cost and who will pay for it ?

The Report admits that the proposals will have economic consequences but does not say what they are. Could we, by financial inducement (e.g. fees per item of service); increase the output of doctors ? The scope for substitution between grades seems substantial.

5. Command over Resources and Priorities

Mr Maynard admitted his bias since he predicted in 1977 that there would be an over-supply of doctors in the 1980s in relation to budgets.

33. 5. cont.....

The net effects of the report's reforms will be greater expenditure. To meet this within cash limits means:

(a) more money on doctors but less for drugs, nurses or beds, or
(b) reduced wages for consultants, or
(c) better use of resources (although more evaluation and better incentives for efficiency are necessary, the returns are likely to be long-term).

Other sources of funds would be:

(a) to ignore cash limits (unlikely) or
(b) expand private finance, which is likely and is a fundamental change which must be incorporated into career structure/staffing arguments.

6. Objectives and Constraints

Mr Maynard felt that objectives need to be clarified before the career structure can be reviewed i.e. who is to get what health care where and have a definition of priorities. A detailed costing of any proposals with a clear indication of sources of funds will be needed.

34. Questions to Dr Ashurst, Dr Coffey and Mr Maynard.

1. "Substitution" Issue

Dr P A Emerson (Westminster Hospital) suggested that in our inflationary situation, the only hope was to reduce the number of registrars by increasing the use of para-medics. He listed some applicable specialties: respiratory care, plastic surgery, community medicine, psychiatry, psychology.

Dr Coffey said there was less scope for reducing the number of doctors in high technology areas. The need was to reduce them in the less technological peripheral hospitals.

Mr Maynard said we had little evidence in UK on the feasibility of substitution but USA studies were indicating plenty of scope in this direction.

2. A "Sub-Consultant" grade ?

Mr G I B da Costa (Shotley Bridge) wondered where the doctors were for this grade: between 1968-79 only around 6,000 of the 16,000 advertised Consultant posts had been filled and many of these were by overseas doctors. The sub-consultant grade (SHMO's) had failed in the past because they were similarly trained as consultants, paid less for doing consultants' work, and some were promoted without open competition.

Dr Ashurst said these figures ignored the increasing number of trained doctors seeking consultant posts recently and Dr Coffey said Mr da Costa's figures gave no breakdown by specialty. Dr Ashurst said we don't have a single tier career grade even now because of the merit award system.

3. The Consultant Grade

Professor Wade (University of Birmingham Medical School) said it was difficult to see why the Consultants could not accept more than one grade. The Universities have three. We need to define length of time in post, not just numbers. The suggestion now, of reaching clinical autonomy around 32 was what had been envisaged in 1948 but had not materialised.

34. /cont.....3

Dr J M Cundy (representing the CCHMS of the BMA) raised the question of Teaching Hospitals as a separate consideration, the successful consultants gaining posts here perhaps at around 45.

WHICH WAY NEXT ? AN AGENDA FOR PROGRESS.

The Chairman for the afternoon session was Dr Alan Bussey, Area Medical Officer, Kent AHA. The purpose of the afternoon discussion was to try to take some of the ideas discussed in the morning a stage further and to reach some agreement on the way forward.

'Reforming Hospital Career Structures'- Professor T J H Clark

35. Professor Clark said that the essential issue is whether we have a sub-consultant grade or not. The proposals would mean the loss of some thousands of junior posts and we need to answer the question, 'who is going to do the work ?'.

36. The Alternatives to meeting the service need:

(a) By an "Assistant"

This would be under the 'control' of the Consultant (whatever that role may be), it could be a conversion of the status quo with a prolonged period at Junior grade level. If this solution were to be adopted we must remove the pretence that it was "all for training". Professor Clark said you could allow the market to regulate the length of time in that grade. Such a system was good for the best trainees and bad for the less able. The 'consumer' suffers if too much 'service' is given by juniors.

(b) Recruit from overseas with service, non-training, non-career posts.

