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MEDICAL MANPOWER THE OPPORTUNITY FOR CHANGE ?

A REPORT OF A CONFERENCE HELD AT THE KING'S FUND CENTRE ON

FRIDAY 14th MAY 1982

BY

PATRICIA DAY

DECEMBER 1982

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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was first established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in developing solutions to problems of health and related social care and its now permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

Further enquiries about the work of the Centre and the Fund and requests for advice or assistance are always welcomed.

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She has since studied the organisation of the purchasing and distribution of supplies within the health service including the manpower and management problems associated with the administration of supplies, particularly following the 1974 NHS reorganisation.

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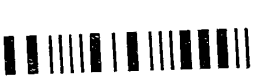

PREFACE

This conference was arranged by the King's Fund Centre to promote informed debate about the report of the Social Services Committee of the House of Commons on Medical Education [1] and the Government's response, published in its White Paper in February 1982. [2] It is hoped that the discussion recorded in this report will not only provide a record of the occasion for those who were present but will also be useful to those considering the local and regional implications of current Government policy.

This conference marks another stage of King's Fund involvement with issues of medical manpower policy. Earlier contributions have included a report of the Fund's working party on 'The Organisation of Hospital Clinical Work' [4] which was published in 1979. A further contribution to this debate was the publication, earlier this year, of a project paper (No.28) entitled 'Women Doctors: Choices and Constraints in Policies for Medical Manpower' [5] researched and written by Patricia Day, the author of this report.

The Fund continues to be interested in this subject and would welcome suggestions about the ways in which it might assist its further development.

DAVID HANDS
Assistant Director
King's Fund Centre

December 1982

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SUMMARY

1. Changes in Staffing Ratios in the Medical Career Structure

The Conference observed a strong and broad commitment by the Select Committee on Social Services and the Government to a policy of change in the NHS medical career structure towards the provision of more patient care by fully trained doctors. Emphasising the importance of the best possible patient care, Mrs Renee Short, the Chairman outlined the Select Committee's major recommendation as the achievement of a higher proportion of consultants in relation to junior medical staff in training in the NHS over the next 15 years. At the same time it was important to maintain good training and working conditions for doctors, improved career prospects, recruitment to shortage specialties and better distribution of medical manpower.

The Minister, Mr Kenneth Clarke, broadly approved these recommendations on behalf of the Government adding that the profession itself must determine the nature and pace of implementation of these changes within the framework of government policies. Although there was general agreement from the floor and the platform that good patient care is a priority, there was some disagreement on the need for this care to be provided by consultant grade staff only. There were some suggestions that fully trained staff treating every patient might be a waste of resources and could threaten the apprenticeship system of training.

There were also suggestions from both the floor and the platform that the changes in staffing ratios should be more gradual than recommended by the Select Committee and that they should be tailored according to the needs of different specialties and districts. The inappropriateness of a policy which aimed to produce uniform changes in ratios throughout the profession were generally agreed. There were also pleas for an integrated manpower policy in the NHS in which changes can be made in consultation with and consideration of other NHS staff and in a way which was consistent with service-planning objectives.

2. Unemployment and the Medical Profession

The Minister did not see any real unemployment threatening the profession at the present time, the Government view reflecting the evidence of the Economic Adviser to the Select Committee. The conference was told that unemployment in the profession was largely frictional and structural; the former contributing to a healthy mobility within the profession and the latter contributing little that is positive and arising mainly because of the present imbalance in the career structure. Other speakers, however, expressed great concern about a real and growing problem of unemployment in the profession. One other view was that the service is suffering not from unemployment but from employment of too many doctors.

3. Medical School Intake

There was a general feeling that the present level of recruitment to medical schools in the UK is about right, based as it was on the Todd Committee[3] recommendations. It was assumed that this level of intake would eventually provide the right number of doctors to decrease NHS reliance on overseas doctors and provide good patient care.

4. Overseas Doctors in the NHS

There was little agreement on the solution to the continuing dependence of the NHS on overseas doctors. However, it was suggested that the present level of medical school intake recommended by the Todd Committee[3] would gradually increase competition from UK graduates thus reducing the numbers of overseas doctors able to get jobs in the NHS. It was pointed out that a great debt is owed to overseas doctors already working in the NHS and for whom permanent jobs ought to be available. This was qualified by suggestions that only particular sorts of jobs should be available. More drastically there was a suggestion that controls should be employed to cut down the entry of immigrant doctors into the NHS.

5. The Role of the Sub-Consultant and Similar Grades

The Select Committee recommended that no attempt be made to create a permanent sub-consultant grade as part of the medical career structure. Although this view was endorsed by other speakers, there was some well informed medical opinion from the floor that an outlet was necessary for those doctors unable or unwilling to carry out consultant responsibilities after training. Most of the opinion in favour of sub-consultant grades wanted the posts to be short-term and ad hoc,

agreeing in principle with the Select Committee that the permanent establishment of such posts would be unwise and unnecessary. In contrast, there was a straight-forward request from the floor for permanent sub-consultant posts to accommodate overseas doctors.

6. Women Doctors in the NHS

The Conference said very little specifically about women doctors although it was acknowledged that the increase in the proportion of women in the profession and their reasonable desire to maintain career progress would require new thinking. The Select Committee Chairman applauded progressive ideas on part-time training for women being put into practice in Scotland emphasising that women doctors with domestic commitments should not find themselves pushed into dead-end jobs in the profession. There was substantial agreement with the view that the "problem" of women could be contained within the broad strategic changes proposed in the Select Committee's Report.

7. Resources available for Change

There was general agreement that changes in the medical career structure will, on balance, incur additional costs although, perhaps, result in greater efficiency. This would be in a context of long-term financial constraints involving a real reduction in resources in the NHS over the next 20 years.

There was some agreement, however, that these factors should not present barriers to starting on proposed changes in the medical career structure and that many could be achieved within the resource constraints operating at present.

CONCLUSION

Implementation of the proposed changes will require a real effort and a real will by the medical profession. The existence of a will to change is questionable. It appeared to be there 10 years ago, but nothing happened. If anything other than either a running conflict with Government or nothing at all is to happen, the message must be that the alternative to a nationally imposed adjustment in numbers and work is an immediate, rapid, local reappraisal of the service needs and staffing structures by the profession with the administrators and health authorities in each District.

MEDICAL MANPOWER - THE OPPORTUNITY FOR CHANGE ?

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Purpose of the Conference

The Conference was organised by the King's Fund to promote examination and discussion of implications of the Fourth Report of the Social Services Committee of the House of Commons, Session 1980/81, "Medical Education with Special Reference to the Number of Doctors and the Career Structure in Hospitals" (1), popularly known as the "Short" Report, and the Government's Response.(2)

Welcome and Introduction

Mr Graham Cannon, Director of the Centre, extended a welcome to the Chairman, the speakers and the participants, noting both the distinguished gathering and the importance of the subject under discussion. Mr Cannon particularly welcomed Mr Kenneth Clarke, QC MP., Minister of State for Health and Mrs Renee Short MP, Chairman of the Social Services Committee of the House of Commons. He drew the attention of the Conference to the diversity of reactions to the Short Committee's Report but pointed out that there was unanimity on the importance of the subject.

Lord Richardson, Chairman of the Conference replied thanking the King's Fund for organising the event and invited the Minister of State to open the discussion.

THE GOVERNMENT'S RESPONSE TO THE SELECT COMMITTEE'S REPORT
- Mr Kenneth Clarke

After mentioning his relative newness to the job and to the policy issues under discussion, the Minister went on to say that,although Government policy on medical manpower had been decided and set out in the White Paper, the implementation of this policy had to be handled with care. He told the Conference that,while not accepting every recommendation of the Select Committee, the Government accepted most of its principal recommendations on changes in the medical career structure and future policy on medical manpower.

The starting point of both of both the Committee' recommendations and the Government's response is patient care. The Minister quoted from the Royal College of Physicians' response to the Short Report and the Government White Paper which began with the following statement:

> 'The purpose of the National Health Service is to look after patients not to provide employment for doctors'.

