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The organisation of hospital clinical work

Report of a King's Fund working party

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THE ORGANISATION OF HOSPITAL CLINICAL WORK

Report of a King's Fund Working Party

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We are also most grateful for all those who attended the two conferences organised by the Fund in 1977. Those who attended these conferences gave us valuable advice and criticism and helped to shape the final report.

We would also like to thank all our secretaries who have produced material piecemeal and at short notice. Without their help it would have been impossible to assemble the text and to them we owe our thanks.

Finally a special debt is owed to Graham Cannon and David Hands, without whose help the working party could never have succeeded in producing a report. To them and their colleagues at the King's Fund Centre we also send our thanks.

TJHC

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FOREWORD

From the beginning of the National Health Service there has been uncertainty about the type of medical staffing structure that would best be suited to the needs of hospital practice in the service.

That is not, of course, to say that no thought has been given to this problem. Quite the contrary. But discussion has centred, perhaps inevitably, upon remuneration and status. The conflict between the need for a well designed system of postgraduate experience for future specialists and the generally over-riding expectation of consultant staff for the provision of competent clinical assistance has not been resolved.

This is no cause for wonder since old attitudes die hard. There is, for example, the unwillingness for registrars to be 'shared' between consultants, and for consultants themselves to pool their ward and outpatient resources with colleagues. And the professional care that has been exercised in the choice of hospital posts suitable for registrar training has not always been accompanied by a corresponding identification of the number of consultant vacancies likely to occur in the future.

One of the consequences of the reorganisation of the health service in 1974 has been to give greater emphasis to the role of the hospital in its district setting and as a result to begin to see a somewhat clearer reflection of changing demand in the pattern of its clinical services. However it is only recently that there has been some renewal of discussion about the role and pattern of hospital medical staffing in the future.

In 1976 it was suggested to the King's Fund by a group of younger hospital doctors that it might be valuable to take a fresh look at the organisation of hospital clinical work and those responsible for it. The Fund

felt that an examination of this kind would be useful, particularly since this important subject had been discussed only in the broadest terms at the time of the 1974 reorganisation.

Although the title of this report focuses upon the organisation of *hospital* clinical work, it was agreed at the outset that the working party, which the Fund set up under the chairmanship of Professor Clark, should take account of medical practice both within and outside the hospital setting.

It may be argued that the working party should properly have included representatives of other professions and disciplines since its discussions and conclusions inevitably impinge upon the work of others. But the Fund took the view that there would be much value in first having a collective statement from a group of (mostly) younger doctors about the staffing structure within which they believe that their professional responsibility in hospital can best be undertaken.

In any consideration of this kind, whatever the profession involved, it is the views of the profession itself which must carry the greatest weight, whatever modification may be judged necessary in response to other claims.

It is hoped that the discussion and recommendations contained in this report will have influence for the better ordering of future hospital staffing in this country.

The King's Fund is grateful to all those who have so generously given of their time and interest in the preparation of the report.

GAP

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1. INTRODUCTION

BACKGROUND AND CONTEXT

The working party was established in March 1976 to consider ways in which medical manpower could be more effectively deployed and used. It was decided to make a concerted effort first to look at the fundamental question, *'what does the patient need to have done?'* and from this to tackle the problem of who might be most suitable to do it.

The idea for the working party originally arose from discussions within the Fund amongst some clinicians, particularly amongst a group of senior registrars from different specialities who attended a course at the King's Fund College in 1975.

The first meeting took place in the wake of unprecedented industrial action by junior hospital doctors who were expressing dissatisfaction both with conditions of service in the NHS and the position and attitudes of senior members of the profession. One of the underlying factors behind this complicated dispute was the knowledge that there was an imbalanace between the large numbers of so-called 'training' posts in the profession and the smaller number of permanent consultant posts available in the NHS. A related issue was that many 'junior' doctors were undertaking work which should have been carried out by trained consultant staff.[30]

The re-organisation of the NHS which took place in 1974, exposed opportunities for change which had been obscured by the former tripartite structure of the Service; particularly the possibilities of moving resources between hospital and community and of developing new patterns of care.

In 1975, the Merrison report,[51] proposed new arrangements for the regulation

of the medical profession. These proposals included more stringent requirements for post-graduate specialist education. These changes are being matched by similar developments in other countries. Two of the effects are the limitation of overseas opportunities for British graduates and further restrictions upon the entry to this country of overseas doctors upon whose services the NHS has hitherto been so dependent.

A further complication, following a change in social values and legislation, is the increasing proportion of women entering the profession. This will undoubtedly force radical changes in the organisation of medical practice.

During the last few years there has been concern and debate about the increasing proportion of the gross national product consumed by the health sector in every developed country of the world.[2,79] The relevance of some high technology, hospital based medicine has been particularly questioned. An extreme position has been taken by Illich[64] but searching appraisals of the value of some aspects of clinical medicine have been undertaken by others including Cochrane[10] and McKeown.[71] This broader context, coupled with the more specific changes already mentioned, stimulated the working party to look critically at existing assumptions about the organisation of clinical work and to consider alternative arrangements.

APPROACH AND METHOD

The working party has drawn largely from the experience, ideas and research of its members and has not generally sought 'evidence' from other organisations. The group has no official standing in the NHS and its members are not representative of any specific interests. Most ideas for discussion were raised by one or more of the members and usually presented to the rest of the working party in written papers. These papers were gradually refined and modified and eventually organised into the continuous narrative of this report.

Most of the members of the working party are doctors. This has limited the ability of the working party to comment extensively and authoritatively on some aspects of the subject, particularly in relation to the overlap between the work done by doctors and that carried out by other related professions. However, the main purpose of the working party's work was to examine the ways in which *medical* manpower could be used more effectively. It is hoped that other professions will feel able to respond constructively to the views expressed here.

When the group had been working for about a year, it identified two fundamental areas where emerging ideas needed to be tested. These were, first, the relationship between the work of hospital-based doctors and general practitioners and, secondly, the problems of hospital career structure and medical manpower planning. Conferences were arranged on each of these subjects at the King's Fund Centre in the summer of 1977. Doctors of different specialties and backgrounds, representative of a wide range of opinions, were invited so that the thinking of the working party could be exposed to critical analysis. These conferences were invaluable in helping early ideas to be refined but the responsibility for the conclusions in this report rests with the working party and not with those who attended.

During the last three years the members of the working party have become increasingly aware of the many complications of this subject and of the potential for further research. Much work remains to be done. This report does not offer a detailed prescription for solving every current problem. It is offered as a *strategic framework* upon which further more detailed work might be based. It is hoped that it will help to stimulate and focus debate on a number of crucial issues which must be given urgent attention by the profession and the service. The working party believes that implementation of the proposals in this report will improve the organisation of clinical practice, clarify accountability and lead to better balanced career-structures. These improvements will lead directly to the achievement of the ultimate objective of improved patient care.

2 HISTORICAL BACKGROUND

THE DEVELOPMENT OF THE NATIONAL HEALTH SERVICE

Unlike many other countries with sophisticated arrangements for medical care, there is a major distinction in the United Kingdom between hospital and non-hospital based staffing. Specialist, or secondary, medical care is based in hospitals, and primary care, or general practice, in the community. The reasons for this are complex and mainly historical. There are many good accounts of the development of the present organisational arrangements within the medical profession and the NHS[1,13,27,44,70,74] and so this will not be pursued in detail here.

In 1948, voluntary and local authority hospitals became part of the (then) new National Health Service. Medical staffing structure followed the voluntary hospital pattern of specialists or consultants as opposed to the former local authority 'Medical Superintendent' model. Gradually, increasing numbers of junior supporting staff were appointed to assist the consultants. Primary medical care was provided for the whole community by general practitioners paid on a capitation basis.

The General Practitioner and the Hospital

It is only in the twentieth century that treatment in a hospital setting has been associated with significantly improved results for surgical and many medical conditions. At the beginning of this century, teaching hospital physicians and surgeons usually had a rather select out-patient practice and some of the junior staff in non-teaching voluntary hospitals also worked in general practice. Poor Law hospitals and other municipal institutions sometimes employed GPs on a part-time basis, but, in general, the urban GP became segregated from the hospital during the first half of this century. By contrast, in smaller towns, cottage hospitals developed. These were staffed by the local general practitioners.[1] By the late 1930's about one in five GPs had admission rights to hospital beds. This number was halved in the early years of the Health Service.

Hospital Organisation

With the introduction of the National Health Service, it was agreed that nationally agreed terms and conditions of service should be uniformly applied. The Ministry of Health recommended that all beds should be allotted to the charge of individual consultants. Consequently, the medical superintendents of the former local authority hospitals lost their principal role as the doctor in charge of all beds, and general practitioners were excluded from independent clinical work. In cottage hospitals in rural areas, however, many general practitioners were allowed to carry on as before, because there were no consultants living locally and willing to join the permanent staff.

In 1948 local authority hospitals were providing comprehensive district general hospital care in many parts of the country and these, together with the voluntary and teaching hospitals provided the backbone of the hospital service when the NHS came into existence. Many of the present problems of career structure stem from this time because most hospitals took teaching hospital staffing as the appropriate model. Gradually it came to be accepted that the 'firm' consisting of consultant and supporting junior staff, was uniformly appropriate. This adoption of a staffing system suitable for teaching, in hospitals not engaged predominantly in undergraduate medical education, has contributed to the present unsatisfactory position of imbalance in the numbers of doctors in the so-called 'training' and 'career' grades and an excess of 'junior' doctors in relation to the number of permanent career posts.

The flawed career structure based on the universal application of teaching hospital staffing structures was obscured by the burgeoning need for staff to cope with the rising work-load. The increased work load should have been met by increasing the number of consultants (and general practitioners) but it was satisfied by a rapid increase in junior staff. This met the service need but it also enabled the teaching hospital staffing structure to spread to all parts of the country. The unfortunate consequences of these policies are only now becoming apparent because of the time lag needed for these

developments to work their way through the system and because much of the expansion in the numbers of junior staff was achieved by importing overseas doctors on short-term contracts. The current expansion of medical school output will gradually enable British graduates to fill progressively more of the junior posts. The fundamental fault in the staffing structure, that arose from the seemingly excellent and well intentioned aim of staffing all hospitals as if they were teaching hospitals, therefore needs to be corrected with some urgency.

MEDICAL MANPOWER PLANNING

Medical manpower planning in the NHS has to take account of the annual production of new graduates from the medical schools, retirements and death vacancies, and of the desired pattern of postgraduate training and education for both hospitals and general practice. In theory, it should be simple to work out how many new medical graduates are needed each year making allowances for those graduates who either emigrate or take up employment outside the NHS with the Medical Research Council, the universities, the armed forces, the prison service, administration and industry. However, the more closely problems like this are examined, the more complicated they become. For example, there is no fixed retiring age in general practice. The career plans of the growing number of women graduates are confused. Within different specialties in hospitals, the current age distribution of consultants and, therefore, their expected replacement needs, show substantial variation (see table 1).

TABLE 1 Percentage Age Distribution of Consultants in England and Wales (30 September 1977)

Specialty	No. of Consultants	% -39	% 40-44	% 45-49	% 50-54	% 55-59	% 60+	All
All	12,004*	19.5	19.1	16.5	16.0	15.1	13.8	100%
Paediatrics	452	25.7	23.2	15.0	12.6	13.5	10.0	100%
Mental illness	1,045	16.8	16.9	22.1	21.2	13.3	9.7	100%
Cardio-Thoracic surgery	114	10.5	18.4	7.9	11.4	24.6	27.2	100%

Note: This table shows that by comparison with all specialties together, Cardio-Thoracic surgery has a substantial proportion of retirement vacancies expected in the next five years (27.2%) in contrast with Paediatrics and Mental Illness where only 10.0% and 9.7% respectively of the consultants will retire in the next five years.

* Excludes 10 SHMOS with an allowance

Over the past decade hospitals have relied increasingly upon foreign medical graduates to fill the rapidly expanding junior hospital grades, and yet, if all UK Medical Schools expand their output to provide sufficient graduates to fill all junior hospital posts, there will be permanent career posts for only half of them. This situation and the factors which have fuelled the rapid increase in numbers of staff in training lie at the heart of the present difficulties.

The Medical Schools and Medical Education

The working party studied the several reports on medical education which have been produced since the war. This included the Goodenough report (1944)[47], the Willink report (1955)[46] and, the most recent, the 1968 report of the Royal Commission on Medical Education, popularly known as the Todd report.[94] A range of other literature* on the subject, was also reviewed.