(c) The "Sub-Consultant" grade.
This would make an assistant grade a permanent post but with no access to a Consultant grade. By definition there would be no clinical autonomy.

(d) Expand the career-grades.
A form of seniority and progression might be acceptable but it may be better to have different types of Consultant post with competition for all of them.

(e) Expand the role of the GP.
The Hospital Practitioner grade is an opportunity which many of the younger GPs may be more enthusiastic about, but their lists must be reduced accordingly.

37. Professor Clark felt the answer was that patients' needs would be best met by fully trained career grades in larger numbers. He was against the use of a sub-consultant grade because he felt it to be impractical.

"Implications for Primary Care" - Professor D H H Metcalfe, Professor of General Practice, University of Manchester.

38. Professor Metcalfe praised the "genuine concern for patients" in this Report compared to 'Patients First' ! He considered the implications for primary care of changes in the organisation and nature of hospital clinical work and the proposals made in the KF Report.

1. Our Changing Society.
   Professor Metcalf said that we live and serve in a rapidly changing society whose characteristics are an ageing population with a change in morbidity to the degenerative diseases. Changes from the extended to the nuclear family, in behaviour, in education, in the politico-economic arena, and in attitudes to health professionals, all have considerable implications for health care: primary, secondary and tertiary.

2. Hospitals.
   They are capital and labour intensive, strongly hierarchial, and the skills are prescriptive with grading linked to the passing of exams. They displayed many of the characteristics of inflexibility.

3. The General Practitioner.

   He is responsible for primary care to individuals in the community but his concern is also with the quality of hospital care his patients receive. The characteristics of primary care are that the skills need to be responsive (i.e. developed according to the demand met). It is low on capital, low on manpower, and non-hierarchial.

38. /cont.....3

Professor Metcalfe illustrated the GPs position with a diagram showing the fluid 'socio-medical' interface between them and society and the rigid 'techno-medical' interface between them and hospital-bound specialist medicine.

4. Medical Education

The aim is this progression: needs ____ education ____ tasks ____ patients' objectives. Most medical educational effort goes into the hospital situation. The students are exposed to the specialties in the mode of the 'Great White Chief' and not exposed to many of the other specialties, particularly where they never see senior doctors getting a great deal of job satisfaction in them.
Professor Metcalf said that it is the exposure of the students which leads to their future career choices, expectations, patterns of treatment and so on.

5. Sub-Consultant level career grades ?

Who should fill them ? If GPs did this it would add to the loss of continuity of care and accentuate the emphasis on hospital care and not on the socio-medical interface. We are already woefully short of preventive personal medicine and the encouragement of self-help at this interface. At both interfaces there is under and over treatment. Professor Metcalfe indicated that GPs are already conditioned towards the techno-medical side: 'A' levels required in three science subjects, passive materials used in learning, and taught in 'high certainty' levels. When doctors reach the community, they need to achieve high adaptation. To take on hospital work again encourages the G.P. to avoid this adaptation by channelling away his anxiety.

6. Some Alternatives.

(a) That medical specialists (whatever grade) be deployed before the stage of the Outpatient Department (in health centres, clinics, workplaces) and thereby help to reduce unnecessary workload in hospitals.

38. /cont.....6

(b) Provision of SHO posts for vocational training

However, Consultants tend to use these supernumerary posts to get more SHO staff and the trainees don't like these because they do not get real job experience.

(c) Add more experience at SHO level to pick up clinical skills in a shorter period in hospital first rather than over a longer period in general practice. Professor Metcalfe agreed with Dr Ashurst that perhaps more prolonged training and retraining was needed. This would fit doctors better to deal with a rapidly changing society.

"The Training Consequences" - Dr R L Himsworth, Consultant Physician, Northwick Park Hospital.

39. Dr Himsworth concentrated his attention on the Report's implications for training those seeking a hospital-based career, particularly in the acute specialties. In these specialties there is a large emergency workload and it may be that in other specialties, there is not such a clear distinction in roles between Consultants and other grades. The Royal Colleges operate a form of manpower control through their examination scheme, the physicians making the selection soon after registration, the surgeons slightly later.