He then went on to say that, although there is widespread agreement that patient care is best provided by fully trained doctors, he had come across the reaction that possibly fully trained doctors for every patient encounter might be a waste of medical manpower involving qualified doctors dealing with minor procedures. The best reply to this had come from the President of the Royal College of Surgeons in evidence to the Social Services Committee:

> 'It is a general principle that there is no such thing as a minor procedure. Though we have artifically designated minor operations they are not minor for the patient and one of the bad things about the service in the past has been that too many of the so-called minor procedures have been done by junior doctors in training, whereas the senior has done very little of this type of work. The result is that this type of procedure has not been improved in quality as it might have been....'.

This highlighted the concept of clinical autonomy, much valued in the profession, and which the Government had no wish to undermine. The Minister also pointed out that there is widespread agreement that fully trained doctors taking full responsibility for their actions were likely to provide a qualitatively better and quantitively greater measure of care for their patients than trainees.

With clinical autonomy went self-regulation by the profession and the apprenticeship system of training, the latter widely regarded, not just in Britain, as a great strength of the British medical tradition. The Government recognised that, without the support and confidence of existing consultants and of doctors in the training grades, schemes to alter the balance of hospital medical staffing would not achieve their purpose. The time had come to put into practice the principles long agreed between the Department and the profession. The Government was not seeking to introduce change by compulsion or coercion. The Government recognised that morale was a key element in the smooth working of the hospital service and attached the highest importance to the profession's involvement in commenting on the best way of translating policies into action at the local level.

The guidelines set out in the recent White Paper indicated that the long-term aim for most hospitals and most medical specialties was an increase in consultant numbers and a reduction in the number of training posts and the proportion of the service load carried by trainees. Many present juniors were overseas doctors who were not getting the post-graduate experience they came here for. This was incompatible with the career structure agreement, the aim of self-reliance in medical manpower, and fair play. The Government welcomed the General Medical Council's initiative to ensure that all training grade posts gave satisfactory training experience.

In the past 10 years there had been too great an expansion of the senior house officer grade. There were now nearly twice as many posts as required to provide specialist training for medical graduates. Health authorities had therefore been asked to prevent further expansion of senior house officer posts in their regions. A standstill on these lines should be manageable since Regional Health Authorities would retain the flexibility needed to respond to changing circumstances in particular districts. Indeed some regions had already applied such a standstill.

The Government accepted that all these changes would take time to achieve but hoped that local policy in all parts of the country would work towards a more sensible balance between the numbers in the training grades and the number of consultants. In other words, the overall and

cumulative effect should be in the direction proposed. This should not be a dramatic overnight change, but a gradual two-stage process with health authorities drawing up plans for completion of Stage 1 over six years and completion of Stage 2 over 15 years.

On the question of finance, the Minister suggested that the task is neither daunting nor impossible and that no-one should argue that financial constraints will hinder change. However, the pace of change will be regulated by the availability of finance. Substantial expansion of consultant posts could be achieved within the revenue allocations available over the next 10-15 years. It would of course be foolish to make absolute financial predictions but, given the past record of NHS funding which by the end of the next financial year will have grown in real terms by 5.8% since 1978/79, it is not pessimistic to assume that if this growth continues, some changes will be possible. Indeed if all the resources devoted to medical manpower in the last decade had been devoted to a growth in the consultant grade, then the imbalances in the career structure would already have been largely, if not totally, eliminated. Between 1971 and 1980 an additional 9,500 doctors were employed in the main grades of the hospital service at the cost of a hundred million pounds per year. Only 7000 extra doctors are needed over the next 15 years to achieve the desired changes in the medical staffing structure. The extra cost of these higher paid fully trained doctors could be offset by a faster throughput of patients, i.e. a shorter patient stay, reduced outpatient attendances and fewer diagnostic tests.

The Minister emphasised that, although the White Paper provides a framework for these changes, the Government is relying on the local implementation of policies. He stressed the need for health authorities to involve the profession locally and sort out priorities between specialties and between the community and the hospitals at ground level. He also stressed the need at the implementation stage to gradually remove the cushion of overseas doctors.

The Minister hoped that the changes would not bring about rifts among members of the profession or between the profession and the Department and hoped also that action would follow policy requirements laid down in the White Paper. He summed up the necessary changes to be made as

cautious evolution at local level with the main object of change being improved patient care. The Minister finally expresssed regret at being unable to stay for the whole day. Lord Richardson thanked him and introduced Mrs Short.

THE SELECT COMMITTEE RECOMMENDATIONS - THE REASONS FOR CHANGE

- Mrs Renee Short

In her introduction Mrs Short reminded the Conference of the impartiality and seriousness of the Select Committee which, as a matter of interest, had a majority of Conservative members and which had made itself available to the widest evidence, hopeful that the Government would accept and implement its recommendations.

Mrs Short made it clear that the Select Committee does not snatch ideas from the air nor is it at a loss for subjects to investigate. On the contrary, the Committee has a long list of subjects waiting for careful and impartial scrutiny and in need of special enquiry. The Committee has created a reputation such that both Ministers and the profession regard it as impartial and unprejudiced; an all-party group that takes a very serious view of problems presented to it and which endeavours by the widest possible consultations to arrive at conclusions and recommendations which are generally welcome.

She went on to say that, of course, no-one can please everyone let alone the diverse group of doctors which make up the medical profession, but hoped that the Government will implement the recommendations made. Signs are favourable and the Committee is hopeful about the outcome.

A whole mass of evidence, written and oral had been received from 91 different sets of witnesses including 8 witnesses from the BMA, 6 from the JCC and 2 from the Conservative Medical Association. In addition, evidence came from the Royal Colleges, the Medical Schools and both the teaching and peripheral hospitals. The former Secretary of State, Mr Patrick Jenkin, also provided some valuable evidence. The main point that Mrs Short was emphasising was that the medical profession was invited to and did give evidence as expert witnesses. Mrs Short was therefore surprised to see letters in the medical press accusing the Committee of not consulting the profession. She said that the Committee were extremely grateful to all those who had helped it to form its recommendations.

Mrs Short went on to refer to all the other preceding Committees and Reports on medical education and staffing where problems had been outlined and after which nothing had happened. Mrs Short said that her Committee did discover during the course of its enquiries the problems affecting poorer families and discovered the significance of differences between the social classes in the medical and other services available to them. Many of these differences came about through disparate levels of nursing and medical skills as well as available facilities in different areas of the country. The Committee wanted to know why the medical career imbalance between specialties and geographical areas had been permitted to develop in this way. The Committee then learnt of the poor working conditions of some junior doctors with their long hours, short-term contracts and dicey career prospects. It saw the differences between teaching hospital conditions and other hospitals.

Mrs Short expressed particular concern about the problems for women doctors who, like other working women, were expected to bear home, job and family responsibilities: in fact, the burden of many roles in a system set up by men. The Committee learnt that surgery and medicine are still the most popular specialties in spite of information available for a long time about needs in the profession. It explored areas of shortage, like geriatrics and psychiatry, where conditions for staff and patients are abysmal and was amazed that the medical profession had tolerated these conditions for so long.

The Committee noted the problem of overseas doctors working in specialties for which they are frequently not suited, such as psychiatry, and was surprised that the medical profession had allowed these situations to fester away with such unfair consequences for large numbers of patients. The Committee had to conclude on this point that the profession had not been acting in the patient's best interests.

The Committee accepted that there should be more consultants to achieve better patient care and that there should be good training facilities for junior doctors, better career prospects and better working conditions for the profession. It proposed the establishment of more consultant posts and an 80-hour week for junior doctors in training.

The Committee found no evidence that the good advice needed to bring more doctors into shortage specialties is being given. That is advice on the specialties with an overall shortage of medical staff as well as those short of staff in particular geographical areas. The Committee came to the conclusion that the major responsibility lies with the Postgraduate Medical Deans to indicate where shortage areas are within medicine while placing some responsibility on individual doctors to go into the less popular areas of the country where they may find satisfying work to deal with patients who need the help of well-trained doctors.

The Committee rejected concepts like the Hospital Practitioner Grade, Mark 2, because of the risk of doctors with domestic commitments, generally women, getting pushed into this grade and losing opportunities to get part-time training and part-time career posts to match their availability. It did find, particularly in Scotland, some very progressive ideas on part-time training for women being put into practice. In some areas, women doctors were able to share consultant posts and it worked very well.