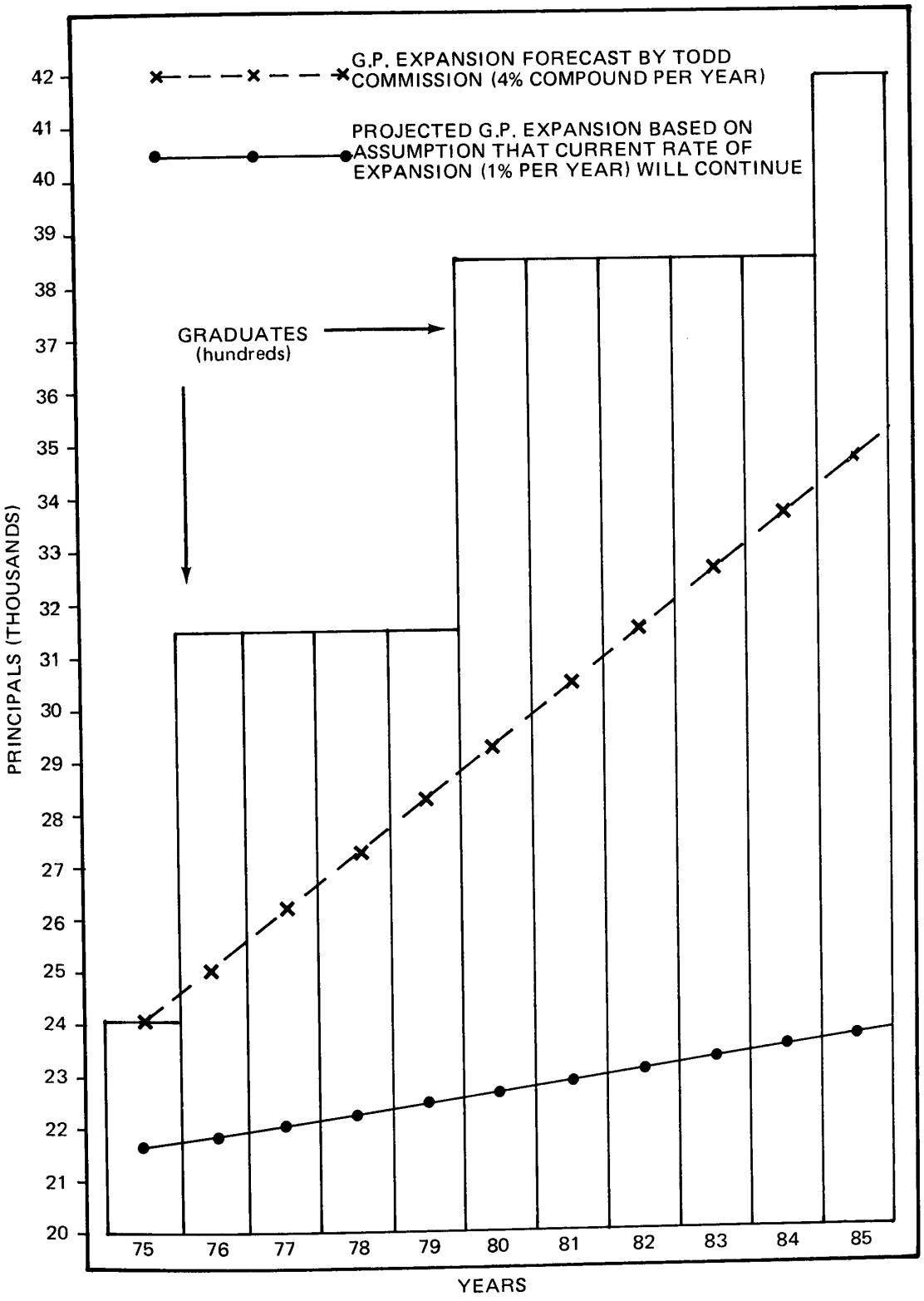
The Todd Commission believed that the projected growth in the population would reach 60.6 million in 1985 and 66.5 million ten years later. They recommended a doubling of British medical school intake from 2,600 per annum (1965–69) to 5,000 a year by 1985–89. One consequence of the commission's recommendations on expansion, including an allowance for an overall 33% loss of each year's graduating class, would appear to be a surplus of almost 15,000 doctors waiting to enter general practice as principals by the 1990's. A doubling of the percentage of women graduates might reduce the surplus to some extent, but a substantial expansion of principal posts in general practice would be required for the remainder. A four per cent per annum (compound) increase in principal posts between 1969 and 1990 would be required. The actual rate of growth in such posts between 1968 and 1957 has been only 1.07%. (See Figure 1)

In the decade 1952–1961 there were only 1,554 retirement vacancies in the Consultant grade; barely half the number needed by the output of the training scheme. Severe bottlenecks developed in the Senior Registrar and Registrar grades, especially in General Medicine and General Surgery. As a result the number of Senior Registrars was reduced by one third. In 1961 the Platt Report [50] found that, without the 3,628 foreign graduates then

* see bibliography

FIGURE 1

EXPANSION OF GENERAL PRACTITIONER POSTS—PROJECTIONS TO 1985



employed as junior hospital doctors, there would be a breakdown of staffing below the Senior Registrar grade. What was true in 1961 is still true in 1978. The service needs of hospitals cannot be met from the 'training' grades.

The Sub-Consultant Grade

A series of reports produced in the 1950s and 1960s,[50,54,55] expressed concern about the service needs of hospitals and rejected the earlier Spens Committee[48] assumption that consultant trainees alone were sufficient. A range of suggestions were made for maintaining hospital needs. All of these committees supported some form of sub-consultant career grade. Other suggestions have included expansion of the consultant grade, importing more foreign junior hospital doctors, use of general practitioners in various capacities and systems of temporary service contracts.

The 'Senior Hospital Medical Officer' (SHMO) grade was discontinued in 1964 on the advice of the Platt Committee largely because the clinical tasks and responsibility proper to the sub-consultant SHMO had never been satisfactorily defined. With the accumulation of experience, members of this inferior grade were often performing tasks and taking responsibility indistinguishable from a consultant. Something similar seems to have befallen the more recently created grade of Medical Assistant.

In their proposals for a sub-consultant grade the Hospital Consultants and Specialists Association (HCSA) have suggested that the work and clinical responsibility of the career sub-consultant grade should fit that of a registrar or a senior registrar in his first year.[62] Unfortunately, because of the lack of a clear definition of 'sub-consultant' work, previous experience suggests that, the distinction between the consultant and even this junior sub-consultant will eventually lessen and the SHMO and Medical Assistant dilemma will recur.[20]

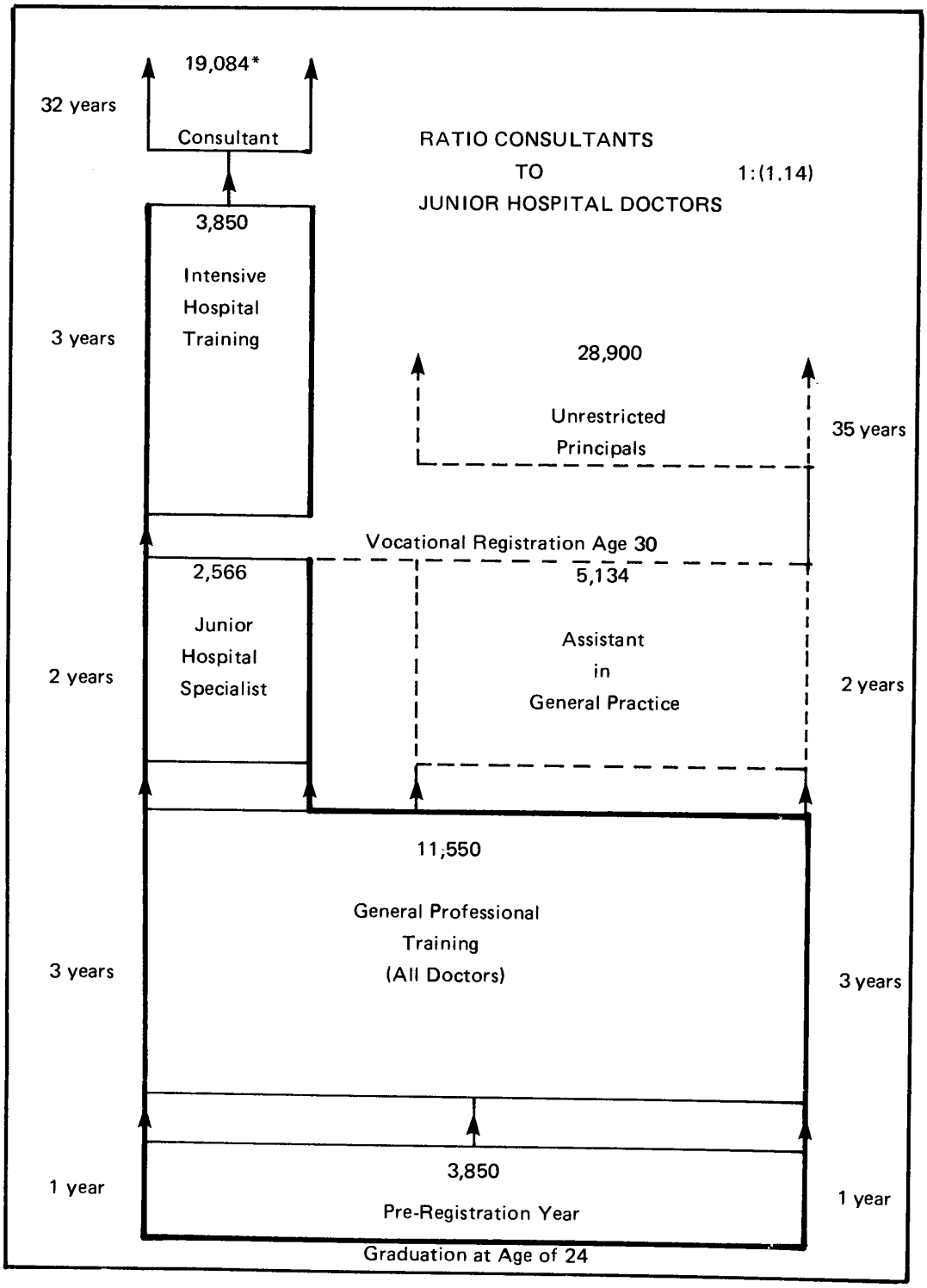
Expansion of the Consultant Grade

In 1969 the Department of Health agreed to expand the consultant grade at the rate of 4% per annum. This would have produced at least one extra

consultant post for every one made available through retirement. At the same time they agreed with the profession to expand junior hospital staff at the lower rate of 2½% per annum until a ratio of 1.3 juniors to every consultant was reached. Experience since 1969 has shown the ineffectiveness of manpower controls at central and local level in implementing this policy. Consultant grade expansion has been less than half the target of 4% per annum and junior hospital staff expansion has been substantially greater than 2½% per annum. Close examination of the 1969 target of 1.3 juniors per consultant shows it to be unrealistic on two counts. First, even with full implementation of Todd vocational training,[94] the ratio rises hardly above 1:1 unless short stay foreign graduates are recruited. (See Figure 2). Secondly, established hospital consultants have consistently employed more junior staff per consultant (Figure 3) and many are claiming to need three junior staff each to run an effective service. The latter pressures have often been difficult to resist in popular acute specialties and have led to a remorseless rise in the number of junior doctors.

FIGURE 2

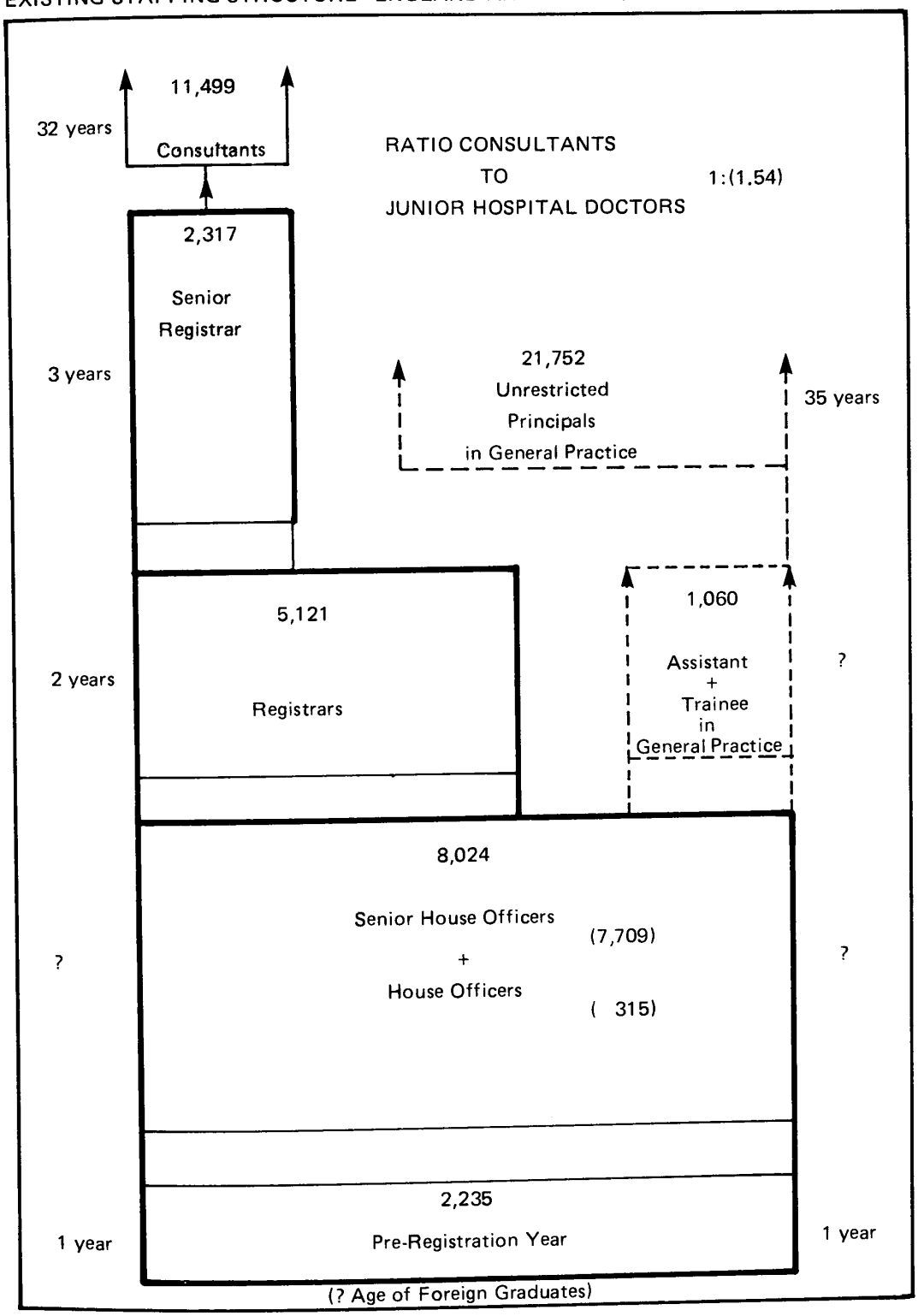
SPECIALIST CAREER STRUCTURE (TODD)—1980–84



* This figure is based on the Todd expansion of the medical schools, not upon the 4% expansion negotiated by the CCHMS, which, based on the 1970 establishment, would produce a figure of between 15–16,000. Even this lower figure will not be reached. In spite of the unrealistic generosity of the larger figure it still presents a severe 'bottle-neck' to the Intensive-Training grade. With 3,850 in that grade, 1,283 Consultant vacancies a year will be needed. To provide that needs either an establishment of 41,056 consultants or an expansion policy of Consultant posts of approximately 10% over 15–16 years.