40. Dr Himsworth strongly supported the principle that patients should be treated by trained staff. He made some definite suggestions about the training grades:

1. The 'service contract' should be sufficient for training and no more;
2. Supernumerary training posts should be created;
3. All training should be given under closely supervised circumstances.

40. /cont.....

He expanded on the problems of supervising training:

(a) a better balance was needed, there has been too much emphasis on the apprenticeship style, but we must not go too far the other way.

(b) more supervision particularly needed for Outpatients and Emergency work.

41. Dr Himsworth suggested that the link between 'service and'training' should be broken; the advantages would be:

1. Better quality training because it could be properly planned if there were no service commitment.
2. Shorter, more intensive, basic training - followed up later with specialist training.
3. The content could be more flexibly responsive to advances in knowledge.
4. Easier to accommodate women into a training programme.
5. Ease manpower planning - iron out the bulges in certain specialties.
6. Career disappointments might more easily be avoided.

Dr Himsworth envisaged that we would then have 'true' training posts: supernumerary, designated posts and in selected departments.

GENERAL DISCUSSION

42. The following is a list of the main points made during the ensuing general discussion:

1. Proposal to have two grades of Consultant

(1) The Working Party proposal does not meet the Brunel prescription of needing clear differentiation between different grades (Jennings, Kent);

(2) Staff should not have to re-apply to the higher level. A flexible contract for Consultants needed to reflect changes made as retirements occur so that on-call and emergency commitments could vary over the years to accommodate changes in work and research interests (Hogbin, Brighton);

(3) The two grades would create similar problems to those which the sub-consultant grade had done previously (Caro, London);

(4) Ranking at 32 may be different to assessment of someone at 45. This system would permit such reappraisal (Simpson, DHSS).

Professor Clark said the intention of the Working Party had been to try to "break up the monolithic structure of the consultant grade", without being too provocative, without resorting to the ill-favoured sub-consultant grade, and to propose a clear structure.

2. The Sub-Consultant Grade ?

(1) We do need to cater for people who do not make it either academically or professionally, but this group will only be very small (Prof. Clark and Dr Coffey);

(2) Not acceptable in surgery, but may be applicable in some specialties e.g. psychiatry (Bevan, Birmingham);

(3) The danger of any sub-consultant role is that it has a tendency to expand to become a consultant one (Roberts, North Shields);

(4) The Clinical Assistant grade may well suit some who do not elect for a consultant career, the Royal Colleges should not insist on such a high level of training if enough local consultants agree on the individual's required competency (Kingsmill-Moore, North Surrey);

42. 2. /cont.....

(5) The sub-consultant grade is unlikely to be sought by women who find that shorter hours and changes in family attitudes make it increasingly easier for them to meet full-time contracts (White, Bromsgrove);

(6) The 3 year vocational training has already begun to create a kind of sub-principal in general practice and this will cause great problems (Harvey, Rugby);

(7) Eventually MRCGP or similar will become a requirement to be a Principal; there is no answer yet to what will happen to those who do not obtain this qualifcation (Metcalfe);

(8) We should open the Hospital Practitioner grade to others than GP Principals, to accommodate those seeking part-time hospital working, whether women or not. The market could be tested by appointing a "full-time" Consultant replacement or two part-time specialists, or Hospital Practitioners, depending on the response to advertising (Foss, HCSA).

3. <u>General Practitioners doing more work in Hospitals</u>.

(1) The whole ethos of GPs is different from hospital clinical work, 'you begin to be a GP when it pleases you that a lab. test result negates your original clinical prediction' (Metcalfe);

(2) If you take GPs away from their practices, then you can't complain about over-referral and excess laboratory requests (Metcalfe);

(3) Far from GPs doing hospital night work, many hospital doctors now provide night cover for practices (Simmons, London)

(4) There is not a rigid barrier between GPs and Hospitals at the "techno-medical interface" model of Professor Metcalfe but a great deal of flow between the two; we must not create any such rigidity (Drury, Birmingham).