The Committee set its face very firmly against the creation of better paid but dead-end jobs in the medical profession. Mrs Short was confident that in conjunction with sensible and accessible local mechanisms and properly organised central control, the right posts in the right numbers in the right specialties could be achieved. However, entrenched attitudes have to change, established work patterns have to be altered, the inertia of years must be broken and a realisation of the need for change has to be accepted by all concerned. Such changes can only be brought about by prolonged effort and they won't happen overnight. However, within the next five or six years, it should be possible to see progress towards implementation of some of the recommendations the Committee has made.

The Health Service is a source of very great pride to everyone, it must remain so and it must meet the claims and needs of patients all over the country, all of them entitled to the best medical services that the Government, the nation and the profession can provide. The Committee urged the need for everyone to work together to make the necessary adjustments as smoothly as possible to achieve these changes within a decade producing the best services available for patients everywhere.

Questions and Contributions from the Floor.

The first question came from Dr Peter Fisher, Consultant Physician representing the NHS Consultants' Association. Dr Fisher suggested to Mrs Short that it would be even more difficult to get enough doctors to go into shortage specialties if the over-subscribed popular specialties are expanded. He went on to suggest that more incentive to join shortage specialties should be directed at senior school pupils before they decide to take up medicine. Further, since pressure to get into medical school is increasing and standards required even higher, many people who would make excellent doctors don't get into medical school because they are not absolutely top-class 'A' level achievers. He suggested a need for more education of senior school pupils into what medicine means; that it includes many vitally needed support specialties and those we might regard as caring rather than curing services.

Mrs Short replied with full agreement that career guidance should be given to potential medical school applicants before they leave school.

Mr Clark also agreed stressing that the Government would want to make sure that the aims of the policy are achieved and that implementation matters as much as the commitment to a policy. Unless shortage specialties are made more popular, then there is no way of ensuring recruitment to them. Obviously, the best career advice is needed in schools but it should include guidance from the profession itself.

The next question from the floor came from Dr Lotte Newman, General Practitioner and Honorary Secretary of the Medical Women's Federation. Dr Newman was pleased that Mrs Short had mentioned the plight of women doctors and that the Medical Women's Federation had been able to give evidence to the Select Committee. However, she was concerned that so far the Minister had not spoken about women doctors and that no-one representing women or overseas doctors was speaking from the platform during the course of the day. She hoped that the increasing number and proportion of women medical students would not be reduced as part of the changes recommended as there was much evidence that women patients, who predominate, do want more women doctors, particularly in general practice. She asked Mrs Short how the implementation of the

Report would affect the position of women doctors particularly in general practice and since there was both a Minister and a Lady MP present, Dr Newman asked about the iniquity of widower's pensions in the medical profession. For example, if Mrs Short pre-deceased her husband, he would be looked after as would Mrs Thatcher's husband, but if Dr Newman pre-deceased her husband, he would not be looked after unless it could be shown that he had been unable to keep his wife financially.

Mr Clarke replied first with apologies for not mentioning women although he had mentioned overseas doctors. He said however that he did subscribe to the need for a higher proportion of women in the profession (and indeed in the professions generally, not only medicine), although, as in other areas, women find it difficult to maintain career progress in medical practice. Mr Clarke confessed however that he did not yet know the specific implications of the Report for women in general practice.

On the subject of pensions, the Minister said that a widower's pension could be introduced in the National Insurance scheme as at present the scheme is biased in favour of women. Women pay less, live longer and draw more benefit. He suggested we should move towards a common retirement age. However, at the moment, it is an enormously intractable problem in the national insurance and occupational pensions field.

Mrs Short replied that the Committee had been particularly concerned about general practice and its need to be more closely integrated with the hospital service. One of the aims of the 1974 reorganisation of the Health Service had been to bring about a closer integration with the hospital service but this had not been achieved. However, there were about 600 principals in general practice doing some work as hospital practitioners and about 7,000 GPs doing sessions in hospitals. The Minister had accepted the proposals of the Committee to develop and expand this.

On the subject of pensions, Mrs Short asked Dr Newman to accept her apologies as she had nothing to say on the subject at the moment. The Select Committee was about to prepare its new Report on the age of retirement and had been struggling for some time in this difficult area. The field of pensions was so complicated and the financial implications so enormous that it will be difficult for the Committee to make recommendations. However, it will be making them of course and it is

conscious that there are inequalities in this area as in many others.

A third question came from Dr Leo Mulrooney, Consultant Anaesthetist and President of the Hospitals Consultants and Specialists' Association. He disagreed with the description of anaesthetics as a shortage specialty made by Mrs Short earlier on, adding that it is one of the most competitive specialties at the present time.

Dr Mulrooney's second point raised the question of unemployment in the profession. He pointed out that it does worry a great number of doctors at the present time and it is extraordinary that the concept of medical unemployment is almost wholly focussed on the hospital service when it is known that for every one doctor entering the hospital service, two are going into General Practice.

He then suggested that it is not sensible to talk of creating extra consultant posts unless the facilities available are adequate. The biggest constraint on the freedom of services are the lack of theatres and beds at District General Hospital level. It is therefore pointless putting more consultants into district general hospitals without these facilities. Many of these hospitals are ill-equipped for medical staff expansion which would only be a waste of money and a potential source of frustration.

Dr Mulrooney's comments on the concept of a fully-trained doctor were that he did not think that such a person exists. He pointed out that many of the profession are afraid that the very virtues of the apprenticeship scheme would make it the first victim of an ill-conceived application of some of the recommendations for change.

The Minister replied to the question of unemployment in the profession saying that he could find no evidence to support the belief that there is real medical unemployment at the present time. Of course figures on doctors registered as unemployed are difficult to interpret and there is some evidence of doctors moving between jobs, but this is a tiny proportion of medical manpower - about half a percent of the total profession and it isn't showing any signs of growing at the present time. That is one reason why there have been no attempts to adjust the target figures for medical school intake, in fact, since there is likely to be a declining supply of overseas doctors, it would seem necessary to maintain the intake at its present level.

On the question of facilities in some hospitals, the Minister said that the point had been taken. The Government's whole policy depended for success on local consultations and the application of local conditions.

In reply to the idea that the first victim of implementation of change would be the apprenticeship scheme, the Minister emphasised that the process of training in post was unique to the U.K. and could not see why the change in balance would be a threat to this system. He suggested that if anyone could persuade him that the present balance between the consultants and the junior training grades was part of some planned and considered policy and an essential backbone to the whole apprenticeship system of medicine, then he would have some concern. Indeed the only changes that have taken place so far in the medical career structure have gone against all policy recommendations ever made. The present system had happened by accident and emerged by chance.

REACTIONS TO THE PROPOSALS FOR CHANGE

1. Mr R K Greenwood

The first speaker was Mr R K Greenwood, Consultant Surgeon, Leicester, member of the Central Committee for Hospital Medical Services, the British Medical Association and Member of Joint Consultants' Committee and Central Manpower Committee.

Mr Greenwood began by saying, that in spite of all the affiliations suggested by his introduction, basically he represented himself and was speaking as a surgeon, a clinician, a tutor of medical students and a potential patient.

He went on to say that he worked on a 1 in 4 rota and was personally on emergency take 1 day in 10, seeing all the emergencies himself on the day they come in or being informed about them at night. He sees 14 new outpatients each week, is the first to arrive and the last to leave. He is responsible for all patients and has an outpatient waiting time of approximately one month, less than one week for urgent cases and a waiting list of 45, 20 of whom he is waiting for. No-one is on a waiting list for longer than two months; all urgent cases are dealt with within a week. Mr Greenwood went on to illustrate the modest size of his firm including not a secretary but a typist. He commented that on ward rounds, he finds wards full of doctors rather than patients.

Listing his comments on the Short Report's recommendations, he said that he approved of a controlled expansion of consultant staff and a reduction in the number of juniors, but he had serious reservations about some of the other recommendations made by the Select Committee. First, they are not in the best interests of patients and may reduce patient care. Also, if they are implemented as they stand, they will destroy the medical profession because they fail to appreciate the basic problem in medical manpower and the career structure. Mrs Short's Report had introduced the concept of the shift system which precludes continuity of care and in which responsibility is blurred. The Report assumes that a consultant-provided service is better. This is not necessarily so. Many housemen can do jobs better than the consultant. What is important is that the service should be consultant supervised and carried out by appropriately trained doctors. The doctors should not be on a shift system. The District General Hospital should be on a shift system with a rota which ensures that all hospitals are not on take all the time. There should be one hospital on duty, as it were,

and in that hospital there should be a 24 hour emergency theatre available all the time.