FIGURE 3

EXISTING STAFFING STRUCTURE—ENGLAND AND WALES (1975)



3 PRINCIPLES AND CONCEPTS OF CLINICAL PRACTICE

PRINCIPLES

The first two chapters of this report show that present patterns of health care and medical organisation owe more to accidents of history and successive crises than to long-term strategic planning. It is difficult to answer the criticism that the distribution of medical work and the way in which doctors are organised have been influenced more by professional interests, financial inducements, rivalries and career aspirations than by analysis of the needs of the patient. Despite the efforts of many working parties, the career structure for doctors still displays a gross imbalance between the numbers in the training and the career grades, and confusion about what distinguishes 'training' and 'service' work.

In order to obtain a clearer picture of alternative and more appropriate organisational arrangements it is necessary to return to fundamentals and to consider the basic (but often overlooked) questions of why doctors and health services exist and what their work is intended to achieve.

First of all, it has to be acknowledged that health services and the work of doctors are not the only (and often not the most important) determinant of personal or national health.[71] However, the broader questions of how society promotes positive health were felt to be beyond the working party's terms of reference, and discussion therefore begins from the present predominant viewpoint that individuals will go to the doctor when they feel less than well.

The needs of such an individual can be (and are) met in a variety of ways. Immediately the question arises whether an individual who feels ill should invariably seek the opinion of a doctor. The individual has the right to do so if he so wishes, although on many occasions advice could as well come from other professionals. Some of the areas in which this might be a serious possibility are mentioned in the next chapter.

Having acknowledged these fundamental issues, it is important to consider ways in which medical care might be better organised *from the patients' point of view.* The first issue is how the prospective patient obtains access to care, or treatment, and whether it might be in the patients' interest to be able to by-pass his GP and have direct access to specialists. The working party concluded that, although the present division of work between generalist and specialist doctors and the attendant referral system from GPs to consultants had arisen through accident of history, it had, in principle, considerable advantages to patients and was the most likely system to lead to a high standard of continuous and appropriate care. The medical profession now has so many specialties and sub-specialties that the generalist doctor is even more important both as a primary physician, and as a co-ordinator of specialist care. Therefore, it was considered that the broad concept of primary and secondary care, and of generalists and specialists, is right and should continue.

Although these broad categorisations of clinical work were felt to be appropriate, the working party did not assume that the existing educational programmes, career and organisational structures, payment-systems or patterns of referral were necessarily the best that could be devised. In many ways they leave much to be desired. The following examples illustrate some of the problems.

First of all, it is well known in theory that, in the referral system, the patient is sent by the general practitioner for specialist advice or treatment to a consultant in the appropriate specialty. Unfortunately, the patient does not always receive the level of specialist care required, partly because of the training requirements of junior doctors, but often for less sound reasons. It is clearly unsatisfactory for a patient to be seen on his first attendance by a junior doctor alone, not only for the patient himself, but also for the general practitioner who has referred him for a specialist opinion.

The patient with chronic illness, such as diabetes mellitus, is often followed up in outpatients but is commonly seen by a different junior doctor at each visit and may therefore receive inconsistent advice. Because of the reluctance

of junior doctors to discharge patients, out-patient departments become crowded with people whose attendance is not always strictly necessary. This is bad enough for the patient but it also undermines the position of the general practitioner. If patients attending outpatient clinics were always seen by *one* consultant, that is, a doctor who is fully trained and entrusted with *full* clinical responsibility, a secure base would be established upon which to build co-operation and trust between doctor and patient and between generalist and specialist doctors.

If the patient's first contact with the hospital is as an emergency case the picture can be even bleaker. Most emergency admissions to hospital are arranged by junior hospital doctors. Few are accredited specialists and there is very wide variation in their experience and abilities. Although they work within the framework of standing orders for clinical practice in their specialist unit, they have considerable freedom in deciding the limits of their competence in diagnosis or management and the occasions on which they should seek consultant help. Inevitably this can result in individual patients receiving less than optimum care. If a higher proportion of hospital medical work were undertaken by accredited specialists, it is likely that the quality of emergency treatment and specialist care would be improved.

The problems so far described can be accentuated when the junior doctor is an overseas graduate because his cultural background then differs from that of the patient and he may have difficulty understanding the English language. Of course, many overseas doctors surmount these difficulties and successfully establish themselves in consultant posts, or general practice, but the general problem remains.

Having identified these weaknesses it was concluded that the following principles should govern medical organisation in the future:

1. That most clinical care whether of a general or specialist nature should be given by FULLY TRAINED medical staff in career posts
2. That ALL of the work of medical staff in training should be closely supervised by qualified and experienced doctors who are clinically responsible for the care given.

These principles exist in theory at present but practice falls short. Ideals are too frequently compromised by the appointment of junior doctors to meet the needs of patient care, rather than by increasing the number of senior posts. If these principles are to be applied in practice as well as in theory, the implications for the organisation of clinical work are far reaching.

There are several ways of re-organising clinical workloads in order to meet these objectives. In the next chapter, the principal options are considered in greater depth. However, in order to avoid ambiguity later, it may be helpful to clarify a number of concepts which are commonly used when discussing medical organisation but which are generally defined inadequately.

CONCEPTS OF MEDICAL ORGANISATION

The basic objective of medical manpower planning and organisation in the health service is to produce, within the resources available at any one time, an equitable distribution of appropriate medical skills throughout the country. This involves production of the proper number of doctors, capable of producing the appropriate quality of work, in the appropriate specialties in the right place, at the right time. There are several variables and conceptual frameworks in this model. Before detailed organisational arrangements can be discussed, a number of general concepts need to be explored a little further. These are:

1. The distinction between the nature (or level) of work performed and the salary-grading or scale attached to that work.
2. Clinical autonomy.
3. Managerial authority.
4. The definition of a specialty.

Each of these will be considered in turn:

1. Level of Work and Salary Grade

Any job has at least six important characteristics:

- The work or tasks actually done
- The place and time at which the work is performed

- The level of personal judgement, skill or capacity required to perform the work
- The prior training involved
- The responsibility attached to it
- The remuneration (including both salary and conditions of service)

Without entering into details of wage determination, it can be appreciated that, in principle, the remuneration of any post should relate to the other characteristics. Examples come easily to mind of particular jobs in which high remuneration is associated with an individual characteristic, but it is more usual for there to be a cluster of characteristics that are significant in describing the work. If one characteristic becomes too dominant, distortions and anomalies occur. This has happened recently in the hospital career structure. Recent negotiations have emphasised hours of work almost to the exclusion of other factors such as responsibility and the nature of the task. This particularly applies to some of the agreements on units of medical time which have been a nonsense in terms of the tasks actually performed.

Discussion about the payment of junior staff are further confused by the variation in practice in duties performed by doctors of nominally identical rank. A doctor graded 'senior house officer' may carry 'registrar' or 'house officer' responsibility and do 'registrar' or 'house officer' work, while a trainee in the registrar grade may receive either general or higher professional training depending on the circumstances of his post. The earnings associated with different medical posts could equate with a number of factors (table 2) but usually the description of expected responsibility, level of judgement, discretion, skill or anticipated attainment remain vague and variable.

Somewhat similar comments can be made for consultant staff. They are facing the same problems over their new contract as those faced by the junior staff since 1976. The content of their work is variable in that consultants sometimes undertake work which neither requires their level of skill or experience, nor merits their level of pay: this they may do

because of preference or through force of circumstance. In terms of responsibility, consultants carry markedly different loads both between and within specialties. This is not overtly recognised by differences in pay, except perhaps as one of the many factors considered by those who make decisions about distinction awards.

TABLE 2 Relationship Between Pay Grades, Responsibility, Work and Training

Grade	Managerial Responsibility	Type of Work	Type of Training
Senior Registrar	Supervisor	'Registrar'	Higher Professional
Registrar	Supervisor	'Registrar'	General Professional Higher Professional
Senior House Officer	Supervisor/ None	'Registrar/ House Officer'	General Professional
Post Registration House Officer	None	'House Officer'	General Professional Pre-registration
Pre-Registration House Officer	None	'House Officer'	Pre-registration

Terms and conditions are entirely different in general practice, but one feature deserves attention, namely, the special practice allowances paid to assist recruitment to unpopular areas. This device has often proved unproductive and it has not so far been used to recruit hospital doctors into unpopular specialties or unpopular districts. Such payments may however become necessary to redress the effect of agreements on units of medical time which have resulted in marked differences in pay between trainees in different specialties, generally to the benefit of the already more popular 'acute' specialties.

These distortions and uncertainties make effective manpower planning very difficult, and have aided in recent years the evasion of controls laid down by the Central Manpower Committee. This unsatisfactory situation is likely to remain as long as posts continue to be described predominantly in terms of level of *pay* rather than in terms of the *kind or quality of work done*, or the *objectives* which a particular post is intended to achieve. The practical difficulties of describing with more precision the work itself or the personal qualities required to do it are considerable but it is important

that it should be attempted, not only in order to avoid intra-professional rivalries and 'leap-frogging' pay-claims, but also to clarify and facilitate the personal and career development of medical staff themselves.

One approach to the solution of this problem might be to separate the concepts of the level or quality of work performed by a particular kind of doctor and the salary grade which governs his pay. If some attempt were made first to describe the kinds of *work* which needed to be done and to define some broad general categories or *levels* of work, it might be possible to use salary grades as the 'fine tuning' within work levels to decide the pay for particular posts. Thus within a broad category of what (for want of a better word) might be described as the 'consultant' work level there could be (say) two or more salary grades which might be applied in different circumstances to reflect the mix of characteristics in a particular job. A similar approach could be used in relation to a broad category of work described as appropriate for a 'trainee'. The attention of the working party was drawn to work which has been done on this problem in other organisations[65] and in the health service [8,9] and some practical possibilities will be explored in the next chapter.

2. Clinical Autonomy

The right to take independent decisions is jealously guarded by doctors and the concept of clinical autonomy is well established in the profession and the NHS. It is justified by the personal and confidential nature of the relationship which the patient generally requires from the doctor, and the responsibility that the doctor takes as a named individual for the care provided.

Decisions taken by doctors in training, or in 'junior' posts may be overruled by their seniors and it is only when a doctor reaches a consultant position, or becomes a principal in general practice, that he fully enjoys the right to take independent decisions and accepts the accompanying responsibility.

The concept of clinical autonomy has been analysed by the Health Services

Organisation Research Unit of Brunel University[9]. Three distinct components have been identified:

(a) 'Binding Professional Standards'

The medical profession, like other developed professions, has evolved certain specific standards and codes of behaviour. These standards are binding upon all members of the profession and upon the employers of doctors. The standards are enforced by the General Medical Council and they serve both to regulate and protect members of the profession, patients and employers.

The organisational effect is that certain *limits* are imposed on those who employ professionals and those who would wish to influence either the work undertaken by the profession, or the way in which it is performed. Such binding standards exist in varying degrees in other health service professions (and in professions generally) but they do not in themselves imply the right to autonomous or independent practice. A member of such a profession may still be managed by senior members of the same profession.

(b) 'Independent Practice'

This is the situation where, even where the practitioner is a full-time employee, he has complete freedom to pursue his professional practice as he thinks best (within available resources) provided he stays within certain broad limits of civil and criminal law, acceptable professional practice, professional ethics, employment contract and accepted norms of behaviour. In this situation, after the training period, the practitioner cannot be managed by others, even if they are members of the same profession or specialty.

This situation arises from the high value placed upon the *personalised* therapeutic relationship between doctor and patient characterised by mutual *trust* and the ability of both doctor and patient to choose both to enter into or dissolve the relationship.

This degree of autonomy may be distinguished from what has been described as *'agency'* service where a professional practitioner of some kind is acting only as the agent of the employing authority, carrying out professional work according to the policies of the employer and the accepted rules of good practice within the specialty. It is the degree of autonomy usually recognised in consultant appointments and principals in general practice.

(c) 'Primacy and Prime Responsibility'

Where a number of practitioners from different disciplines or professions work together in any given setting, one of these disciplines or professions has primacy in the setting concerned if prime responsibility for all new cases automatically rests with one of their members, whatever further referrals they may make thereafter. Primacy always relates to a field of work (and perhaps even to a particular setting). Where health or sickness is the issue, prime responsibility usually rests with a doctor who co-ordinates (or in some circumstances, prescribes) the care or treatment to be given by members of other professions. Questions of primacy can also arise between specialties within a particular discipline, for example when prime responsibility for care passes from a general practitioner to a specialist.

In modern health and social services, where many independent professions now make a variety of contributions, the concept of primacy, and the ability to distinguish the profession or specialty which is prime in any given situation is vital to the protection of the patient's interest. This will be explored further in relation to multi-disciplinary settings in the next chapter.