42. 4. Smaller number of Registrar Training Posts

(1) Should concentrate them in a few centres to ensure high quality training with the best consultants (Professor Wade, Birmingham) but it was also felt this would be unacceptable to many Consultants (Simmons, London);

(2) If we adopted nationally a system (used by himself now for 8 years) of one trainee per 2 Consultant Surgeons, there could be a 50% reduction in the number of surgical registrars. Perhaps we could have a national quota of 50 posts annually to be open to conversion from registrar to consultant grade within cash limits (Professor McColl, London).

5. Supernumerary Training Posts

(1) These are a nonsense, one must work to learn (Caro,London)

(2) These would be unacceptable to Junior Doctors (Coffey) but training in a service post as now is totally inflexible (Himsworth);

(3) Such training could feasibly be provided by a system of student loans (Maynard).

6. The situation for women doctors

(1) Women already work in effect as sub-consultants, some very well trained doing a variety of sessions, or with GPs, or as clinical assistants (Ashurst);

(2) Women do not want to be treated as a special case; the problem is one of the general increase in the number of highly trained doctors all seeking full professional responsibility (administrative as well as clinical) (Roberts, North Tyneside);

(3) Part-time appointments, for those who want them, should be easier if there were more consultants in a department (Holt, Coydon);

(4) The Medical Women's Federation, in their report on medical eduction due out in June, will be suggesting a system of credits for postgraduate training (Grüneberg MWF).

42. 7. The Economics

(1) The present system is highly efficient in the quantity of work done, to aim for a higher standard with more clinical work being done by Consultants will cost us a lot more (Hogbin, Brighton);

(2) We have not considered the revenue consequences of having more consultants i.e. demands for more diagnostic and other facilities (Kilpatrick, Cardiff); Professor Clark said the reason the Working Party did not do detailed costing of the expansion of the consultant grade was because the first step was to get the Profession to agree there was a problem and it had taken 4 years just to do that. It was important to decide the sub-consultant option too before costing proposals. To Dr Kilpatrick's comment, he suggested a well-trained experienced Consultant uses those facilities more efficiently than the less experienced juniors.

42. 8. No Universal Solution to all Problems

(1) A number of participants drew attention to the fact that many of the suggestions made though may be relevant to some specialties were not applicable to all. For example, Pathology cannot get enough trainees despite the expectancy of a consultant grade by 28-30 (Professor Anderson, Glasgow);

(2) We may also need to review the provision of services in some areas. We may not be able to run a 24 hour service as now in as many acute hospitals but have night emergencies taken to a major centre;

(3) The Royal College of Surgeons has had a committee looking at the problems for a year now, and are aware that no radical solution is possible, but we must look at trends and tendencies to decide what directions to take (Bevan, Birmingham);

(4) Past policies have failed because other objectives got in the way, such as regional equitability and helping poorer specialties. We need to take account of the range and interdependency of the various objectives in making any changes in constructure. (Dr Engleman, Edinburgh).

