Scenes from Postgraduate Life

Achieving a balance

As a founder member of the Hospital Junior Staffs Committee of the British Medical Association (BMA) in the early 1950s, I wrote a report for one of our meetings called 'The registrar problem'. If the paper hadn't yellowed, its contents could easily be passed off as a summary of present dilemmas. People don't seem to realise that the career problems of junior medical staff were apparent within a few years of the founding of the National Health Service (NHS) in 1948. Some of my friends were worried about competition among too many registrars, others were already time-expired senior registrars with no jobs in sight. The issues haven't changed in nearly 40 years – they have merely become more intractable – and a solution can only be found if the medical profession is willing to act, rather than endlessly argue over solutions which are bound to be contentious.

Efforts over the last 20 years have been confined to tinkering with the system, usually only adding to the difficulties. Unfortunately the Short report (entitled incidentally Medical Education) was *too* radical and appeared at the wrong time: imagine the shock waves in the Treasury at the idea of doubling the number of consultants (was *that* the price to be paid for destroying their power?), and as for getting rid of most registrars and making consultants do the work Its clear analysis of the numbers problem may, however, have done the greatest good by alerting everyone to the seriousness of the crisis. So it would be nice to feel that the present initiative by Barney Hayhoe, the ex-Minister for Health, was sparked off by his Labour colleagues' misgivings about medical staffing in the NHS. At least he seems to have got agreement between health departments, consultants, chairmen of regional health authorities (RHAs) and junior medical staff, which must be a major achievement. And it's fair to say that everyone I've met who has read *Hospital Medical Staffing – Achieving a Balance*, has been favourably impressed. Perhaps because, unlike most official documents, it is a good read; perhaps because, by its own admission, it is a report which stresses general principles. Only when you consider the details on a second or third reading do you begin to be pestered by awkward questions.

The package is essentially in three parts: an immediate injection of 50 new consultant posts each in medicine and surgery (there are at present just over 14000 consultants in the NHS); the creation of a

limited cadre of *Regional* registrars, whose numbers would relate to consultant requirements; and the establishment of an intermediate grade to accommodate those who have lost out on the rat-race for consultant appointments. What is surprising is that such unoriginal suggestions, which have been debated to and fro over the years, should have been accepted so speedily by all parties. Let us fervently hope that it is not a gesture of despair.

Just a few out of many examples will make clear my own misgivings. A contribution of £15,000 a year is promised towards the cost of each new consultant post. Over 1,000 posts are at present vacant throughout the country, the most common reason, we are told, being the desperate need of district health authorities (DHAs) to economise. Last year the respected National Association of Hospital Administrators (NAHA) put the extra cost of a new consultant between £150,000 and £500,000 depending on specialty. How eager will hard-pressed districts be to accept the munificent offer of Hayhoe and his colleagues?

Equally important, especially for those at the top of the training ladder, will be to know what chances they stand from early retirement (no age given) of consultants. For example, there were 249 consultants over 55 in 1984. Will these possible vacancies be available to mop up the 200 plus time-expired senior registrars who are fully-trained, often doing consultant work, and who virtually always obtain consultant appointments if they hang on long enough? Hayhoe *et al.* have an excuse for remaining silent on the scandal of senior registrars because the future of the latter is currently being reviewed by the Joint Planning Advisory Committee (JPAC), but they could have underlined the urgent priority of a solution.

The registrar grade is not only grossly overcrowded but effectively blocked by the delays above. The average age at which registrars obtain senior registrar appointments is around 32, and most of those in the popular specialties have had so much practical and research experience that it is difficult to see what further training they need. The report fails to spell out (by not giving numbers) the radical nature of the solution proposed. Across the specialties only about a third of the current number will be needed for career posts (*Regional* registrars in the present context); the rest are to be reserved for overseas graduates (*District*

registrars). Since a minority of our own graduates will become career registrars there should still be opportunities for them to take District posts, thus allowing for interchange, competition and flexibility. Besides which the fall-off in doctors from overseas suggests that it will not be possible to fill the majority of registrar posts from this source.

The most debated issue in the report is likely to be the intermediate grade. Already dubbed by its detractors as a 'subconsultant' it is important that a proper name for the grade ('specialist'?) be established urgently. Those involved with medical staffing know only too well that there are already a great many doctors – clinical assistants, associate specialists, women with domestic commitments – doing valuable work in the hospital service who are not consultants. In addition, there are appreciable numbers of doctors in senior house officer and registrar grades for up to 10 years and more (for training, so called), who have no hope of becoming consultants. Surely Hayhoe and his colleagues are right to highlight the many exceptions to a consultant-based service, but they should not fall into the trap of producing a subconsultant like the discredited senior hospital medical officer (SHMO). If there were opportunities at all levels for entry from

those aspiring to be consultants and exit from the 'specialist' grade into the consultant ranks, then a convenient cul-de-sac for the destitute could be avoided. In time the 'specialist' grade would have its own structure with incremental salary scales, and be seen as a job which provided self-esteem and job satisfaction. Who knows – in time it might become part of the career structure of the hospital service – middle management, as a colleague suggested.

Maybe the report was right to avoid numbers at this stage; they have so often caused trouble in the past. Instead each Region has been asked to nominate two or three Districts in which the implications can be worked out on the ground. The Minister has said he wants action by next January. As someone whose job it is to help people sort out their careers I hope the profession will match him by a similar commitment.

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Reference

Hospital Medical Staffing – Achieving a Balance (1986)
DHSS.