These conceptual distinctions between the different elements of clinical autonomy are important because of their organisational implications. It can be seen from this analysis that only clinical consultants and principals in general practice are in positions of independent practice. The proportions of the elements of clinical autonomy differ considerably between specialties. Doctors in training grades have

little more than the first element (binding professional standards). Community Physicians do not need to be in positions of independent practice because their work does not involve them in treatment and care of individual patients. Pathologists or radiologists only rarely exercise primacy in patient care. Many psychiatrists, consultants in mental handicap and geriatricians do not give an entirely personalised service: a large part of their patient workload is determined more by geography than by patient or general practitioner choice. Some surgeons have organised pooled waiting lists among themselves for dealing with common minor procedures and may have thus diminished the personal element in this aspect of their practice.

To summarise, therefore, there are many elements which together comprise the concept of clinical autonomy. Full clinical autonomy (independent practice) does not arise automatically merely as a result of registration as a doctor or because a doctor has passed certain examinations and achieved a certain rank. It is an attribute of those medical roles where personal and final responsibility for the care of individual patients is central. The organisational consequences are that, where this requirement is not present, the service concerned may be organised managerially as an 'agency' service. This applies not only to the 'laboratory' specialties but also to some clinical areas and possibly some primary care areas such as accident and emergency services.[84]

3. Managerial Authority

In addition to their responsibility towards patients, many doctors are accountable for the work of other staff. Some posts have a large amount of responsibility for individual patients but little for the work of other staff. Other posts involve substantial managerial responsibilities but little direct responsibility for the care of patients. Many senior jobs include large elements of both.

Most doctors have other staff who work for them and they may therefore have *managerial* authority. The minimal attributes of managerial authority have been defined as: authority to affect the

selection and appointment of staff, to prescribe their work, to assess performance and to apply sanctions including, where necessary, the initiation of the removal of staff from post.[8,65] Clinical consultants will have such authority over doctors in training working for them although the establishment of long term posts involving rotation through a number of clinical departments may reduce the authority of an individual consultant in this respect.

Clinical consultants usually have managerial authority in relation to only two or three individuals, but consultants working working in service departments may have managerial or co-ordinating responsibility for 20-30 health service workers belonging to a number of related disciplines.

Hospital doctors who have not attained consultant status do not have the right to independent or personalised practice although they frequently take prime responsibility for organising the care of individual patients. Because the consultant is in a managerial relationship (as defined above) with each of his medical staff, such a relationship cannot exist between individuals working for him. A registrar is not the manager of doctors in the senior house officer grade. Characteristically, the registrar has *supervisory* authority in that he helps the consultant to assign work, informs the consultant of the senior house officer's progress and assists the SHO with his work problems. As a supervisor the registrar does not carry authority to veto house officer appointments nor to discipline the house officer.[78]

The specific tasks carried out by doctors of different grades in the hospital service has never been clearly defined and there is no consistent pattern. The situation has been further complicated by current manpower policy which has severely restricted growth in the training grades above SHO level but allowed rapid expansion of the SHO grade.

Many consultants consider that, in their NHS work, there are certain tasks which should only be done by subordinate doctors although

it is not clear whether this view is shared by their patients. The nature of these tasks has not been defined, but the consultants' concept of 'non consultant' work appears to include not only resident on call work, and routine technical tasks (for example, the setting up of intravenous infusions) but also more sophisticated work peculiar to individual specialties. The concept of 'non consultant work' seems mainly confined to the acute specialties; in specialties such as pathology and radiology, consultant and non-consultant medical staff tend to do similar tasks.

Among non-consultant hospital doctors in the clinical specialties there appear to be two types of work. 'House officer' work encompasses such tasks as the clerking and ordering of initial treatment and investigations for in-patients, the day to day monitoring of patients' progress, and first on-call duties. 'Registrar' work includes supervision of the 'house officer', duties in out-patients and the operating theatres. The development of these two roles has led to demands that each clinical firm should have separate individuals carrying out each role and each specialty should have both a 'registrar' and 'house officer' on call continuously. The workload sometimes does not justify such provision and many on-call rotas could be reduced without detriment to patient care, if the 'registrar' and 'house officer' duties were carried out by the same person.

4. Specialties

The tendency, in recent years, for major specialty divisions to spawn sub-specialties and the appointment of consultants as either 'generalists' or 'specialists' has not been fully appreciated by medical manpower planners. Confusion is greatest in the medical group of specialties although similar problems occur in surgery and pathology.

The Joint Committee on Higher Medical Training (JCHMT) now recognises eighteen hospital specialties and has laid down training programmes for each of them. It has also defined three different types of consultant post: the general physician, the general physician with special training and experience in a particular specialty and the

specialist practising exclusively in a particular specialty. The term 'general physician' has not been defined by the JCHMT but a useful definition, 'a consultant who deals with acute unselected emergency referrals' has been developed by the Standing Committee of Members of the Royal College of Physicians. The JCHMT has laid down somewhat different training programmes for the generalist with special training and the specialist.

Specialties differ in the balance between specialists on the one hand and generalists with special training on the other. Neurology, dermatology and nuclear medicine, are, for the most part, staffed by specialists who do not deal with acute unselected emergency referrals. Thoracic medicine and gastroenterology, on the other hand, are staffed predominantly by generalists with special training and experience in the specialty.

It has been generally accepted, by the bodies responsible for medical education, that the training of aspiring hospital consultants should be divided into general and higher professional components. In addition to this, all consultants will normally have achieved membership or fellowship of their college or faculty. The postgraduate examination is a frequently forgotten, but important, manpower control. Progress from general professional training to further professional training in most cases requires the appropriate examination passport. Recruitment to the senior registrar grade in anaesthetics is poor, not because there are too few registrar posts, but because so few registrars pass the FFARCS, the passport to higher professional training. Table 3 shows the examinations usually required to enter higher professional training; the minimum time in which they can be obtained; the limit, if any, to the number of attempts; and the number of different specialties available to a passport holder. The number of years in professional training before taking the examination, and the number of attempts at the examination are two manpower planning controls which must be considered in any change in the NHS medical manpower structure.

If the number of training programmes is to be balanced with the number

TABLE 3 Passports to Higher Professional Training

Examination	Post Registration Experience (Years)	Limits to Attempts	*Number of Hospital Specialties Available
FRCS (general)	3	None	7
FRCS (eyes)	3	None	1
FRCS (ENT)	3	None	1
FFA	3	None	1
FFR (therapeutic) Part 1	—	None	1
FFR (diagnostic) Part 1	—	None	1
MRCP	½	Part 1-4 Part 2-6	16 + 1**
MRC Psych	3	None	4
MRCOG	3	5 years after 1st	1
MRC Path Part 1	—	None	7

* Higher professional training in Accident and Emergency Medicine can be entered by obtaining one of a number of higher qualifications

** Responsibility for haematology shared between Royal College of Pathologists and Physicians

Source: Published information of the Colleges concerned

of consultant opportunities, it is essential that more accurate information about the mix of specialist and generalist work in each specialty is made available. Current medical manpower statistics have not been designed to give this information. The specialty of a consultant is recorded according to the entry on his contract; information that frequently fails to correspond to the JCHMT classification. For example, many gastroenterologists are listed as general physicians and senior registrar posts are designated by the work content of the post not by the type of training. Thus a senior registrar post in cardiology might be a four year post in one hospital, training the holder to be a specialist cardiologist; or it might be a year's slot in a rotational scheme aimed at producing a consultant physician with some cardiological responsibilities.

The confusion caused by the inappropriate information system is illustrated in table 4. This shows the number of consultants and senior registrars in general medicine and the five medical specialties with a high proportion of generalists with special experience who were in post on September 30 1977. These figures include holders of honorary appointments but exclude posts vacant on the census day. It is unlikely that these figures bear much relationship to the reality of the day-to-day work of the doctors concerned.

TABLE 4 Staff in Post in Six Medical Specialties (1977)

Specialty	Consultants (Number)	Senior Registrars (Number)
General Medicine	1044	200
Diseases of the Chest*	276	24
Cardiology	94	39
Nephrology	42	13
Gastroenterology	15	6
Endocrinology	8	4

* Includes 4 SHMOS with an allowance

The situation in the surgical specialties is more rational. Specialties such as ENT surgery, traumatic and orthopaedic surgery, plastic surgery, thoracic surgery and neurosurgery are all staffed by specialists. Paediatric surgery and urology suffer from the generalist/specialist dilemma which has still to be resolved.

Apart from the different training requirements, specialties differ markedly in the type of work performed. The two factors which bear most directly on the employment of medical manpower are the presence or absence of a continuing clinical commitment and the level of emergency work. A specialty such as obstetrics and gynaecology requires continual medical cover. A large proportion of the work is dealing with acute situations. Radiology on the other hand, does not have a continuing clinical commitment and the

emergency workload, except in the sub-specialty of neuro-radiology, is light.

In Table 5, examples of the workload in different specialties are demonstrated. Specialties with a twenty-four hour in-patient commitment and a high proportion of emergency cases have the greatest need for medical manpower. It is in this context that the distinction between the general physician with special expertise and training, and the specialist, is important; the former deals with unselected emergency referrals and so has a heavy emergency workload.

Some specialties differ markedly in workload in different health service districts. Geriatricians, for example, may operate as general physicians taking their share of the acute emergencies, or they may act only as second referral doctors, largely admitting to their beds from their acute sector colleagues. The varying work pattern between specialties suggests that a single medical staffing pattern uniformly imposed for all specialties is inappropriate either to meet service needs or to make the most effective use of the manpower available.

TABLE 5 Differences in Workload Between Specialties

Emergency Workload	Continuing Clinical Commitment	
	Usual	Exceptional
Heavy	Obstetrics/Gynaecology General Surgery General Medicine Paediatrics	Accident/Emergency Anaesthetics
Light	Psychiatry Dermatology Rheumatology Neurology Endocrinology	Radiology Pathology Venereology Nuclear Medicine

4. PROVIDING MEDICAL CARE WITH FEWER JUNIOR HOSPITAL DOCTORS

The earlier chapters of this report have traced the development of the current crisis in medical manpower planning and have established fundamental principles and objectives for patient care in the future. An attempt has also been made to establish some conceptual frameworks for the analysis of organisational problems. If the objectives identified in the last chapter are to be achieved, and if the manpower planning bottle-necks of earlier decades are to be avoided, the implications are that the health service of the future will have to function with fewer junior hospital doctors of the kind that exist at present. This chapter reviews the ways in which the medical staffing structure could be adapted to this end. Consideration is also given to some of the ways in which other professionals in the health service may be able to share to a greater degree in clinical care.

MORE CONSULTANTS

It has been shown earlier that if patients are to be assured that, when they are referred to hospital, they will receive care from a fully accredited specialist in fact as well as in theory (and coincidentally, if doctors in post-graduate training posts are to have an opportunity to become established in the NHS at an earlier and more appropriate age than at present, particularly in the acute specialties) a radical change in the balance between the numbers of training posts and established posts will be required. There will be a need for more established specialist posts and only sufficient training posts to provide succession to those established posts. This points to the need to examine again the possibility that there might be merit in having more than one grade of established post available, to specialist, hospital-based doctors.

Pruning of training grades and reciprocal expansion of the consultant grade within the present structure would mean that, on average, doctors would begin work as consultants in their early thirties and be employed

in this grade for in excess of thirty years. Even now there is quite a widespread feeling among younger consultants that the current contract arrangements give them little for which to aim. Certainly there is no higher status they can achieve and movement between consultant posts is generally discouraged. It is true that a proportion of consultants will receive distinction awards but secret financial incentives do not enhance status and the incentive effect is weak because the criteria for obtaining such awards are not defined.

Career progression within established career grades can be achieved in two main ways: either each successive grade can be in a line management relationship (i.e. the 'junior' specialist is managed by the senior) or independent clinical responsibility can be a feature of each grade. If high standards of practice are to be maintained within a specialty, a managerial relationship is the only one which is tenable for any established grade with a level of attainment *below* that associated at present with specialist accreditation. The medical assistant grade is such a grade but the profession has firmly set itself against posts of this type, except on a personal basis, arguing that standards would fall because the NHS would expect too much of its specialist work to be undertaken by doctors employed in the grade in order to effect economy in the salary bill. The history of the SHMO and similar 'sub-consultant' grades reviewed in chapter two, demonstrates that unless there is an 'agency' practice assumption, such positions are not tenable for any substantial period of time.

The interest of the patient in securing personal care from his specialist and the interest of the specialist in securing some form of progression in status and job satisfaction once he is an established employee, might best be served by having more than one grade of specialist within the 'consultant' work level, *each with independent clinical responsibility to individual patients,* the lowest grade being set at the present level of specialist accreditation. Such an arrangement would be likely to overcome two weaknesses which are evident at the present time. First, within a single consultant grade, it is difficult to arrange

for work which makes heavy physical demands on the consultants involved to be done in the main by the youngest people (particularly emergency work at night). Secondly, equality of status of all consultants in any particular specialty may well be failing to ensure that the consultants in a district make the sort of contribution they should be doing in organising comprehensive service provision for their specialty. This is particularly the case if there are any personality clashes between consultants or if none of the consultants happens to possess marked organising ability. The planning of comprehensive services is not one which can be left to community physicians and administrators: it requires specialist knowledge of the specialty concerned. With two grades of specialist, it could be that, in the aggregate, the senior grade would take a lighter clinical load and undertake this co-ordinating role. Theoretically, of course, these problems could largely be covered by a series of contracts within a single specialist grade. However, human nature is such that, until now, little progress has been made along these lines. The introduction of more than one grade of specialist could facilitate it.