FINAL SUMMARY BY THE CHAIRMEN

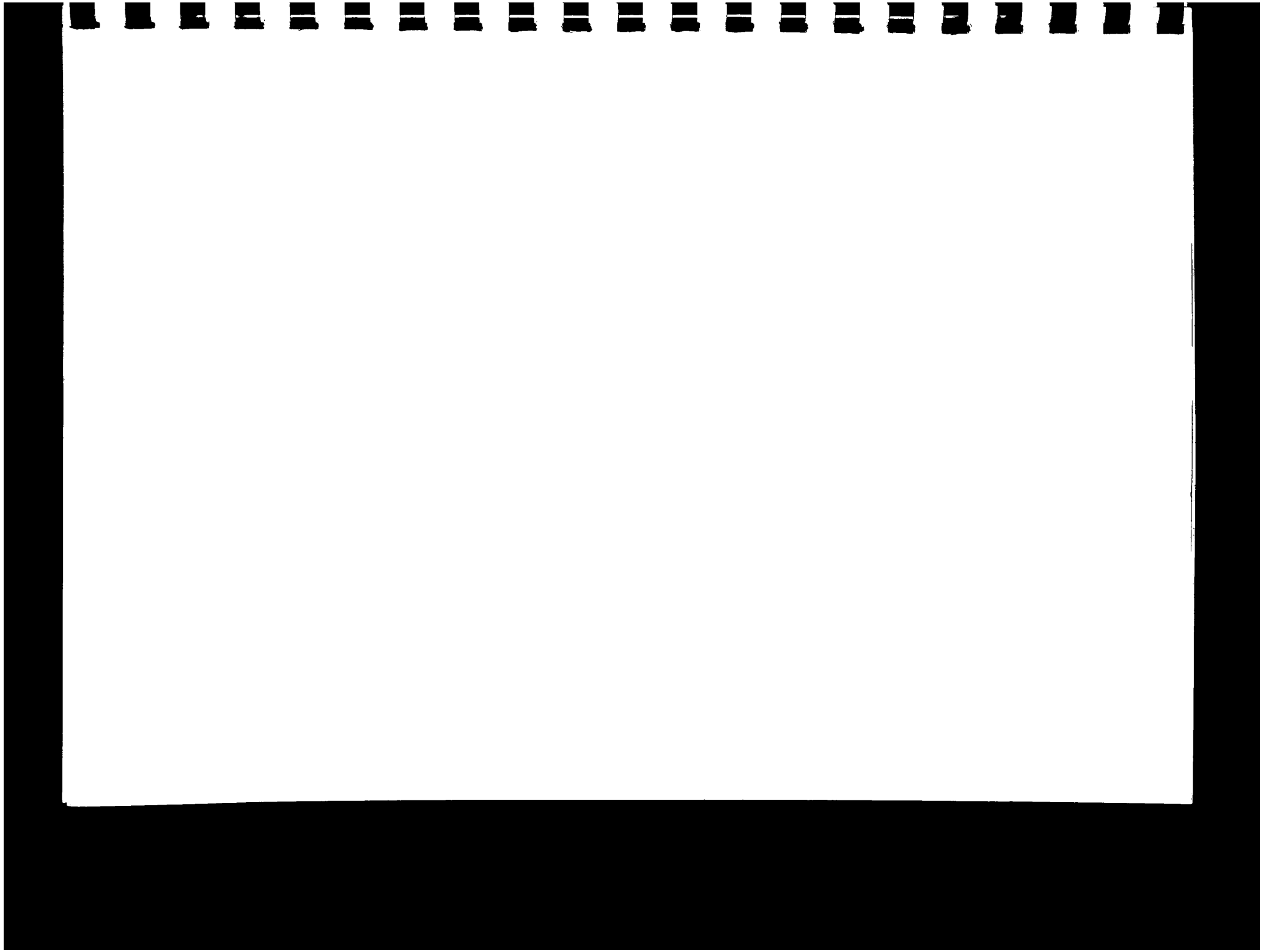
Dr Alan Bussey summarised the dominant views expressed at the Conference as:

(a) that evolution of the present system is an option many prefer but there is a problem which has to be tackled;
(b) there may need to be a variety of solutions for the different specialties;
(c) no-one seems to want a "sub-consultant" grade.

Professor Clark thanked participants for all their comments. Today had originally been intended as the "grand finale" to 4 years' work by the Working Party. He felt, however, that they must now summarise the ideas expressed today and try to identify the lines along which progress might be made. Although the day's conference had not produced unanimity about solutions, there was a clear recognition by the participants that a severe problem confronted the profession and the service and that it would quickly get worse if nothing were done soon. Acceptance of the need to do something was at least a beginning and a sign of hope for the future.

Susan Taylor
King's Fund Centre
April 1980

For further information about this conference or suggestions for additional related activities, please contact David Hands, Assistant Director, King's Fund Centre, 126 Albert Street, London NW1 (Tel: 01-267 6111). A copy of the original working party report (KF Project Paper No. 22) may be obtained from the same address for £1.50 plus 25p postage for single copies.