The Select Committee's Report, if implemented, would destroy the profession by changing the nature of the consultant's work. It would be changed towards an industrial pattern. The ascent of the 'Unit of Medical Time' was the biggest disaster to have befallen the medical profession. The UMT was just a device for getting more money and he had never met a patient who had a unit of medical illness. The changes recommended are also changes in terms and conditions of service and as such should be negotiated.

Mr Greenwood referred to the Minister's insistence that the NHS is for patients, not as a career structure for doctors. The assumption that more doctors would provide more treatment and that more treatment meant better care was not necessarily true.

Mr Greenwood compared the service with a bath that is overflowing. He suggested that Mrs Short's solution is to use a ladle to take out the water. He thought that it would be more appropriate and more simple to turn off the tap. Referring to the possibilities of imminent medical unemployment he could, he said, unfortunately see no danger of unemployment. He was concerned that the extra doctors would be employed to do more and more unnecessary work, talk and go to committees and not look after patients.

Hospitals are already over-staffed but not with clinical nurses: these are the nurses who in the old days dealt with blood, urine and distressed relatives not the ones who sit in offices. He said that hospitals are so over-staffed they don't work efficiently until they have been on strike for at least two or three weeks.

Mr Greenwood proposed, as an alternative to the Select Committee's recommendations for improving patient care, making more efficient use of the present resources, beds, finance, manpower and services.

Mr Greenwood's final plea was for a general improvement in communications.

2. DR MICHAEL REES

Dr Michael Rees, Chairman of the Hospital Junior Staffs Committee of the British Medical Association followed Mr Greenwood's criticisms of the Short Report by expressing intense relief at the findings of the Select Committee which pointed, in his view, to a common sense way out of the chaos brought about by the medical profession on themselves.

Differential expansion in the profession had led to inequalities of services between geographical areas and between specialties and had been largely the fault of the profession itself; although the Department must accept some of the blame. Dr Rees declined to discuss at this point whether the excessive hours worked by junior doctors were unproductive as suggested by Mr Greenwood. He did however emphasise the poor prospects of junior doctors, particularly if they happened to be overseas or women doctors as well as juniors.

He referred to a recent survey of 500 junior doctors, carried out by the Office of Manpower Economics for the Review Body, that showed that junior doctors' hours have increased over the past 10 years and, further, that a larger proportion of these hours have become unsupervised. At the present time 75% of work activity of junior doctors is unsupervised. In Accident and Emergency for example, only 3.9% of activity of juniors is supervised by consultants. It should also be stressed that the relatively inexperienced junior doctors in Accident and Emergency generate extra cost to the system by taking large numbers of X-Rays to back up their inadequate knowledge. This is defensive inadequate medicine practised by untrained doctors. A more experienced doctor would not need an X-Ray to confirm his diagnosis. The survey showed that on the level of training, the present system provides poor training and teaching and that only 3.1% of their contracted 90 hours approximately per week is taken up with attending training. Dr Rees suggested that the medical profession in general has either been unwilling or unable to put its own house in order.

Turning to the Select Committee's recommendations, Dr Rees cited paragraph 106 of the Report where two aims were put forward as being shared by most of the bodies who gave evidence to the Committee. The first was to achieve a good reliable service and care for patients in all specialties where patients can be seen and treated by fully trained

staff and where care given by junior staff is fully and adequately supervised. The second aim of the Report was to provide good training programmes for all junior doctors which are related to the number of career posts required for patient care and appropriate for the work and responsibilities expected at each stage. Dr Rees suggested that most recommendations in the Report actually follow from these aims.

Dr Rees went on to list his reservations about the Select Committee findings. He began with medical school intake and unemployment admitting that, unlike the Minister, he was not convinced that medical unemployment was not a problem. In 1976, 270 doctors were unemployed and in 1981 it was just over 1,000. The Minister suggested that it was temporary in nature, but so is the employment of junior doctors. It is a real problem and an increasing cause for concern.

Dr Rees' second reservation was on the Committee Report's estimates of vacant posts and shortage specialties. In fact, no one knows the real figures on shortage specialties. Since doctors have been flooding into the lower grades, the anaesthetic specialty can no longer be called a shortage specialty and a severe imbalance between junior and senior grades has emerged.

At this point Dr Rees mentioned the bogey of shift medicine, said to be inherent in the Fourth Report's recommendations and mentioned by Mr Greenwood as an undesirable outcome. He suggested in fact that the majority of junior doctors and GPs already work shift medicine.

Turning to the Government's response to the Select Committee, Dr Rees welcomed the Government's endorsement of most of the Committee's recommendations. Dr Rees then agreed with Mr Greenwood's suggestion that there were too many junior doctors and that in many instances they do not provide a satisfactory service. For example in Outpatient Clinics, there are too many doctors seeing patients and there are too many changes of doctors. This is not good for the patient who is usually anxious, it consumes too much of the doctor's time and, further, it wastes money on excessive numbers of drugs and tests.

A recent study carried out in the North East of England by General Practitioners on repeated outpatient attendances found that, by and large, most of them were useless and that 90% of them did not alter the original diagnosis or treatment. More than 50% of the attendances did not add any further information. The GPs made two points: firstly, most of these patients could be better treated by their general practitioners than by a succession of junior doctors and, secondly, this sort of very expensive encounter is perpetuated by the fact that the patients are looked after by junior doctors and not consultants.

Getting back to the Government's response, Dr Rees pointed out additional areas of concern to junior doctors. Firstly, the implementation of the targets. Surely, he said, the correct way of getting consultant expansion under way would be, first, to reduce the number of junior posts with little educational content. Dr Rees expressed doubts about achieving the interim target. He said he had greater confidence in the achievement of the total aims spread over 15 years.

Dr Rees agreed with the Select Committee's recommendations that the level of growth money in the NHS should be increased sufficiently both for the process of change in the career structure to be rapidly accelerated and for other high priority areas to be adequately funded. He agreed with the Select Committee's recommendations that consultant contracts should be sited at district level and criticised the Government's decision that they should be at regional level. He did however think that it was very important that junior contracts be held at region, this being the only way to sort out the severe local imbalances in the system, to provide mobility of manpower and structured training programmes.

Finally, Dr Rees summed up his overall reaction to the Select Committee Report and the Government's response as both implying to him a more secure better-trained future for junior doctors and prospective doctors, a more efficient cost effective service and a better deal for patients.

3. MR JOHN MALVERN

Dr Rees was followed by Mr John Malvern from the Royal College of Obstetricians and Gynaecologists and Chairman of the RCOG Manpower Sub-Committee.

Mr Malvern summed up the main responses of the Royal College of Obstetricians and Gynaecologists to the Select Committee Report: first an agreement that there should be more patient care provided by appropriately trained staff and second that there should be a properly based structure for the training grades. He pointed out however that although obstetrics and gynaecology is a unified service, nevertheless the nature of obstetrics is such that it has to provide a 24-hour emergency service and this renders it different from many other disciplines. The Royal College fully accepts that a higher proportion of patient care should be provided by competent trained staff but hastens to point out that a graded level responsibility for trainees is the only satisfactory way of bringing them up to a position where they can undertake independent specialist care. The RCOG Manpower Sub-Committee fully agrees that this means an expansion of the consultant grade but believe this can only be achieved gradually over a considerable period of time.

In the U.K. there is no significant alternative to the practice of obstetrics and gynaecology in the NHS and there is increasing difficulty in transferring from one specialty to another, particularly with the advent of vocational training in general practice. Further, in recent years, there have been limited outlets for UK doctors in North America and Australasia. Particularly in this specialty there is a high dependence on the service role of overseas-born doctors who make up 73% of Registrars and 50% of SHOs.

The RCOG Manpower Sub-Committee anticipates that there will be a decrease in the quantity, if not the quality, of postgraduate overseas doctors. Mr Malvern re-emphasised the need for gradual change in staffing ratios taking into account service and training as well as staffing requirements. He suggested that perhaps the Select Committee Report was recommending too great a reduction in junior posts as after all consultants do evolve from junior doctors.