In this debate, the patients' expectations must be kept to the fore. In specialist practice a high value is set upon the *quality* of the therapeutic relationship established with the individual patient. To succeed, such a relationship must be based upon independent practice because of the pre-eminent need to establish a voluntarily maintained relationship of trust and co-operation between an individual practitioner and an individual patient. Thus, in considering the relationship between two grades of specialist, it needs to be emphasised that *each* should be in an independent practice position in respect of dealings with individual patients. The relationship between a 'junior' and 'senior' specialist should not be managerial in that there should not be any possibility of a junior specialist's treatment of a patient being over-ruled by a senior specialist. However, as indicated earlier, in chapter 3, it is important to recognise that there are still limits to freedom, even in independent practice.

If there were two or more grades in such a system, one essential difference between the work of the junior and that of the senior specialist might be that the former would be making systematic provision of particular services to meet the needs of a continuous sequence of present problems, while the senior would be ensuring comprehensive provision of these services according to the total and continuing needs for them in the specialty concerned.[9] It is also possible to envisage the appointment of senior specialists identified not so much for this sort of organising role but rather for their ability to pioneer clinical advances or direct research. Extensive clinical experience in independent practice would also seem to be an important pre-requisite for specialists who are designated to train those undergoing higher professional training. Accordingly the supervision of this training might fall to senior specialists. Where there were higher professional trainees, the trainees could be responsible for much of the emergency service of the clinical practice of the senior specialists in the way that senior registrars are today, while junior specialists coped without such assistance. The senior specialists could give an appreciable proportion of their working time to management and to planning, or to special clinical activities, and could act as tutors for doctors undergoing higher specialist training.

Nevertheless, a fair proportion, perhaps 50%, of the time of the senior specialist, would be taken up with routine clinical care of individual patients. It might be that a senior specialist could be accountable to his employing authority in respect of the junior specialists:

1. for helping to select him (either in an advisory role or with the right of veto)

2. for providing advice to him in the specialist field concerned where such was requested

3. for co-ordinating his work with that of other similar participants in the field where necessary.

Promotion to the senior specialist grade would normally be from the ranks of junior specialists who would only be eligible to compete for senior posts after having spent a minimum length of time (perhaps five years) in the junior specialist grade. Such a proviso would ensure that those appointed to the senior posts would be experienced in independent practice while still making it possible for particularly outstanding individuals to gain promotion at a reasonable age, perhaps in their late thirties or early forties. Advisory appointments committees might be expected to look for such things as managerial ability or outstanding contributions to clinical knowledge and the possession of higher university degrees.

The existence of more than one post-accreditation specialist grade would open up the possibility of securing that, once a trainee had completed higher specialist training, he could be assured of established employment within the NHS. This could be done by moving some way from the concept of completely open competition at the time of taking up the first permanent post in the service, an idea which should be more acceptable than it is at present if there were more than one grade within the established specialist workforce. It might then be possible to think of selection for the junior specialist grade taking place when doctors were being selected for higher professional training. Acceptance for this training would then mean that, subject to satisfactory completion, the employing authority would guarantee to make a junior specialist post available. It might be argued that this would inhibit movement between regions, which would to some extent be true for movement between the grades of higher professional trainee and junior specialist. However, reciprocal arrangements could be envisaged which would still permit some movement at this stage. This disadvantage would need to be viewed in the perspective of open competition for posts in the higher specialist grades.

In summary, the need for some formalised arrangement for career progression for established doctors in the hospital service is evident and will become more obvious if an appropriate balance is struck between the numbers in training and in established posts. It is essential to preserve independence in clinical practice in relation to individual patients which suggests that such arrangements can only be contemplated for doctors who have already reached the stage of specialist accreditation. One possibility is a system of changing contracts within the consultant grade as it exists at present, but there would appear to be advantages in having more than one grade of accredited specialist.

As indicated earlier, what is required is a general description for each specialty of what is recognised as the appropriate work of fully accredited specialists with much greater latitude to arrange particular posts on scales within a broad salary range, to suit the requirements of a particular local situation and also to cope with local workloads, training commitments or specialty organisation. Having once gained the rank of specialist in a junior grade, it would be possible for individual doctors to progress to senior posts within the 'specialist' work level, thus avoiding the present 'life sentence' and providing the opportunity for a more varied career pattern and rewards system. The corollary of this arrangement would be fewer staff in the 'training' grades and possibly similar arrangements for a series of different salary grades for trainees.

MORE GENERAL PRACTITIONERS

Any consideration of a redeployment of medical work in hospitals is bound to raise the question of greater involvement of general practitioners in this setting. This, in turn, prompts re-examination of the traditional boundaries between primary and specialist care. The subsidy of an inflated trainee workforce has led the specialist services to accumulate or duplicate tasks better left with the general practitioner. But without it, could, or should, the level of medical cover that has become to be regarded as necessary for in-patients be maintained?

A vital characteristic of the NHS has been its emphasis on the general practitioner as the individual's primary physician. Improvements, particularly over the last decade, in the expertise, training, aspirations and status of general practice, coupled with better organisation and interdisciplinary collaboration, promise to consolidate the responsibility of the primary team for the individual's continuing health care. By contrast, the narrowing range of the specialist, will restrict him to limited spells of technical assistance in a partnership in which the GP should be the principal strategist. Such trends should radically alter the future pattern of specialist consultation, with emphasis on greater availability and dialogue, and restriction of much of the follow up of a traditional out-patient department. Similarly, a greater collaboration by GPs in the management of spells of inpatient care and the preparation for routine specialist procedures (e.g. surgical operations) should increase the efficiency and relevance of their primary care.

In addition to these professional developments, the extension of the GP's work into the hospital has, of course, commended itself to the working party as one of the alternative sources of medical manpower following rationalisation and reduction of the trainee establishment. Formal part-time employment in hospitals is already well established through the clinical assistant and hospital practitioner grades.

At a conference on this topic, held at the King's Fund Centre in June 1977, it became clear that, in many parts of the country, particularly rural areas, GPs are responsible for a wide range of acute and chronic hospital services under the guidance, but not necessarily the control, of local specialists. In some cases these responsibilities have been designated to particular GPs or group practices with individuals specialising to some degree in a particular field, and thus working closely with the specialist concerned. In such settings patients receive a high standard of hospital care, in many cases without contact with the specialist. In other situations, contact with the specialist is limited to crucial stages of the illness or to some technical intervention (for example, an operation). Those who require more prolonged specialist care or technical back-up are treated by specialists in the District General Hospital (DGH) or the appropriate regional unit.

Himsworth has suggested [59] that much of the medical care of patients in the larger DGH could similarly fall within the skills of their own GPs. The place of transfer from GP to consultant care could be inside the hospital, rather than at the hospital gates. However, it is appreciated that the problems of the larger scale (travelling distances, difficulty in co-ordination of staff and bed usage) might preclude this as a practical model of care everywhere. There is, however, considerable experience in the involvement of GPs on a part-time basis as members of specialist teams in a DGH. This model has been adopted more widely in the less acute specialties where general medical cover in many long stay geriatric, psychiatric and mental handicap units is guaranteed by regular brief attendance and general availability of the GP member (s) of the team. It has also lent itself to fields where work can be confined to discrete sessions for which the GP can arrange to be totally committed (for example, anaesthetics or minor surgery) and, in such instances, his contribution may incorporate highly technical skills for which special training and experience have been necessary.

Although the two patterns of involvement referred to above are particularly suited to the urban GP's timetable and offer ample scope for expansion, the working party has also looked closely at the prospects for hospital practitioner appointments in the more acute specialties, where loss of trainee manpower would be most threatening. At the conference mentioned earlier some successful examples of such involvement were described and it is clear that suitable training (in the vocational period through experience in the specialist team) could produce a technical expertise in hospital practitioners to match that of the registrars they might replace. Indeed there might be enhanced stability of patient care and increased efficiency in a clinical team in which each member had his established role and pattern of working, in contrast to the fluctuations associated with the cycles of trainee appointments holding on but temporarily to the consultant's coat-tails.

A hospital team manned by specialists and hospital practitioners could maintain the same medical cover for in-patients now provided by resident staff. Further operational research into the actual frequency and urgency of medical emergencies in hospitals is required to work out

the size and composition of the team for different specialties. With greater technical responsibility being taken by appropriately trained professionals from other disciplines, it is likely that most of the 'emergency' medical cover could be provided by a rota of non-resident members of the specialist team. A skeleton resident staff might then cover the hospital as a whole, being called upon to provide only first-aid in the most urgent situations until the arrival of the unit doctor. This arrangement works adequately in many North American hospitals and private hospitals in the U.K. However, it should be noted that the traditional lines of authority and responsibility within the team would need modification. The hospital practitioner could accept a greater degree of responsibility for his own clinical work than could a trainee, with the specialist's responsibility focusing more on standards, priorities and level of delegation within the service.

A bone of contention at the birth of the hospital practitioner grade has been the question of security of tenure. A clear career structure will be necessary if future modifications are proposed. This would need to encourage the development of training modules as extensions of vocational training schemes (giving eligibility for hospital practitioner posts), but also to allow established principals the opportunity to undergo in-service training on short term appointments. As with consultant posts there would be much to be said, from the point of view both of the individual and the service, if 'permanent' contracts were subject to renewal or modification after a certain interval (say 10 years).

Future patterns of recruitment of GPs to part-time hospital work are difficult to predict but any major increase would be impossible without additional payments sufficient to offset the reduction in list size which will be necessary if hospital practitioner sessions are not to be regarded as a form of overtime. It will also be incumbent on specialists to take a positive attitude to the development of such posts and the training facilities necessary for them.

Although general practice is amply attractive in its own right, part-time involvement in specialist work should add an extra facet of interest and

may help with the problem of keeping abreast of the current technical advances (particularly where members of a group practice have taken on a range of such part-time interests). If we are approaching a period of relative surplus of doctors its impact will extend to general practice with increasing competition for posts and a fall in list size. In such circumstances, eligibility for a hospital practitioner post may come to be regarded as an asset in a potential partner, particularly if his predecessor is vacating such a post. It is clear, too, that such appointments might be more satisfactorily achieved if there were collaboration between the specialist and primary care teams involved.

Thus the much more extensive involvement of GPs in hospitals, bring a number of advantages more important than the initial concern with the problems of manpower. In terms of patient care in hospital the GP would bring a greater stability, maturity and breadth of experience. If the hospital practitioner grade becomes distributed more evenly through all specialties and is drawn from a wider segment of general practice, the diffusion of skills should also enhance the performance of the primary care team. Most important, however, it draws specialist and GP into a number of areas of common interest, which should help to reduce the misunderstanding and duplication of effort which occurs at the boundary between secondary and primary care. Such benefits can only result in better patient care.

SUB–CONSULTANT CAREER GRADES

The essence of the history of the sub-consultant grades has been covered in Chapter 2. In general, these grades have not been found to provide a pattern of clinical care which most of the medical profession believes to be satisfactory for patients, or to offer career satisfaction to doctors employed in them. The reasons for this lie first in the difficulty of the weakness of a therapeutic relationship with patients which is not based upon the principles of independent practice.

The creation of *personal* sub-consultant posts in the medical assistant

grade during the last decade has met with rather more success. Doctors are appointed to these posts only after representatives of the medical profession have satisfied themselves that, for such reasons as failure to obtain higher qualifications, the doctors to be appointed in this way were never likely to be in the running for consultant posts. By employing such doctors in a sub-consultant capacity it has often proved possible to make use of whatever skills they have painstakingly acquired. Although only one sub-consultant grade, the medical assistant, is used in this way at present, it can easily be envisaged that a case could be made out for more than one grade within the 'sub-consultant' work level.

A sub-consultant grade or grades can provide a way of employing doctors on a limited range of specialist work when they are severely physically handicapped, or when, because of compelling domestic commitments, they are unable to devote sufficient time to training or to specialist practice to make it reasonable for them to be employed as consultants. The need to arrange employment for doctors who suffer from psychiatric disorders or who have needed treatment for alcholism or drug dependence must not be forgotten. Adequate supervision cannot normally be provided in general practice but a personal sub-consultant post within the hospital service could well offer a useful niche in which skills would not go to waste. Such posts should carry incremental scales and security of tenure as for consultant appointments. This should not, however preclude the holders applying for consultant posts if their circumstances change (e.g. acquisition of skills and experience, or capacity for further commitment).

The conclusion reached by the working party was that there continues to be a need for a sub-consultant grade or grades, providing that appointments are only made on a *personal* basis after careful professional vetting. The medical profession is understandably anxious that sub-consultant grades should not become a cheap way of employing doctors of consultant calibre and this is particularly relevant to the place in the career structure of part-time women doctors (see chapter 5). At the same time it must be recognised that a proportion of medical graduates is unsuited to fully independent

clinical practice and that a sub-consultant grade in hospital work may be a suitable goal in these cases. The possible risk to the populace of such doctors continuing to drift into general practice (a move which in itself may be more difficult with recent changes in general practice training), is one which the medical profession and the NHS should be unwilling to accept.

SHARING CLINICAL WORK WITH OTHER HEALTH PROFESSIONS

A hospital patient is dependent on staff from a range of disciplines and professions for comprehensive medical care. Over the last decade two major factors have had particular influence on the relative contribution of, and overlap between, different disciplines caring for patients. These are, first, the growing professionalism demonstrated or demanded by a variety of disiplines and, secondly, the increasing contribution of specialist techniques and technology. Both these factors will continue to influence the nature of the work medical staff will perform in the future and the ways in which clinical work will be shared in multi-disciplinary teams.