APPENDIX A.

THE ORGANISATION OF HOSPITAL CLINICAL WORK

List of Participants at Conference on 18.3.80.

Dr M E ABRAMS	Senior Principal Medical Officer	DHSS.
Mr D A AITKEN	Consultant Obstetrician and Gynaecologist	Nether Edge Hospital, Sheffield
Prof J R ANDERSON	Professor of Pathology, Western Infirmary, Glasgow	Rep. Royal College of Pathologists.
Mr P C BERMAN	Medical Services Administrator	Federated Dublin Voluntary Hospitals.
Mr P G BEVAN	Consultant Surgeon, Dudley Road Hospital, Birmingham	Rep. Royal College of Surgeons.
Mr M T BLUNT	Asst. Secretary (Manpower Planning)	Trent RHA.
Mr C BRUN	Consultant Surgeon	Blackburn Royal Infirmary.
Dr H CAPLAN	Consultant Pathologist, Highlands Hospital, London N21	Chairman, Enfield DMEC.
Mr D CARO	Consultant-in-Charge, A & E Dept.	St. Bartholomew's Hospital, London.
Mr A K CHOWDHURY	Consultant, A & E Department	Doncaster Royal Infirmary.
* Prof T J H CLARK	Sub-Dean, Medical and Dental Schools	Guy's Hospital, London.
* Mr W G CANNON	Director	King's Fund Centre.
Dr J M CUNDY	Consultant Anaesthetist, Lewisham Hospital	Rep. Central Committee Hospital Medical Services BMA.
Mr G I B da COSTA	Consultant Orthopaedic Surgeon	Shotley Bridge General Hospital, Consett, Co. Durham.
Dr A M DAWSON	Consultant Physician	St. Bartholomew's Hospital, London.
Mrs P DAY	School of Humanities and Social Sciences	University of Bath.
* Mr F S A DORAN	Consultant Surgeon (Retired)	Bromsgrove, Worcestershire.
Mrs R DOWIE	Research Fellow, Health Services Research Unit	University of Kent, Canterbury.
Dr V W M DRURY	Senior Clinical Tutor in General Practice, University of Birmingham	Rep. Royal College of General Practitioners.
Dr P A EMERSON	Consultant Physician (Thoracic Medicine), Westminster Hospital, London	Rep. Royal College of Physicians.
Dr S R ENGLEMAN	Senior Lecturer (Health Economics), Dept. of Community Medicine, Usher Institute, University of Edinburgh	Rep. Faculty of Community Medicine.
Mr M V L FOSS	Consultant Traumatic and Orthopaedic Surgeon, Luton and Dunstable Hospital	Rep. The Hospital Consultants and Specialists Association.
* Dr C GODBER	Consultant Geriatrician	Moorgreen Hospital, Southampton
Sir George GODBER	Formerly Chief Medical Officer	DHSS.
Dr D GOOPTU	Consultant Physician	South Shields General Hospital
Ms J GRIFFITHS	Research Assistant	Unit for the Study of Health Policy, London.
Dr A GRUNEBERG	Consultant Anaesthetist, Mount Vernon and Harefield Hospitals, Middlesex.	Hon. Secretary, Medical Women's Federation.
* Mr D M HANDS	Assistant Director	King's Fund Centre.
Mr L P HARVEY	Consultant in Obstetrics and Gynaecology, Hospital of St. Cross, Rugby, Warwicks.	Chairman, West Midlands Regional Manpower Committee
Dr B HICKS	Senior Lecturer in Medicine, Consultant Physician	Guy's Hospital Medical School.
Prof P M HIGGINS	Department of General Practice	Guy's Hospital Medical School.

