Scenes from Postgraduate Life

Mobile consultants

Some years ago I was a member of a committee concerned with research in general practice. On the occasion in question we were to interview applicants for a two year, full-time fellowship in research. Before we started, the chairperson, a very distinguished general practitioner, said: 'We must be very careful in assessing the candidates this afternoon; we should ask ourselves why an established general practitioner should wish to give up a secure job for a fellowship such as this'.

In the event we appointed someone who went on to become a distinguished academic, but I was reminded once again of the suspicions we all have about people who kick against security, can't settle, have itchy feet, are looking for greener pastures – and how we expect they must be failures. I was talking to a colleague about a mutual friend who had been a consultant in the NHS, then transferred to a professorial chair, and after a few years gave that up to go abroad. 'What is the matter with him?' I caught myself saying, and yet I have been advocating that consultants should move for years (Paton, 1971) – and in a limited way have practised what I preached.

The trouble is that Britain is too small and homogeneous, and it is also riddled with local (provincial) jealousies. There are repeated calls, for example, for medical schools to provide jobs locally for all their graduates, and what is more, to discriminate positively against those from outside, especially London. (I speak as someone who has spent half his professional life in the provinces; no doubt the discrimination depends which side you're on.) But there is also a more practical problem: standards in hospital medicine have risen throughout the country, so that moving sideways is not likely to result in a different sort of challenge. And there are a limited number of other jobs that the average hospital consultant can do. Some years ago Hamilton & Kopelman (1971) suggested that consultants should be appointed for a limited number of years to one hospital post and would then be at liberty to apply for a more senior post or a more prestigious hospital. Unfortunately the profession is set against what it calls 'sub-consultants', but different grades of seniority (as, of course, there are now) might solve a little of the career problem.

Here is my scenario. A senior registrar would be appointed in his or her early thirties to a hospital which, for whatever reason – deprived area, lack of resources, inadequate staff – did not normally attract too many applicants. Young and enthusiastic (not, as

now, forty, frustrated and time-expired) he or she would continue to take much of the service load and do clinical research with minimal support; there would be virtually no involvement with administration (management). Committees, whatever one feels about their usefulness, are a demonstrable taker-up of professional time. At one of ours recently we debated for a couple of hours the damaging effects on patient care that were likely to follow continuing financial cuts in services. There were 12 consultants round the table, and I wondered idly how many clinics and ward rounds and operating sessions they were missing between them. In a previous clinical incarnation I gave up all my committee memberships – and found that I hadn't got enough to do.

To get back to our new-style consultant, performance would be judged over the next five or ten years by the efforts made to overcome adverse conditions. In his or her early forties there would be the opportunity of applying for posts in other parts of the country and in teaching hospitals, if he or she wished. In their early fifties they could, if they wanted to, give up some of their clinical practice (to the keen young junior consultant) and take on the burdensome duties of management, health authority committees, tribunals, appointments committees, etc., etc., which at present seem to occupy so much of the time of people who perhaps ought to be doing more doctoring.

There will, of course, be the usual moans from a conservative profession about not wanting to move, children growing up, schools, security, spouse's job, etc. But a growing number of individuals have shown that these difficulties are not insuperable. At the hospital where I worked three consultants left during my time to take up other jobs (admittedly abroad) in the middle of their careers. Unfortunately outsiders regarded this, not as a feather in our cap which we thought it was, but as an indication that there must be something wrong with the hospital, which there wasn't.

These days we are obsessed with hospital buildings, most of which are so old that in a monied society they would have been pulled down long ago, or so new that we have difficulty in adapting to them and fall back on finding fault. We forget that it is not buildings but the people in them that matter: the rise and fall of institutions like hospitals doesn't depend on bricks and mortar. Nice as it would undoubtedly be to have everything bright and shiny, we need reminding that it is leadership, enthusiasm, dedication and hard work

that produce centres of excellence. Such qualities are in danger of disappearing under the present unbearable load of frustration, cutbacks and shortage of facilities.

I was a senior registrar in a centre of excellence south of the Thames and got a consultant job in Britain's second city. The commonest questions my friends asked me were 'Where's that?' and 'Why do you want to go up north?' The North of Watford syndrome is still very common among young doctors in London, and as someone who was brought up in

South-East England and enjoys culture, I sympathise. But people do live (and survive spiritually) in other parts of the country, they do have the same diseases, and with increasing resources from RAWP they will perhaps be able to provide better facilities in the future for doctors prepared to escape from London's enchantment. Go north young men and women, and you will, I suggest, be agreeably surprised by what you find.

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References

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