The range of specific clinical tasks and procedures currently undertaken by medical staff which could be performed by non medically qualified staff is extensive. Nursing staff with specific highly specialised training are the largest professional group now performing tasks previously undertaken only by doctors. Specialist nurses exist in a variety of medical sub-specialties ranging from intensive therapy to behaviour therapy in psychiatric treatment. There are major differences between specialties both in the extent to which tasks which were previously seen as medical are undertaken by other health service staff, and in the degree of discretion and clinical autonomy exercised by them.

In acute specialties a number of tasks which were once exclusively performed by doctors are now carried out by nurses, technicians and paramedical staff. Technical procedures such as electrocardiography, pulmonary function tests, and venepuncture are frequently done without medical supervision. Much of the administrative work involved in a

patient's admission, hospital stay and discharge can be competently controlled by administrative or clerical staff. Specialist clinical nurses in midwifery and intensive therapy units and, more recently, in developing sub-specialties such as oncology, often exercise considerable clinical discretion. They commonly carry the clinical responsibility both of initiating certain treatment and of deciding when medical intervention is required. Senior paramedical staff such as occupational therapists and physiotherapists tend to have access to their services controlled by doctors, but have considerable discretion in the management of patients once referral has been made.[60]

In the specialties concerned with the care of the elderly, the mentally ill and mentally handicapped there has been particular emphasis in recent years on multidisciplinary team work with consequent modification of traditional medical tasks and overlap between disciplines. For example, initial assessment of patients experiencing short-term acute medical or psychiatric problems may be undertaken by trained nurses, social workers or medical staff.

It is the view of the working party that the services capable of offering the best patient care are those in which the issues of responsibility, status and team work are understood and resolved satisfactorily between team members. Medical staff traditionally have high status but do not automatically have authority over the clinical work of nurses or paramedical staff. The next two decades are likely to see more disciplines in hospital practice moving from subordinate or semi-independent positions (in relation to medicine) to seek independent professional standing. Major problems will arise if medical staff fail to agree and accept the degree of professional autonomy sought by other disciplines or professional groups.

The emergence of clinical psychology as a discipline which has sought independent professional status illustrates many of the organisational problems to which doctors need to adjust in the context of multidisciplinary team work in the future. The Trethowan committee

on the Role of Psychologists in the Health Service[36] examined, in detail, interprofessional relationships and responsibilities. Part of the discussion in this Report is quoted in full because many of the issues apply to other disciplines:

'Like that of any other profession, the role of psychologists is continually evolving . . . . . the professional status of clinical psychologists in the National Health Service should be fully recognised and should be reflected in the organisation of their services. Thus, psychology should not be regarded as an adjunct of any other profession and psychologists should be recognised as constituting a responsible group having specific skills to contribute to patient care in co-operation with the other professional groups concerned.

'At the same time the work of any group involved in the care of patients has to be considered in relation to the patients' needs as a whole . . . . . We fully recognise that, for any patient under treatment in the NHS, there is a continuing medical responsibility which cannot be handed over to any other profession. If psychologists are to be seen as having an independent professional status, it is essential to consider how this is related to the principle of medical responsibility which is exercised by the medical profession alone.

'It seems to us that the only way in which these two principles can be reconciled is through multi-disciplinary teamwork. We are aware that this is a growing practice and obviously generalisations about it should be put forward only with caution. But, as we understand it, multidisciplinary team work implies the mutual recognition, by the members of the different professions concerned, of a shared responsibility of patient care. This does not, we must emphasise, mean that every decision affecting a patient will necessarily be a team decision. Each profession has its own sphere of competence and its members are responsible for their decisions within that sphere. They are also individually responsible for recognising the limits of their own competence and enlisting the involvement of their colleagues when

this becomes necessary. The decisions which involve the team as a whole are those concerning the patient's care as a whole which involve a choice between different forms of professional intervention.

'There is thus a distinction between independent professional status, as we have defined it, and full clinical responsibility which in the NHS can be exercised only by certain medical practitioners (consultants and general practitioners, depending on whether or not the patient is receiving hospital treatment). Professional independence within a team setting clearly does not imply an absolute hand over of responsibility from one member of the team to another . . . . . .' *

Many professions in the NHS can legitimately aspire to a certain degree of autonomy but for most this will not extend to full clinical independence. Although doctors will in many circumstances retain primacy, they need to accept novel ways of sharing clinical tasks and responsibilities. The nursing profession is particularly likely to develop more specialist practitioners and new definitions of nursing roles over the next decade which will require adjustments in practice and policy by medical staff.

CONCLUSION

Any of the changes indicated in this chapter would be likely to improve matters and help to achieve the objectives set out earlier in the report. It is unlikely, however, that any single change will, by itself, be adequate to resolve the serious manpower problems which exist. Progress will depend upon a successful blend of the policies outlined here.

The most pressing need is to reorganize the hospital - based specialist staffing, with the establishment of more consultant posts and the

*The distinctions made here between 'independent professional status' and full clinical responsibility' bear some resemblance to the concepts of 'binding professional standards' and independent practice' considered in Chapter 3.

introduction of more than one grade of consultant. This should improve patient care and help to resolve medical manpower bottle-necks in hospital work.

Such reorganisation within hospital specialties needs to be linked with changing patterns of general practice. The hospital practitioner grade and other forms of GP involvement in hospital work can help hospitals to cope with clinical workloads but this development ought to be seen in the context of a more fundamental need for change in the boundaries between general and specialist practice. It is no longer adequate to think of 'specialist' work as synonymous with 'hospital' work. The changes suggested are likely to reinforce the quality of both general and specialist practice.

Additionally, there will continue to be a need to offer, to some doctors, career posts of limited clinical responsibility. Because of the nature of general practice this can best be done within hospitals. However, such sub-consultant posts should not be regarded as contributing more than marginally to the resolution of the current medical manpower crisis. There is still scope for extending the role of members of professions who share with doctors the task of caring for patients. The working party has not felt able to comment authoritatively on further moves in this direction but several examples and desirable trends have been mentioned.

5. ISSUES TO BE RESOLVED

It has been the purpose of this report to define a broad strategy for the development of medical organisation during the remainder of this century. In proposing the changes set out in the last chapter the working party is fully aware of the many pitfalls that lie ahead. Experience with other major changes in the service over the past few years suggests that an evolutionary development towards the goals identified here would be preferable to sudden and dramatic changes, but a great deal of detailed work needs to be done, both nationally and locally, to move in the directions indicated.

This chapter highlights some of the nettles which must be grasped early on by the profession and its planners. The first is a basic theme of this report, the clarification of what is meant by 'consultant', and 'subconsultant' work, and the appreciation that the latter may play only a limited part in the training of consultants of the future. Secondly, the increasing proportion of women among medical graduates, only a few of whom can fit the model of continuous full-time commitment that characterises the present hospital career structure, demands that greater flexibility in both training and career grades is encouraged. If general practitioners are to play a larger part in hospital work (with vocational training keeping them longer in hospital, and with the proposed expansion of the 'hospital practitioner' establishment) the training they are offered must be more appropriate to their needs. Finally, the implications of these proposals for the pay of doctors working in hospitals must be recognised.

THE IMPACT OF THE RATIONALISATION OF SPECIALIST TRAINING

In the more acute specialties in particular there is no doubt that the streamlining of training grades will throw much more work on to consultants. Although a corresponding increase in the consultant establishment is envisaged, the profession will have to adjust to a

broader definition of what is appropriate work for a consultant. That there is no hard and fast definition under present circumstances is evident from the wide scatter of activities subsumed in the roles of consultants in different specialties, and even within specialties, Indeed, a consultant whose work spans both NHS and private sector will, in the latter, often involve himself in tasks that he would automatically delegate to his juniors in the team structure of the NHS.

Surgery exemplifies well the problems that will be involved when such delegation is no longer feasible. A member of the working party, Mr Doran, has analysed the distribution of surgery between consultants and trainees in the West Midlands region and has shown the extensive overlap in their respective spheres of activity.[20] Although consultants monopolised the more complicated cold surgery their juniors did almost all the emergency operations at night, usually with little or no direct supervision. With this specialty no longer able to rely on a workforce of relatively experienced SHOs, this emergency work will fall heavily upon consultants. This is certainly, however, an aspect of the redistribution of work which is likely to improve patient care. Doran has produced another paper which demonstrates how many consultant appointments would be needed in general surgery to get through the work if the number of registrars (both grades) were to be reduced to that required to fill the vacancies of retirement and premature death. *

If the principle is accepted that the service work of hospitals should not depend on trainees, recent efforts to redistribute registrars to peripheral hospitals are clearly ill-conceived. Specialist training must inevitably become confined to a limited number of hospitals chosen for their capacity to combine good teaching, a sufficient range of clinical experience and a co-ordinated (and rotating) training programme. Consultants and hospitals involved in such programmes will need to regard them as a responsibility, a stimulus maybe, but not a source of extra pairs of hands. In this respect it is hoped that such schemes will tie in to a greater extent with the individual's longer term

* A copy of this paper is available, on request; from the King's Fund Centre.

career plans, with senior registrar training frequently taking on more of a proleptic character.

It is likely of course that the more technical specialties, such as surgery, will continue to attract postgraduate students from overseas. There will need to be a shift, however, to short term training posts over and above those necessary to replenish the consultant establishment. In order that these, too, are not used to prop up the service workload, it would be desirable that such trainees should be predominantly sponsored from outside the NHS (on fellowships from their own countries, the British Council, etc.) The less technical, and often more 'culturally-bound' specialties (e.g. geriatrics, psychiatry) would have much less to offer on this sort of basis, in contrast to their heavy dependence on overseas graduates at present.

The establishment of this rather more healthy basis for involvement of overseas doctors in the NHS is more likely to be attractive to those who have been unhappy about the situation that has prevailed hitherto. For those who are already working in this country it is unlikely that prospects for training and promotion will change drastically. It is, however, important that those who have not yet embarked on specific training programmes, or those contemplating immigration, should be aware of the dwindling chances of permanent careers, or of prolonged occupancy of training posts, in this country.

PART-TIME TRAINING AND THE EMPLOYMENT OF MARRIED WOMEN

It is undoubtedly a weakness of the working party that its membership has not included a woman doctor with experience of the problems of combining a medical career with the rearing of a family. The group is well aware, however, of the great wastage and frustration that has resulted from the failure by the NHS (and the medical profession in particular) to keep such people efficiently employed in medicine. At the Sunningdale Conference on Women in Medicine in 1975 it was noted that,

of the 22 percent of medical graduates in this country who were women, one third were not working as doctors. Part-time work in hospital specialties had been particularly difficult and only 8 percent of consultants were women.[39]

Despite the pioneering work of the Oxford region, the tentative support by the DHSS for part-time training posts[33] and the Women Doctors' Retainer Scheme[40] it is still difficult to remain in hospital work while having children, or to return to it afterwards. Exceptional ability or drive has often been necessary and the specialties chosen have usually been those with recruitment problems and those most obviously suited to sessional work. Tied geographically, such women have often had great difficulty finding career posts suitable to their training and ability, a frustration that was apparent in the findings of a working party of the Royal College of Psychiatrists in 1977.[93]

Removal of discrimination against women in selection for medical schools is resulting in a rapid rise in the number of women graduates. This is likely to reach 35 percent in 1980 but, with some medical schools now up to 50 percent, that proportion will go higher still. The NHS cannot afford an equivalent rise in the wastage of those who elect to have families. To avoid this it becomes a matter of urgency to establish a career structure which allows for a period, or periods, of very restricted involvement while children are young, followed by a gradual but variable increase in commitment. Because geographical mobility will be common in the early years of marriage, such training posts will need to be personal and transferable from area to area with the holder. Conversely, by the completion of such training, most married women are tied geographically and it will therefore be important for authorities to anticipate the need to offer suitable local career posts in their manpower planning. Matching the individual needs to those of the district will clearly be a complicated matter, and will necessitate counselling of trainees in their choice of specialty and their likely ultimate level within it. There would obviously also be some onus on the trainee to try to anticipate her likely future level of commitment (in time and responsibility) and to modify her

aims and training to meet the constraints of the local and national manpower situation.

A much higher yield of consultant appointments from these part-time training posts than occurs at present must be achieved, with sub-consultant grades to harbour only those unsuitable for promotion to consultant posts, or those deliberately choosing to restrict their training or commitment. These exceptional sub-consultant posts should carry security of tenure, an incremental scale, and the option of adding sessions subject to local manpower needs. Although a substantial number of women will no doubt wish to take such posts, it must be reiterated that we cannot afford to continue the wastage and frustration of underemploying women of consultant calibre in them.

If the arguments in this report for reducing the service dependency of hospitals on trainees are heeded, many of the profession's reservations about part-time training would be removed. The value, in training terms, of full-time work and residency in house officer and SHO posts (through which all graduates have to pass) will need to be reviewed. This will also apply to some of the hoops through which trainees have to pass in some of the acute specialties, particularly in surgery. There are certainly many fields traditionally less popular with men (geriatrics, psychiatry, anaesthetics, pathology) which are particularly suitable for part-time work, or to which women may bring special aptitudes and insights. The more acute specialties lend themselves less well to the part-timer (or the person whose capacity for full time work may only return later in life), but there may be some very suitable niches in branches of surgery and some of the high technology fields. In the latter respect the Colleges must again distinguish between the *real* training requirements for branches of their specialties and the need for pairs of hands for basic work. Should obstetrics and gynaecology remain one of the hardest fields for the doctor with personal experience of child-bearing to enter?

There is clearly no simple way of matching the specialty choice of part-time trainees with their ultimate appointment to permanent career posts.