* Dr R L HIMSWORTH	Consultant Physician	Northwick Park Hospital and Medical Research Council Clinical Research Centre, Harrow
Mr B M HOGBIN	Consultant Surgeon and Surgical Tutor	Brighton General Hospital.
Dr V M HOLLYHOCK	Regional Specialist in Community Medicine (Manpower Planning)	Wessex RHA.
Dr M C HOLT	Consultant Cardiologist, Croydon General Hospital	Consultant Member of Croydon AMT.
* Dr R B HOPKINSON	Consultant Anaesthetist	East Birmingham Hospital.
Dr L B HUNT	Senior Medical Officer	DHSS.
* Dr P M JEFFERYS	Consultant Psychiatrist	Northwick Park Hospital and Medical Research Council Clinical Research Centre, Harrow
Mr P J JENNINGS	Consultant Surgeon, St. Bartholomew's Hospital, Rochester, Kent	Consultant Member Medway Health District DMT.
Dr G S KILPATRICK	Dean of Clinical Studies	Welsh National School of Medicine, Cardiff.
Mr J M KINGSMILL-MOORE	Consultant Traumatic and Orthopaedic Surgeon, Ashford Hospital, Middlesex	Clinical Member North Surrey DMT.
Dr W LEES	Senior Principal Medical Officer	DHSS.
Dr G B MADDOCKS	Specialist in Community Medicine (Medical Staffing and PGME)	Trent RHA.
Mr R T MARCUS	Consultant Surgeon	Stratford Hospital, Stratford on Avon.
Mr R B MARTIN	Chief Executive	The Hospital Consultants and Specialists Association.
* Dr A MASON	Senior Medical Officer	DHSS.
* Prof I McCOLL	Professor of Surgery	Guy's Hospital Medical School.
Dr S McHARDY-YOUNG	District Consultant, Brent Health District.	Chairman, Hospital Medical Staff Committee.
Dr W J E McKEE	Regional Medical Officer	Wessex RHA.
Dr G P A WINYARD	Senior Registrar in Community Medicine	Oxford RHA.
* Prof D METCALFE	Professor of General Practice	University of Manchester.
Dr N A MILES	Area Medical Officer	Lincolnshire AHA.
* Dr W J MODLE	Senior Medical Officer	DHSS.
DR I MUNRO	Editor	"The Lancet".
Mr R W PARKER	Consultant Surgeon	Hospital of St. Cross, Rugby.
Miss A PERKINS	Principal	DHSS.
Mr G A PHALP	Secretary	King Edward's Hospital Fund for London.
Prof P RHODES	Regional Postgraduate Dean, Faculty of Medicine	University of Southampton.
Dr J RICHINGS	Senior Medical Officer	DHSS.
Dr S ROBERTS	Consultant Physician (Med. & Gastro.), Preston Hospital, North Shields	Rep. Medical Women's Federation
Dr D S ROBERTSON	Consultant Anaesthetist	Hallamshire Hospital, Sheffield.
Mr J M ROGERS	Principal	DHSS.
Dr D H ROSE	Consultant Radiologist	City Hospital, Nottingham.
Prof R W ROWBOTTOM	Professorial Fellow	Brunel University.
Dr J SALEM	Area Medical Officer	Trafford AHA.
Dr N A SIMMONS	Consultant Clinical Microbiologist	Guy's Hospital.
* Dr J E P SIMPSON	Medical Officer	DHSS.
Mr R H STEARN	Consultant Obstetrician/Gynaecologist Poole General Hospital	Consultant Member of DMT.
Dr T K SWEENEY	Senior Principal Medical Officer	DHSS.
* Dr I G TAIT	General Practitioner	Aldeburgh, Suffolk.
Mrs S TAYLOR	Reporter	King's Fund Centre.

Prof O L WADE	Dean of the Faculty of Medicine and Dentistry, The Medical School	University of Birmingham.
Mr J WHEELER	Surgical Registrar, Charing Cross Hospital	Rep. Hospital Doctors' Association.
Dr M WHITE	Department of Surgery	Bromsgrove General Hospital Worcs.
Mr D F WOODHOUSE	Opthalmic Surgeon	Wolverhampton & Midland Counties Eye Infirmary.

* MEMBERS OF THE WORKING PARTY