The Manpower Sub-Committee does however agree with the Select Committee that there should not be a sub-consultant grade or two tiers of consultants. It believes that the main area of doctor substitution for the obstetrics and gynaecology specialty is midwifery and to some extent in general practice and that the subordination of midwifery in general nurse training is counter-productive to this concept. It fully endorses the proposal that inadequate training posts should be frozen but the immediate proposal to freeze new SHO posts is unrealistic and does not recognise the difference between specialties, increasing medical school output, requirements for medical training for general practitioners and a proposed reduction in working hours for junior staff. It is essential that full discussions on changes must take place between the Department and the Colleges.

Mr Malvern expressed concern about the Department saying one thing to the College about changes then finding Regional Authorities going off and implementing consultant expansion with undue haste. The Manpower Sub-Committee has been running for 18 months and in the next two months, the RCOG will be issuing its own strategic framework for change and proposals for implementation in the specialty.

4. DR J D NABARRO

Dr J D Nabarro, Emeritus Consultant Physician, Chairman of the Joint Consultants' Committee followed Mr Malvern and began by explaining the composition and the function of the Joint Consultants' Committee. The Committee is joint between the senior members of the Central Committee for Hospital Medical Services, the BMA's autonomous senior hospital doctors committee, and the Royal Colleges. In addition it has representation from the Hospital Junior Staffs Committee and it has observers from community medicine and from undergraduate deans. It is primarily concerned with the maintenance of standards in the hospital service and for that reason is the most concerted voice to speak to the Department and the CMO about the maintenance of standards in hospitals. It is therefore very much concerned with questions of staffing and career structure.

Dr Nabarro suggested that before he gave the Joint Consultants' Committee's recommendations for improving the present chaotic situation, he should consider the two general points already touched on by the Minister and Mr Greenwood. He endorsed the view that the primary role

of doctors is the care of patients although the profession has an important role in training doctors for the future both for the hospital service and for general practice.

Dr Nabarro's first comment on the Select Committee Report concerned recommendation 16. The JCC could not agree with the aim that all hospital patients should be treated personally by consultants or by junior doctors only under the direct care of the consultant. This would rule out the acquisition of sufficient training for junior doctors to become proficient consultants. Consultants have to train junior staff as well as treat patients.

Secondly Dr Nabarro commented on the question of continuity of patient care regretting that it is becoming more and more difficult to achieve. It was in the 1960s that the single-handed GP began to disappear and was replaced by the group practice to which was added the less attractive deputising service. Junior doctors started having rotas and UMTs in the 1970s and inevitably there was some loss of continuity of care. Dr Nabarro suggested this was a regrettable but inevitable feature of medical practice in the 1980s.

Dr Nabarro expressed some disagreement with Dr Rees that consultants already work a shift system. Rotas should not be confused with shifts. There are two aspects of continuity of care: one is the emergency admission previously unknown to the hospital and which can be dealt with by any consultant. The second is the situation which arises when something goes acutely wrong with a patient already in the hospital: then, clearly it is better if it can be handled by the same team, particularly by the same consultant. If, as seems likely, it is going to become increasingly difficult to achieve this then the solution would be to have teams of consultants in a department so that more than one consultant has knowledge of each patient.

Dr Nabarro went on to express anxiety about some of the Department's independent initiatives and mentioned issues that have antagonised at least some members of the consultant body. He agreed entirely that there is a place for increased consultant numbers but this must be achieved gradually; that is, a reasonable expansion of the consultant grade provided the facilities are there for them to be usefully occupied. He expressed dissatisfaction with the Minister's assurance

of adequate finance to meet the cost of changes. He suggested that the changes will cost a great deal of money, more than implied by the Minister.

Commenting on the scale of change recommended, Dr Nabarro said that there is only a modest excess of senior registrars, not in obstetrics and gynaecology, but enough to step into consultant vacancies in general medicine and general surgery. He did suggest however that not enough attention has been given to the problem of the registrar grade which is the biggest disaster of the junior staffing structure. He quoted the staffing figures for general medicine where there are just over 200 senior registrars and 660 registrars at any one time. There are 330 registrars seeking to move into 50 senior registrar vacancies. This means that the bottlenecks are in the Registrar grade which is an excessive and grossly expanded grade. This grade is also confused by being a mixture of general training and the beginning of higher training. With this in mind, the JCC has accepted the idea that a clarification must be made between higher training and general professional training. It believes that general professional training should be undertaken in the SHO grade and that higher training should start in the Registrar grade and continue in the senior registrar grade. Training posts at SHO level are valuable and necessary and should not be reduced; rather there should be an actual expansion in some specialties of SHO posts and a marked reduction in Registrar posts, particularly in the medical and surgical specialties, and obstetrics and gynaecology. He pointed out that the JCC is currently looking at ways of providing real general training at SHO level with some channels for moving into other specialties after starting in general medicine and general surgery.

Dr Nabarro then pointed out that the JCC was looking at the ways in which these changes will affect overseas doctors. It would prefer not to see posts earmarked for overseas doctors and he regretted Mr Malvern's views on this. The JCC would prefer to see a number of posts in each Region available for overseas doctors but not so that a particular hospital comes to be known as always having, for example, an overseas Registrar. The posts should be rotated around different hospitals in the Region.

Finally, Dr Nabarro considered how the recommendations of the JCC

could be put into practice. He commented that it is all very well for the JCC to be forming its ideas but there is a very big gulf between the JCC and the consultant in the district. There is however a mechanism for interrelating the two through the Central Manpower Committee and it is to be hoped that the Department will support the Central Manpower Committee in suggesting numbers and distribution of medical staff to be achieved according to each specialty and region.

OVERCOMING THE OBSTACLES TO CHANGE

The afternoon speakers built on the morning discussion by examining the obstacles to further development and the practical ways in which they might be overcome.

DR GILLIAN MADDOCKS

The first speaker was Dr Gillian Maddocks, Specialist in Community Medicine, Medical Staffing, Trent Regional Health Authority.

Dr Maddocks began by applauding the straightforwardness of the recommendations of the Select Committee Report adding to the general agreement that there was a real need for change. She stressed however that these changes do not need to involve radical surgery to the profession. The approach should be to look at the best way of achieving good health care for patients, improving the medical service to the Community and providing value for money for the tax-payer.

Dr Maddocks suggested an examination of the proposals for change in order to see what is expected of the profession. She went on to suggest that an examination of the Government's response to the Short Report might further illuminate the nature of the changes being considered. Both the report and the response appealed for a much higher proportion of patient care to be provided by fully trained doctors with the Department having set a target for doubling the number of consultant staff in the next 15 years and reversing the present ratio of 1 consultant to 1.8 junior doctors; that is the ratio should become 1.8 consultants to 1 junior doctor over the same period. In addition, the Government is expecting Regional Health Authorities to show a considerable interim improvement in the balance by 1988, reaching if possible a 1 to 1 ratio of consultants to junior doctors. Dr Maddocks then suggested that the other recommendations of the Government's response would seem to follow on as a natural consequence of that recommendation.

Dr Maddocks asked why this suggested change was meeting with such opposition from the profession. Is it a fear by consultants of an imposed change in the pattern of their work; a fear of a changed role for consultants; working as a team rather than the master of a crew ? Is it a fear of a change in status, a loss of expertise or that it would be too costly ? She stressed the importance of examining these fears carefully as a first task and then to go on to quantify the changes required not in terms of ratios but in terms of exactly how each

district general hospital unit will provide patient care in the future. She advised the profession to forget ratios and estimate the demand for consultant time, developing the techniques for medical manpower strategic planning as laid out in the Short Report. The Service has to be looked at specialty by specialty by consultants and the District Management Team. This is not an obstacle to change: it should be seen as a challenge.

Dr Maddocks then illustrated the variations between districts in just one Regional Health Authority by the use of prepared slides. One Health District in the Region has a ratio of one consultant to 0.98 junior staff. Another Health District in the same region, which in many ways is not dissimilar, provides a medical service with a ratio of one consultant to 1.9 junior staff. One explanation for this difference could be an actual variation between hospital facilities available and capital development. In addition, specialty mix, type of service provided and teaching hospital activities all contribute to differences between districts. She suggested that the first question that the profession should ask itself is, can the differences between standards and costs of care be demonstrated by looking at the differences that already exist ? The next question is, do specialties differ ?