The original choice may have been made in a different place and at a time of very different recruiting needs. Thus trainees will need careful counselling, not only at the outset, but as their training proceeds, and they may need to modify their plans accordingly. Local manpower planners will need to be closely involved in this dialogue if the career openings are then to be available. For women settling firmly in an area and matching their needs to local requirements there should be a firm obligation on the employing authority to find the appropriate permanent post. It would obviously be less easy to guarantee a consultant post for those less firmly committed within an area, who would probably need to settle for specialties likely to generate sessional work. There should be less of a problem finding posts in a sub-consultant grade which could be interchangeable with the pool of part-time hospital posts for general practitioners.

With increasing numbers of doctors coming through to consultant posts from part-time training schemes in this way, it is clear that the tradition of advertising all consultant posts as full time and in open competition will have to be abandoned. As much as a third of all consultants appointed could eventually be clinically part-time and, within some specialties, this proportion would rise much higher. Furthermore, it would be very important to build in to the arrangement the expectation that further sessions could be added, subject to agreement with colleagues, as domestic commitments decreased. Bearing in mind the prospective nature of many of the training posts, the part-time sector will really need to be identified separately from the point of view of local and national manpower planning. On the national level there may be a tendency for women doctors to cluster around university centres and in the south of England. This may exacerbate the difficulty of recruiting consultants to less attractive areas and may strengthen the argument for financial and other inducements to doctors to work in them.

Although this suggestion may smack (to their colleagues) of feather-bedding the married woman doctor, it will undoubtedly remain much easier for the non-child-bearer to persue a career in medicine. Part-time training

is at present hard work and, with no tax concessions for domestic help, poorly rewarding financially.

Some male doctors have been anxious at the prospect of exclusion from consultant opportunities by local aspirants from part-time training schemes. Better career counselling, pruning of the trainee establishment, and expansion of the consultant grade should modify this threat. The men from the present bulge of male graduates should reach the consultant ranks well before their housewife counterparts. There is also likely to be a fall in the number of consultant posts going to candidates from overseas. The sooner the number of part-time appointments is expanded, the sooner these will generate a supply of retirement vacancies. Eventually, the part-time consultant sector will reach a point of equilibrium.

In summary, we are entering a period of increasing female medical graduation which ought, eventually, to account for about one third of our medical force (in terms of sessions of career grade employment). No such yield on the £30,000 investment of a medical training will be obtained unless the training and career outlets for married women doctors are drastically improved. The working party's proposals to relate trainee establishments and workload to training needs, to expand and develop more flexibility in the consultant grade, and to encourage part-time work in hospitals, would greatly facilitate this. Special attention will have to be paid to the career counselling of women doctors, to the effects of geographical restrictions on their training and ultimate career appointments, and to the need for flexibility in their sessional commitment. These doctors should not be regarded as fodder for the undesirable specialties and sub-consultant grades. The colleges, employing authorities and the rest of the profession will have to recognise (as this all-male working party has had to) that it is in their interest that these women doctors should in future be able to work within medicine to their full potential.

It has not escaped the working party that there will be many instances where such facilities for part-time training and employment would also be appropriate for male doctors. These might include those whose wives have heavy professional commitments (even shared posts for medical

couples), doctors whose careers have been limited by disability or illness, or those for whom a late change of specialty is desirable for personal or strategic reasons.

Finally, it needs to be stressed, that women in medicine will not, cannot, and should not provide an escape route from the self imposed problem of career structure. Female graduates will want a career structure to meet their special needs fully recognising that they will not accept a longstay sub-consultant role and will wish to devote almost as much time to active clinical work as their male colleagues.

IMPLICATIONS FOR TRAINING IN GENERAL PRACTICE

The essential change recommended by the working party is that the number of career posts in hospital should be greatly increased while the number of junior hospital 'training' posts should be reduced so as to match them to the predicted vacancies in career posts either in hospital or general practice. Such a solution implies that much of the work now done by junior hospital staff would be done by doctors holding career posts of one sort or another. It is anticipated that a significant section of this work would be done by general practitioners taking part-time appointments in hospital. If this is to be achieved the future general practitioner will need to be trained not only for general practice, but for any field of hospital work that he may undertake. In trying to anticipate the implication for the training of general practitioners of the working party's proposals it is helpful to separate basic training for general practice from any further training the GP may undertake for specialist for specialist work in hospital.

So far as his basic training is concerned, the future GP requires a certain minimum experience in training posts in hospital. There is, as yet, no precise agreement about the content of that training but a general agreement is expressed in the new regulations for vocational training. It must be emphasized, however, that these vocational training posts will differ from those vacated by the rationalisation of the specialist training in their distribution

between specialties, their training requirements and the expertise of their occupants. These will generally be rotating posts, with specialties such as geriatrics, psychiatry, dermatology, paediatrics, ENT and accident work most in demand. Medicine and obstetrics will usually be included. In each instance it will have to be remembered that the training content should lend itself towards the work of general practice rather than that of the particular specialty.

The tightening of academic and training standards for entry to general practice is likely to standardise the route to principal status in a way similar to that to consultancy. This will favour an early choice of general practice as a career though it is hoped that the vocational training system will allow flexibility for the late decision, not least because it may prove an important source of doctors wishing to combine general practice and hospital work.

It must be emphasised, however, that the NHS and the profession can no longer afford to regard general practice as an appropriate niche for a low calibre doctor. It offers too much room for unsupervised error. Such doctors should be encouraged to remain within the hospital sector.

The training of general practitioners for specialist work in hospital is best considered as a subject in its own right. Some GP trainees will develop a clear interest in a hospital specialty in their basic training, but most will not. They are more likely to develop this interest later as a result of practical experience and local opportunities when they are settled as principals in general practice. If these new general practitioners are to be brought into hospital work it is very important that the right kind of training and career posts should be available. The kind of training needed is very different from that of the future consultant. It will need to be based much more on informal arrangements between an individual GP and a local hospital department. There will, however, have to be a suitable structure of posts to make this possible.

Such a structure should start with a post that is essentially for training rather than to meet a service need. A variant of the Clinical Assistantship could be used in this way. This could be followed by a post which filled a service need but was of limited tenure. Finally, a post is needed that offers security of tenure to a GP who is wanted by a hospital department and has proved his competence. Security of tenure is necessary if the general practitioner is to commit himself and his practice to the work involved. The present Hospital Practitioner grade alone is too rigid to offer the general practitioner this sort of re-entry to hospital work. GPs' must be provided with the specialist training they need and hospital departments must be able to be sure that the doctor they appoint with security of tenure is going to prove suitable for the post.

THE PROBLEM OF MONEY

The working party's proposals to streamline the training of specialists, to appoint consultants at a younger age and to increase the number of consultants and general practitioners will probably cost more money and alter radically terms and conditions of employment. However, unless widespread medical redundancy were contemplated, much of the extra cost must have been anticipated with the expansion of the medical schools and the career pattern suggested by the Todd Commission. Only the impact of these changes on the financial expectations of the different groups of doctors working in hospitals will be considered here. First, it is worth considering some of the criteria by which medical pay has been governed.

Traditionally the major determinants have been seniority and length of training, as evidenced by the very long incremental scale of doctors in the hospital specialties, seniority payments in general practice and the inter-specialty differentiation of the distinction award system. The various item of service payments, the recent introduction of overtime payments for junior staff and the re-negotiation of the consultant contract have produced a variable loading for heavy or inconvenient work. The 1966 changes in general practice remuneration, on the other hand,

attempted to use pay as an inducement towards better standards or patterns of practice. Finally the introduction of the Hospital Practitioner grade can be seen as a way of persuading doctors of senior status in one field to take on less 'senior' work in another field by offering 'senior' rates of pay. The medical profession will need to accept the relevance of all these factors as it faces the implications of this report.

It has been emphasised that more work will fall on the shoulders of consultants, although it is proposed that this should be offset by an increased establishment. Much of that extra work, however, will be irksome either because it comes at unsociable times or because it is work which has previously been regarded as 'junior'.

It would be unlikely, however, that consultants would offer to take a lower rate of pay for this 'dilution'; indeed the more direct on-call commitment would be seen as grounds for an increase.

Different types of consultant contract have been suggested and it may well be that these should vary in their earning potential, although not necessarily as envisaged in the contract under negotiation at present. The option of a senior grade of consultant has also been raised, although if this implies a pay differential, some of the problems of the Salmon structure in nursing will need to be avoided.

The conflict between the 'pay for the man' and the 'pay for the job' has already been clear in the reaction to the introduction of the Hospital Practitioner grade. There has been resentment that this brings the rate of pay well above that of the ineligible part-time women doctor who may, nevertheless, be doing identical work, or close to that of the consultant with his greater training in the field. It has to be accepted however that if a GP is to give up time from his practice (as opposed to 'moon-lighting') he must be paid at a rate which compares favourably with that, and which will offset the cost to the practice (in terms of overheads and under-utilisation of ancillary staff and plant in his absence). Indeed,

ways in which extra reward can be made for particular skills and contributions developed in such posts may need to be examined.

These comments should not prejudice the case of other part-time workers in hospitals. Clarification of the criteria for permanent sub-consultant posts would make it easier to ensure that these carried with them the security and conditions of service of other permanent posts. This would leave clinical assistantships for purely temporary use as suggested earlier.

Finally, the financial implications for trainees must be considered. The workload of the very junior doctor in hospital has not been precisely defined in this report but the future specialist trainee should not need to work the long hours of his predecessor. The present system of overtime payments for junior doctors arose from the profession's failure to recognise the real financial hardship engendered by its archaic system of differentials. The working party's proposals for much earlier consultant appointment will help, but, if the loss of overtime is not to be a serious stumbling block to acceptance of an improved system of training, the basic salaries for trainees will need to be substantially increased.

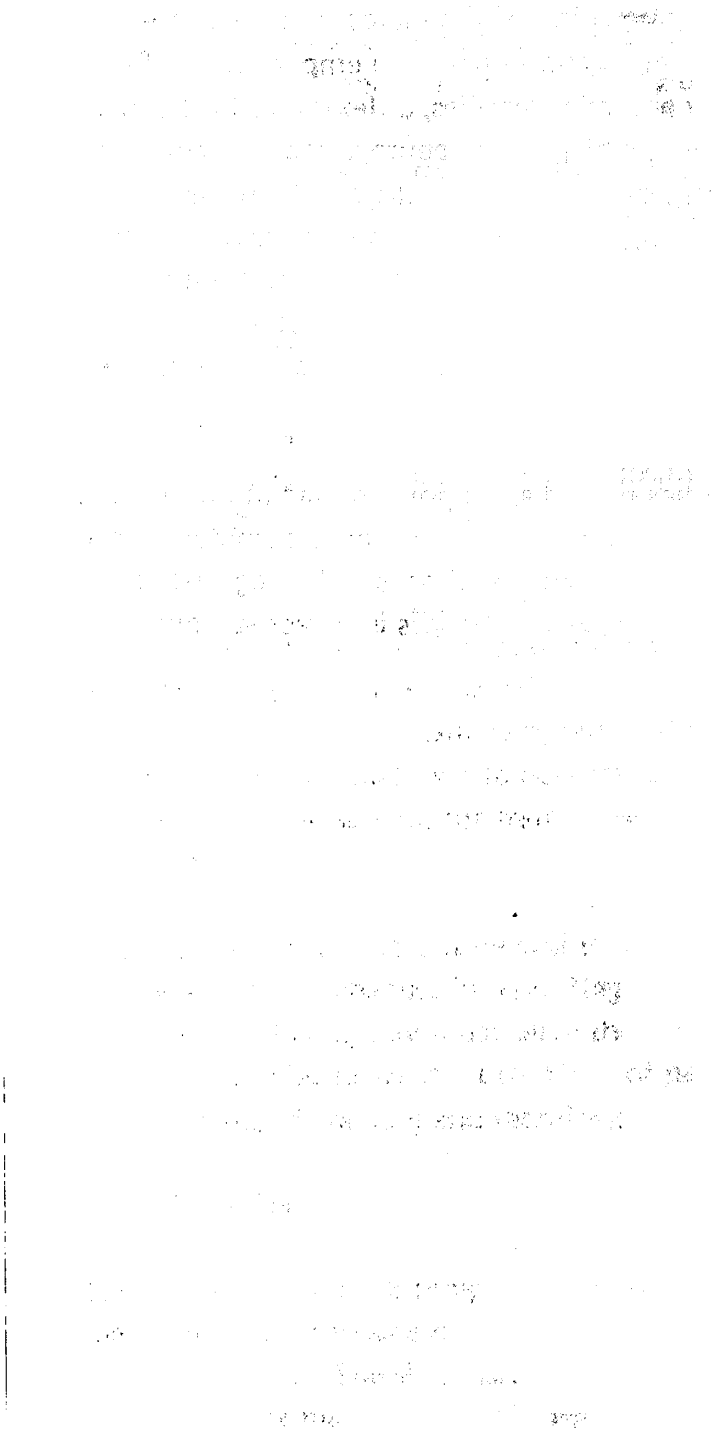
Any change in career structure will therefore have to be accompanied and facilitated by changes in pay. Negotiations about both will need to go hand in hand. Pay must serve the needs of a career structure which in turn should be subservient to needs of patient care and the professional requirements of training and recruitment into specialties.

CONCLUSION

The previous chapter attempted to set out some of the options open to the profession to escape from the problems of the present medical career structure. The signposts in this chapter have more to do with identifying the major minefields along that route.

The importance to this whole discussion of the increase in the proportion of women among medical graduates has been emphasised. With many of these likely to marry and raise families, a flexibility in the manpower structure must be created which will encourage them to continue training and later establish careers in hospital medicine. If this is not done, the wastage of the past will be multiplied. These considerations should also apply to male doctors who may need to wish to train or re-train on a part-time basis. Once again, the vested interest of hospitals; in developments in the training and career structure of general practice have been emphasised.