Dr Maddocks' next slide demonstrated the need to look at the ratio requirements of the service specialty by specialty with the first task being to compile "strategic guesstimates" at District Hospital level until the aim has been achieved. This would involve taking into account the geography, capital stock and the phasing of developments in different districts. She suggested that the profession cannot begin to cost the implications for implementing the proposed changes nor can it look seriously at the need for career balance and medical student numbers until some 'guesstimates' are made. Although 'guesstimates' can only be guesstimates, an aim carefully thought out is better than nothing.

Dr Maddocks then suggested that the next step would be to look at each hospital's requirement for resident staff. It appears that one of the largest anxieties of the consultants is that, arising out of the proposed changes, they may occasionally have to live-in on duty. Dr Maddocks remained unconvinced that this would be an inevitable outcome but suggested that the second stage of the phasing should include a look at resident staff requirements, district by district and specialty by

specialty and to see how best residential requirements could be fitted in with service and training requirements.

Dr Maddocks suggested that the eventual ratios of senior and junior medical staff will reflect the needs of different specialties. She illustrated the present position with the use of slides. At pre-registration and senior house officer level, there will need to be enough posts available in, for example, general medicine to enable not only the General Medical Council requirements to be met but also the general professional training requirements of doctors entering the clinical specialties, those entering general practice and those entering other specialties such as radiology. It is expected that the ratio of consultants to juniors in that specialty will reflect this and is shown at present.

Districts need to quantify their need for resident staff and the information needs to be aggregated by specialty and in total. The distribution of these posts must ensure that all patients who require it have resident doctor cover and it should provide necessary training for all British graduates and all overseas doctors who require it. She went on to suggest that considerable thought needs to be given at District General Hospital level to the numbers of resident staff required and how to provide cover and care for the patients in the hospital. Unless the profession is prepared to sit down and discuss resident cover in a flexible way, there will always remain junior doctors occupying resident posts which would seem on the face of it to provide little in the way of training or stimulation in the long hours spent on duty.

Dr Maddocks then said that reaching this stage would impose no threat to the profession; only problems on how to provide the best service. Further it would not be imposing a national consultant ratio and distribution pattern. She saw it rather as a process of asking the profession to decide what doctors it wants to run a service in their district.

Having achieved the two aims of adequate resident staff and the provision of training for all junior staff, the next task would be to look at the number of training posts required specialty by specialty taking account of the already established district general hospital generated data concerning consultant expansion.

Then it would be necessary to identify the numbers of registrars and senior registrars required nationally and regionally in each specialty. The Short Report recognised the need to see the Regional Senior Registrar workforce as a flexible workforce; their distribution based on the requirements for training. If this is done district by district taking into account the district's need for resident doctors, it would be possible to quantify specialty by specialty the need for registrars and senior registrars. This change may be the bitterest pill the profession has to swallow because where there is no need for expansion in a specialty, there will be a decreased need for Registrar and Senior Registrar posts.

Dr Maddocks then produced an illustration of the present position in one region where, with an establishment of 222 Senior Registrars in post, 100 posts were filled by doctors who had undertaken their Registrar training in the same Region. 99 of these 100 had held Registrar posts in the teaching districts and only one had held a Registrar post in a non-teaching authority. At present, over half the Senior Registrar posts were filled by doctors who had completed Registrar training outside the Region. More significantly, only 0.6% of the Region's own Registrars in non-teaching districts manage to gain Senior Registrar posts in the Region whereas 32% of Registrars in the Teaching Authorities in the same Region manage to be successful in getting Senior Registrar posts.

Dr Maddocks suggested that doctors who at present occupy junior posts in the periphery are different from those in the Teaching Authorities. She again illustrated with slides that in one Region the average age of senior house officers in teaching areas is 27.5 years and in non-teaching areas is 31 years. In the same region, the average age of Registrars in teaching areas is 31 years and in non-teaching areas is 34 years. There are also considerable variations specialty by specialty in the Region. For example, senior house officers in post in the specialty of obstetrics and gynaecology have an average age of 31 years while SHO posts in general medicine have an average age of 27 years. In Accident and Emergency Medicine, the average age of Registrars is 36.7 years and the average age in general medicine is 29 years.

Dr Maddocks discussed the high dependence on overseas-trained doctors. She gave the example of one region where 91% of Senior House Officers in general medicine are fully registered compared with 61.8% holding full registration in obstetrics and gynaecology in the same Region. In the same Region, 91% of Registrars in post in Obstetrics and Gynaecology hold full registration whereas 63.6% of Registrars in post in Mental Illness hold full registration. Dr Maddocks said that although this had been mentioned earlier by Mrs Short, it certainly should not be assumed that overseas doctors and the holding of limited registration are synonymous.

Dr Maddocks then quoted some figures on the distribution of staff by age in one Health Authority. On the 13th January 1982, the age span of Registrars was from 28 years to 46 years and that of Senior House Officers from 25 years to 43 years. While accepting that these are the figures for people progressing normally through the structure, it appears in this Region that in non-teaching hospitals, Registrars have less chance of promotion into higher professional training in the Region than those in teaching hospitals. This is not due to training opportunities but to the imbalance between the number of Registrar posts and the number of Senior Registrar posts. The first step is to remove all training posts nationally and to re-distribute them in a way in which doctors training in specialties can get the best training possible and the widest experience necessary to occupy consultant posts in the future not only in the Centre in Teaching Authorities but in the peripheral District General Hospitals. To speak therefore of substitution of junior posts by consultant posts is almost to turn the problem on its head. The profession must recognise that all specialties do not fit the pattern of training at present suggested and accept that staffing ratios will vary according to the specialty. For example, Accident and Emergency is a service dependent on large numbers of senior house officers providing a 24 hour service and therefore has an inbuilt imbalance of ratios and consequent lack of continuity.

In conclusion, Dr Maddocks suggested that the profession as a whole must decide for itself whether it wishes to participate in the long-term planning proposed by the Select Committee and accepted by the Government. Careful consideration must be given to the overseas doctor requiring specialist training before returning home as well as the overseas doctor who has remained in this country for a long time occupying a training

post with little chance of being promoted to a post of higher professional training. Both these doctors have provided an irreplaceable service, some with 10 to 12 years' experience at the SHO level. Dr Maddocks suggested that the profession should look at the requirements of these doctors in the short term both for the sake of the service and for that of U.K. graduates and help them to stop blocking Senior House Officer posts as they move from one to another. She suggested that a short-term expansion of the associate specialist grade for 5 to 10 years would in fact help the profession over a tremendous difficulty. Further, the profession should review the position of the specialty-specific senior house officer post. In some specialties doctors have got over the problem of working without junior staff. Nevertheless, hospitals cannot exist without resident staff and consideration must be given to the implications of these changes for the input to medical schools and on opportunities for overseas doctors.

Dr Maddocks' final words were that the whole of her suggested processes of change took full account of the fact that nearly 50% of medical graduates are women. To enter into these processes assuming that women doctors are a special problem would be counter-productive. She urged that the profession should get the structure right with women as an integral part.

2. DR STEPHEN ENGLEMAN

Dr Stephen Engleman, Senior Lecturer in Health Economics, the University of Edinburgh, Economic Adviser to the Select Committee.

Dr Engleman said that he was in general agreement with the Select Committee's recommendations. However, since he was mainly concerned with the financial aspect, he wished to underline at the beginning that the logical conclusion of the implementation of the proposals in 15 years would be to increase costs. There was, he said, no question about it. He stressed however that it is important to examine the different effects on costs that are likely to occur. First, the efficiency argument should be examined. It has been suggested that consultants use resources more efficiently than juniors. Although there is sparse empirical evidence in this area, there is certainly some support for this argument. Although it does not hold true for every area of medical service and every specialty, it can be accepted that it is true in aggregate that there will be a reduction in the use of some resources

by the employment of more consultants. In addition, the potential for increasing efficiency in the NHS through improved clinical decision-making is really very substantial and should not be ignored. The potential for making savings is far greater than the potential in such things as the reorganisation of the NHS. It is doctors who make decisions, doctors who commit resources and it is the doctor's behaviour which can be influenced and produce savings.

Dr Engleman then considered the ways in which some costs would go up under the proposed changes. First there would be an increased salary bill from a staffing structure containing more highly paid people. However, measured in units of medical time, the additional salaries cost would not be very great, estimated as amounting to 4.3 million pounds each year for England alone. Other costs associated with hiring additional consultants would be, for example, the cost of secretarial services. In addition, there may be consultants with particular research interests who require extra facilities. If, at this point in the calculation, expected efficiency savings are weighed against additional costs, the picture looks close to breaking even, possibly a little saving, but there would not be that much in it.

Dr Engleman stressed that developing the kind of system which was proposed would make it possible to provide more services, not only because of additional manpower but because of a more efficient use of resources. What would be likely to occur, until a constraint appeared, would be an increase in throughput, that is, more cases going through the system. This would mean that unit costs would go down but, on the other hand, additional cases going through the system would put up total costs. At the point at which these curves intercept on the graph, the cost increases will be greater than the cost savings and there will be additional overall costs.

Dr Engleman went on to say that he did not think that there was any question that, long before the end of the 15 years development period proposed by the DHSS, cost increases are going to be substantial. They will be substantial because there will be a significant increase in the volume of cases. This is in itself a good thing and it also means that more cases will be treated at a lower cost per case. The increase in cost should therefore be associated with increased efficiency and capability of the service.

The total increase in the costs is likely, however, to be considerably in excess of the existing planned growth rate of the NHS. Dr Engleman drew the Conference's attention to what the Minister had said earlier - that clearly there is no guarantee that there will be enough resources available to implement changes all the way through the 15 years but this doesn't mean that a start cannot be made. Rather it means that the eventual target figures will not be met unless more resources are available than is currently envisaged. In the meantime, it is a micro-economic problem which has to be looked at at hospital, district and regional level and there is no reason not to proceed at the local level. There will be no shortage of money in the immediate future and it is only in the medium term that financial constraints will be met.

Dr Engleman suggested that if the current proposals for change are not implemented there will continue to be, as there is now, a dis-equilibrium situation where the demand for consultant posts exceed supply. This is an unstable situation. In the late 1960s and early 1970s this unstable situation was already in evidence and the severity of the problem at this time was considered to require fairly radical action over a 10 year period. A failure of the manpower policies of the 1970s widened the gap and generally worsened the situation.

Dr Engleman turned to the discussion on unemployment in the medical profession and the two most popular solutions offered to this problem which are employing fewer overseas doctors and decreasing medical school intake. All the evidence points to a decrease in the numbers of overseas doctors in the NHS as competition for consultant posts increases among U.K. graduates.

Dr Engleman considered the proposal to cut back medical school intakes as inappropriate. In his view, as an economist, he felt that unemployment in the medical profession is neither a problem in itself nor relevant to the day's discussions and gave the following explanations for his stand on this issue. He suggested that if no one in the profession was registered as unemployed, it would not be a good thing. All professions need a certain amount of unemployment: this so called 'frictional' unemployment is a means to mobility within the profession. In a booming economy, the periods of frictional unemployment are relatively short: 3 to 4 weeks on average and, in a less than booming economy, the periods of frictional unemployment get longer. This is one type of unemployment.

A second type is "structural". This is where jobs are available and there are people looking for jobs but there is a mismatch between these jobs and the people. A third type of unemployment arises out of inadequate demand. In the UK Labour Market today, there are three million unemployed and more than one million of these have been unemployed for more than a year. This represents inadequate demand for labour in a depressed economy. It is sustained inadequate demand.

Dr Engleman then suggested that available evidence points to medical unemployment as fitting largely into the frictional unemployment category as it represents less than 1% of the total profession with a duration of unemployment for about half of these people being less than three months. It is in no way a reflection of inadequate demand. What the increase from 500 to 1000 medical unemployed in the last year or two means in practice is that, at worst, doctors who were unemployed for one month are now unemployed for 6-8 weeks, a slight increase in the duration of unemployment. In fact, last month's unemployment figures within the medical profession dropped by about 85.

Dr Engleman went on to add that it is amazing that the numbers of unemployed doctors are as low as they are considering the present economic situation in the U.K. He did suggest finally that there is also some structural unemployment in the medical profession with jobs available in some geographical areas and specialties while unemployed doctors are looking in other geographical areas and other specialties: a direct result of immobile doctors.

Returning to the medical school intake, Dr Engleman said that reducing the intake would have very little effect on this kind of frictional and structural unemployment. If the career structure problem of imbalance within the profession worsens and people cannot move up between grades, then they could be out of work for longer and longer. Until the ratios change it will continue to be a structural problem within the profession. Cutting the intake to medical schools would not solve the problem of this kind of unemployment. The career structure is the problem, and there is unlikely to be any totally costless or painless solution to it.

Dr Engleman said that the time is now right to begin to resolve the problem by implementing the proposals put before the profession by the Select Committee. However these changes will need to be planned at

Regional and District level and, will need to take into account the relationship between doctors and other staff employed in hospitals.

Finally, Dr Engleman responded to the comments made earlier in the conference implying that the Short Report recommendations might make things worse for the shortage specialties. He suggested that implementation of these changes could only make things better and increase rather than decrease recruitment to shortage specialties. The experience so far is that doctors do not choose their specialty according to the number of posts available but rather that they continue to prefer to go into the crowded specialties and not the shortage specialties. The effect of the recommendations will be to increase the number of posts in the popular specialties and reduce the number of training posts at junior levels, requiring people to look elsewhere at the training post level. Hopefully they will look to the shortage specialties for training posts.

3. MR R M NICHOLLS

Mr R M Nicholls, Regional Administrator, South Western Regional Health Authority began by confessing his limited experience in the field of medical manpower and his feeling of being an outsider at a family squabble. He added however that, as an administrator, he needed no convincing of the importance of the subject to health care generally as doctors who are only 6% of the NHS directly employed labour command most of the resources used.

Mr Nicholls commended the structural diagrams showing the patient at the top of the chart and recalled the chart produced by the DHSS at the time of the 1974 reorganisation of the NHS. He urged that patients should be at the top of any charts of health care services and everyone else there in some way as support.

Mr Nicholls felt that it was absolutely critical that these recommended policy changes are seen as part of a process of negotiation and developing commitment. If changes are to occur, the policy objectives must embrace medical opinion and approval but they should also relate to the policy objectives of the service. It is no good having a policy objective, such as, for example, development of services for the elderly, at a time of low or nil resource growth if in fact the next consultant manpower approval for that particular part of the country is for a cardio-thoracic surgeon. This has happened.

One of the other key elements in the NHS is the interdependence of the manpower mix. The medical manpower problem should not be considered in isolation from other NHS staffing arrangements. Mr Nicholls expressed his disappointment with medical manpower planning which is too often isolated from other planning and policy objectives in the service and added his criticism of successive governments of both parties and their assumptions that the NHS can respond to such a wide range of objectives. The latest medical career structure changes recommended could be just another isolated objective unless both the administration and the medical profession are able to integrate it. In particular, medical manpower planning seems for too long to have been a detached activity carried out mainly by the medical profession and medical administrators. Mr Nicholls blamed equally administrators and doctors for this stage of affairs, although he thought that warring factions of doctors at all levels, from local cogwheel committees through to regional and central manpower committees, all being lobbied by professional bodies, had contributed to the troubled and long history of medical manpower reports.

In fact, there had been rather more reports on medical manpower than there had been on supplies, a field in which Mr Nicholls suggested he was rather more familiar. The conclusion of the latest NHS supplies service report was that it is better taken away from the health authorities and given to a new special health authority; he suggested this should be a warning for the medical profession. Further, in spite of all the reports that have been published, this problem appears to remain intractable and is in fact getting worse in some regions. His own region, the South West, is rather better than some having had only two additional senior house officers last year. He suggested that perhaps the existing medical manpower mechanisms should be given more teeth.

Mr Nicholls said that his limited direct practical experience had left him with the powerful impression that there should be a reduction in junior doctors' hours and an increase in the number of consultants. This would be in the interests of doctors' careers, and more particularly in the interests of patient care. He did take Dr Maddocks' point however that it isn't a general problem to all districts and regions or to all specialties. He gave the example of his own region where only four out of the eleven districts are very far from achieving the first target. Consultant junior ratios in the other 7 districts are very near 1:1 and,

of the four districts where the average is 1 to 1.4 (the national average is 1 to 1.6), three are in the old teaching areas. So, as Dr Maddocks pointed out earlier, it is not one single problem and it should be examined at district as well as regional level.