Finally, recognising that pay has played an important part in influencing change within the medical profession, some constructive comments have been attempted because this thorny issue will have to be negotiated to facilitate the introduction of necessary changes in career structure.



6. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The working party was set up in 1976 in the belief that the career structure for doctors in hospitals was seriously flawed. The imbalance between the number of doctors in the training and permanent grades was obvious, as was the very large amount of 'service' work being undertaken by those in 'training' posts. During the early months of the existence of the working party, the belief became widespread within the medical profession that an excess of junior doctors already existed, that not all of these could expect to obtain permanent posts within the existing NHS system, and that the excess would no longer be able to overspill abroad. Furthermore, fears grew that these problems would be compounded by the steadily increasing output of doctors from the medical schools.

All clinical care should be given by fully trained staff. Patients have every right to expect that staff in training should be closely supervised. The working party believes that patient care now suffers because many junior doctors are incompletely trained and inadequately supervised for the work they are required to do. Junior doctors also fail to provide the necessary continuity of care necessary to good medical practice, particularly in out-patient departments undertaking long-term surveillance of chronic diseases. A further, although declining, problem is that a high proportion of those in training are from other cultural backgrounds which can hamper the doctors' understanding, particularly of the social aspects of clinical conditions.

The amount of 'service' work performed by those in training should be determined solely by the needs of the training programme and the length of the programme by the complexity of the specialty. Breaking the link between service and training would permit the number of those in training for any specialty to be varied over a short time span according to forecasts of the need for trained staff in the specialty and without

such variations affecting patient care. A system of such flexibility would go far to allay present fears amongst doctors training for consultant posts about their career prospects.

Although the working party soon concluded that the number of junior hospital doctors would have to be reduced to a level consistent only with training needs, it examined the existing proposals to deal with the problem. None was found to be satisfactory.

The system cannot be left unchanged, for even with the present, albeit modest, expansion in the number of consultants and general practitioners, the number of junior doctors who have completed their training will rapidly overtake the number of vacancies. Simply to increase the number of permanent posts, without reducing the numbers in training, would require an enormous expansion of the total number of medical staff and would imply a further substantial rise in medical school output to fill the vacuum in the junior grades which would result from such a policy.

A career structure balanced between training and permanent grades would therefore have many fewer junior hospital posts. This restructuring would also coincide with moves to reduce dependence upon foreign medical graduates who fill many junior posts at present. The inevitable consequence of such a reduction in numbers of junior doctors is the transfer of some of the work that they do at the moment to other staff. Thus, a change in the career structure necessitates a broad review of professional practices and the organisation of hospital clinical work.

The members of the working party believe that a deliberate policy of markedly reducing either the quantity or the availability of hospital care to match this reduction in junior staff would be unacceptable politically, socially and professionally. They anticipate that, with a rise in the number of old people, there will have to be increased provision for chronic care within existing resources but they also expect that this same rise will put a greater burden on the acute clinical services.

Hitherto, it has proved easier to maintain a satisfactory relationship between the number of trainee and trained doctors in the fields of chronic care than in the acute specialties. Although the proposed mandatory training schemes for general practice will result in the retention of some aspirant general practitioners within the hospital sector for longer than at present, these doctors will not usually be working in acute medicine and surgery, anaesthetics and diagnostic services (pathology and radiology). In considering these specialties the working party was repeatedly confronted by the conflict, which was especially sharp in medicine and most surgical specialties, between the training requirements and career aspirations of young doctors on the one hand and the need for round-the-clock clinical cover by trained staff on the other.

The working party, having come to the conclusion that the total number of junior hospital doctors would have to be substantially reduced, then examined the ways by which this could be achieved whilst maintaining or improving patient care. It was recognised that any solution must take account of existing and future constraints on the evolution of the NHS which include the likely rate of growth in the economy and that fraction of public expenditure which will be available for health care.

The Consultant's Role

A progressive and considerable increase in the number of hospital doctors in permanent jobs with full clinical autonomy, coupled with a decrease in the number in the present junior hospital grades, was felt to be the proper keystone of future staffing structure. This has to be accompanied by a change in the role of consultants, because such a transfer of staff and work will force an alteration in the working pattern of the present single hospital career grade, the consultant. Not only would many consultants have the assistance of only pre-registration house officers but more out of hours work would fall to their lot. The age on appointment to the first of the consultant grades would, however, be usually the early thirties. A substantial expansion of consultant numbers, especially with a lower age of

appointment, would inevitably require a variety of grades which could be defined either by seniority or responsibility. Having more than one grade would encourage consultant mobility, enabling consultants, should they so wish, to change their pattern of working during their careers. The working party felt that such movement of consultants from post to post within districts or regions or about the country, should be actively encouraged, for it would be beneficial to the doctors and to the National Health Service.

A further need for a range of career grades will result from increased numbers of trained staff, often working in teams, and is further prompted by the desirability of having some consultants responsible for career guidance of the younger consultants as well as helping general practitioners working in hospitals. The scope for such a role might also extend to responsibility for looking after those in career grades with limited clinical commitment and responsibility. Thus, some consultants will have to have more managerial responsibilities than others, whilst others would also have a particular role in teaching and research. A single uniform career grade cannot possibly satisfy such divergent needs. Ways of providing more than one consultant grade have been discussed.

General Practitioner Participation

At present, about 7,000 general practitioners do some hospital work on a sessional basis which, in total, is equivalent to 1,800 hospital posts. The pattern of work varies widely throughout the country often in response to local needs or because of the continuation of a local mode of practice. It was felt that this variety was desirable and further experiment should be encouraged.

The new vocational training programmes for general practice are likely to produce doctors who will want closer hospital associations. If general practitioners were to take on hospital work, there must be a substantial reduction in list size to afford them the necessary time. With time, planning and goodwill, a considerable redistribution of hospital work to general practitioners would be possible, desirable and welcomed by old

and new generations of general practitioners. Sessional work within a single hospital department is a simple matter to organise. Even continuous clinical care of in-patients by their own GPs in a DGH was not thought to be impossible with hospital consultants acting as *consultants* if needed. Not only would closer integration between consultants and general practitioners be good for both career grades but patient care is also likely to benefit.

Career Grades with Limited Clinical Commitment and Responsibility

The working party reviewed once more the proposal that a permanent sub-consultant grade was required. At present, such a sub-consultant grade exists in all but name being composed mainly of overseas doctors working at the level of SHO or Registrar. The working party was unanimous in the belief that British trained doctors would not take over posts with such poor professional and financial prospects. On the other hand, it was felt that, although a full-time career grade without independent clinical responsibility could not be created, there is a place in the hospital service for those doctors who do not wish to or could not commit themselves unreservedly to clinical practice. The working party was especially concerned about the position of married women and felt that inadequate and insufficiently flexible provision for them to continue in medical work had been made in the past.

Redistribution of Work outside the medical profession

Although the working party was composed of doctors it did not ignore the possibility of transferring to some other hospital staff work at present done by junior doctors. Already, in intensive care units, specially trained nurses often carry out jobs traditionally done by junior doctors. In some specialties, notably psychiatry and geriatrics, the concept of a clinical team is becoming well established and non-clinical members participate in clinical decision making. The development of the clinical nurse is felt to be particularly important. The whole interface of clinical practice with the work of other professionals was felt to merit further detailed study.

The Future

Universal agreement that the hospital staffing structure is dangerously unbalanced must lead to changes. These need not be sudden and dramatic but should follow a broad strategic plan. The basis for change is to adjust substantially the ratio of fully trained posts to junior training appointments. By itself this would expose the heavy dependence on junior doctors for routine clinical cover and therefore, in company with the adjustment of career to junior posts ratio, other changes will be required to meet the shortfall. These might include increasing general practitioner numbers so that they could work more closely with their consultant colleagues. A greater emphasis on teamwork should be extended to non-medically qualified staff, in particular suitably trained nurses.

To make these changes simultaneously will not be easy. Negotiations about pay must also coincide with those concerned with the new career structure to facilitate the changes in work practice. The complexity of the problem has so far inhibited attempts to solve the basic staffing imbalance but the nettle must be grasped before two further events conspire to force a solution upon us. The first, easily forecast, event is the expansion of medical school output which will rapidly produce an excess of British trained junior staff without clear prospects of career progression. The second event will be the growing number of women doctors who will not accept a second class role in the NHS.

Within the near future the growing number of British trainees and women doctors will demand changes in career prospects and they will correctly question why no action has been taken because the problem has been clearly evident for years. The problem will not go away; it can only get worse. The solutions are to hand: all we lack is the will to succeed. Waiting will not help. Agreed solutions eased by new terms and conditions of service and a greater emphasis on clinical teamwork can provide the paths along which changes can take place. There is no reason

for further delay.

RECOMMENDATIONS

1. Patient care throughout the National Health Service should be given by fully trained doctors in career posts. The amount of 'service' work performed by those in training programmes should be determined by their educational needs.

2. The number of career posts in hospitals and in general practice should be increased and the number of junior hospital jobs reduced. The number of training posts in a specialty should be related to the anticipated number of vacancies for career jobs and the length of the training programme.

3. Posts approved for training may not all be filled if the opportunities for career posts in that specialty are restricted. Some hospitals will have few junior staff. All hospitals should review their use of junior staff and consider how they might be replaced.

4. A permanent sub-consultant grade of the kind which has been discarded in the past is not acceptable to the profession. It has not been successful in the past and will not be in the future. There is, however, a need for flexibly constituted, shared or part-time posts within the hospital service for doctors with commitments outside medicine and for those unable for a variety of reasons to meet the demands of a full-time clinical career.

5. Most of the work at present carried out by junior doctors in excess of training needs could be covered if the numbers and grades of consultants and general practitioners were to be increased. The biggest changes in practice are needed in the acute specialties for it is in these that the ratio of trainees to consultants is greatest.

6. A significant amount of the work at present done by junior doctors

should be transferred to consultants, the number of consultants being increased accordingly. Appointments to consultant posts should be made when training is completed and thus at a much earlier age than is now customary. There should be more than one grade of consultant. Each grade should have independent clinical responsibility and movement between posts should be encouraged.

7. The number of general practitioners should be substantially increased so that the number of patients on their lists fall, thus freeing them to participate in more hospital work. The local scale of this change could be determined by local needs. Districts should be encouraged to experiment with different modes of integrating general practitioners into hospitals, bearing in mind that they are not being asked simply to take on delegated hospital work, which consultants might find disagreeable and socially inconvenient.

8. Some clinical work in hospitals at present carried out by junior doctors could be assumed by nurses and personnel from other professions given further training where appropriate.

9. The need for a special career structure for part-time married women must be met. This structure must encompass geographical immobility and varying time commitment in the training grades while finding permanent posts for geographically-tied women in training.

What is immediately required of the profession is a recognition of the problems and agreement to move in the directions proposed. No sudden regarding and transfer of posts need take place. Negotiations about pay for new career grades and their job descriptions will have to coincide with discussions about the new career structure to facilitate change.

What cannot wait is an agreed, coherent strategy for patient care and the creation of the most appropriate career structure. Career structure

should serve the needs of patient care rather than distorting care to meet career and professional aspirations.

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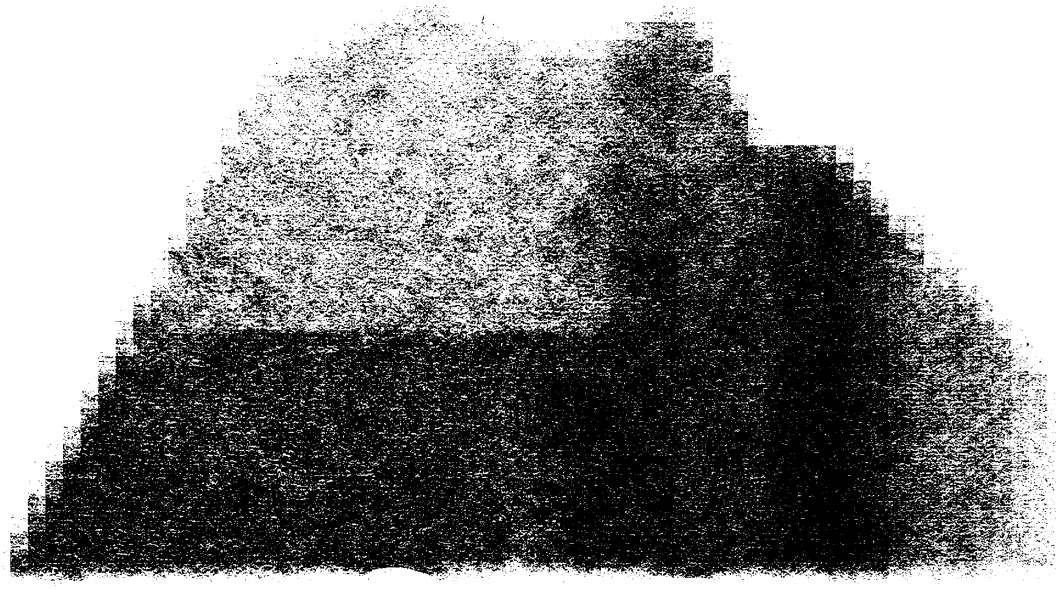

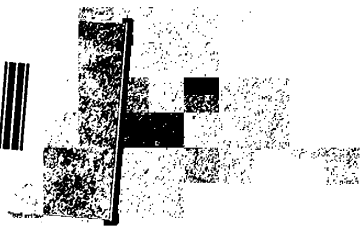

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