Mr Nicholls went on to comment on the speakers' contributions and the reasonably clear aims and objectives that emerged overall with both a Minister of State and a member of the opposition in general agreement. However, whilst there appears to be agreement on the ends of the recommendations of the Short Report, the means are still causing concern. Resources must be at the top of the list as a key factor in change. Mr Nicholls quoted Rudolf Klein as saying that the record of predicting the future from the past in the Health Service has not been very good and the chances of more resources in the NHS in real terms and in the short term are very low. This was candidly and honestly put by the Minister himself. In fact for the first time in 20 odd years, the NHS is looking to a reduction in resources in real terms. However, although the resource outlooks are bleak and should not be fudged, they must not delay making a start on the changes at district level.

He suggested that changes could begin with a bottom-up approach. The Government have set targets and, however unrealistic, it is better to have set targets than no targets. Referring again to the Government's reactions to the Select Committee Report, Mr Nicholls approved the general enthusiasm of the White Paper and circulars suggesting that although they were hedged about with references to resource problems, progress on the issue of resources might be regularly reviewed.

Mr Nicholls expressed disagreement with the recent decision to locate consultant contracts at Regional level. This would, in his opinion reduce the ability of districts to carry out comprehensive planning. His final plea was that medical students should not receive so much exposure to the acute specialties when there are lots of other jobs to be done in medicine which are rated low in early career choices.

In summary Mr Nicholls outlined the action needed to achieve changes. He suggested an examination of specialties at district level rather than a blanket freeze on senior house officer posts which would not solve the problem. There should also be an examination of delegation upwards as well as downwards in the NHS and the work done by junior

doctors needed to be looked at for ways in which it might be done more effectively and cheaply by other categories of staff as well as putting it up the line to senior doctors. Mr Nicholls suggested that since everyone was agreed on the aims, what remained to be done was to tease out the practical difficulties in the implementation of policies for change. He offered to the Conference the thought that the day had left him better informed and not as dispirited as he thought he might be.

GENERAL DISCUSSION

Mr Nicholls was the last platform speaker and the Chairman therefore invited questions and points from the floor.

The first question came from Dr J Todd, District Medical Officer, Sheffield Health Authority, who asked about the time-scale for change proposed by the Short Report. He suggested that it was not possible to achieve change without a proper planning time-scale of posts approved centrally from the Department. In spite of past policies for expanding the consultant grade over the past 12 years, there seems to have been only a worsening of the situation. Inadequate planning of central approvals appears to have been a greater obstacle to change than lack of resources.

This was followed by comments from Dr Anne Grüneberg, Consultant Anaesthetist, from the North West Thames Region. Dr Grüneberg suggested that the reason why there had been no increase in the proportion of consultants over the last 12 years was that the manpower committees have no mechanisms to increase consultant numbers. She also expressed doubts about financial constraints not being a bar to an increase in consultant numbers. She mentioned her own district where there was a delay in increasing or even replacing consultants because of financial restrictions imposed locally by people at the periphery who have disposal of the resources.

Dr Paul Abrams of the DHSS was asked by the Chairman Lord Richardson to reply to both these last points. Taking up Dr Todd's point about central approval for posts, Dr Abrams said that the Department wished to move to the sort of system that Dr Todd was demanding where approvals are given for three or four years ahead, in fact, in good planning time. In reply to Dr Grüneberg on the question of finance, Dr Abrams agreed with the Minister that financial constraints should not thwart a start on expansion. He emphasised that the Minister did not say that there would not be financial constraints but that within the growth money available, some progress can be made.

Mrs Short came back into the debate at this point re-emphasising the Select Committee's awareness of the acute problem of resources. She expressed her own personal concern about the lack of finance for the NHS, particularly for preventive medicine, and her advice to the medical profession was to keep on pressing for more resources but urging them at the same time to be selective about their demands and not to press for everything.

Next Dr Michael Joy, Consultant Physician, St Peter's Hospital, Chertsey, wished to add his own specialty of cardiology to the list of shortage specialties mentioned by Mrs Short. He said that, within cardiology, the situation throughout the country was disgraceful; with the exception of Eire the UK has the lowest number of cardiologists in the western world and only half the total health districts before the reorganisation had a cardiologist with special training. This is in spite of a high death rate from coronary illnesses in this country which has not fallen over the last two decades as it has in the United States. Further there are 60 to 70 fully trained senior registrars in this specialty with a prospect of only 6 consultant posts becoming available each year over the next 10 years. However, without money for additional equipment and resources, new consultant appointments in cardiology would be a waste of time.

Dr W Lees, Specialist in Community Medicine (Medical Manpower), South West Thames Regional Health Authority, returned to the problem of resources suggesting that the Royal Colleges and Faculties of Medicine should be asked to look at training posts surplus to requirements and their career prospects and particularly they should be asked to consider them at the hospital as well as the regional level.

Mr D Innes Williams, Director of the British Postgraduate Medical Federation, suggested that the priority aim of the Health Service structure was generally agreed to be meeting the needs of patients rather than the needs of the profession. However, there would always remain the problem of matching service needs to training needs and overseas doctors are part of this structure. He suggested that one practical activity needed at the present time was to look at the numbers and quality of overseas doctors who come to the UK. At the moment the situation is unregulated, restricted to only a small extent by General Medical Council standards, and not sufficient to regulate the flow of overseas doctors. Mr Innes-Williams went on to suggest that only those overseas doctors who are likely to return home after training should be accepted. If this is not done by immigration rule, then it should be done internally in this country. In addition, there is a need for a career appointment in a lower grade for those who do not want to go to consultant level.

Mrs Short replied that the creation of a lower grade career post would only lead to the shunting of women and overseas doctors into dead-end jobs and therefore neither she nor the Select Committee could approve of the creation of a sub-consultant or similar post. Further, she assumed that the Department also disapproved of the creation of these posts.

Professor Ian McColl, Professor of Surgery, Guy's Hospital Medical School, made the point that while others talked of the theory of the numbers game in the medical profession, the system had been practised successfully in one-third of the South East Thames Region over the past ten years. He went on to say that there is in fact one surgical trainee for every pair of surgeons and half the number of trainees are from overseas and are expected to return to overseas after training. This makes the effective ratio of one trainee for every four surgeons and everyone is quite sure that the system works in the South East Thames region. However, it cannot be said that it would necessarily work elsewhere. If an attempt is made to impose a rigid system throughout the country, the consultants will object because they want to know that it is going to be appropriate for their situation before they put it into practice. Professor McColl felt that it was politically inept to say that the number of consultants should be doubled in the next 20 years. Radical changes over the last 10 years in the NHS have been disastrous and there is a need to progress by gradual evolution. It would have been better to suggest that each region increase its consultant posts by say three each year. This would mean a decrease of 45 Registrar posts and an increase of 45 consultant posts over the next 15 years and it would be possible to monitor the effect of these changes. If that were the approach, then some progress might be made. Consultants like gradual evolution based on facts and pilot studies and would appreciate no more abuse from various sectors suggesting that they are the cause of all the trouble. It is certainly the case that everyone is responsible for the present situation as was pointed out by Mr Nicholls. In this country we have our democracy which means we shuffle along and perhaps that is the best way of doing things.

Dr Ridout, Specialist in Community Medicine, (Medical Staffing), South East Thames Region, questioned the timing of the changes recommended suggesting that the number of consultants could be doubled over the next 30 years rather than the next 15 years. The lifetime of a consultant is approximately 30 years and it would have been more sensible to aim to make the changes over this time span. Consultants now being appointed will expect fewer juniors and so on gradually until the planned reduction in juniors and expansion of consultants is achieved over the 30 years time span.

Dr J C Leonard, Consultant Physician, South-West Manchester Health Authority, asked Mrs Short about numbers and the 4,000 medical students being admitted to medical schools each year. Each cohort of school leavers in the UK is approximately 600,000 per annum. This means that 1 in every 150 school leavers is training to be a doctor. Dr Leonard wondered how long this situation could continue.

Mrs Short replied that no one knows how many doctors are needed but most certainly the Department did not intend to introduce a rigid notion of how many doctors should be trained. It is a matter for the profession as a whole including the medical schools and Royal Colleges.

Mr Sandbach, a Personnel Officer from the Shropshire Health Authority asked if the cost of expansion could be examined further. If a flexible and imaginative approach to medical staffing is adopted, then expansion need not involve much additional cost. Mr Sandbach said that he had actually calculated this for his own Authority and would recommend it to other Authorities anticipating change.

Professor James Parkhouse, Postgraduate Dean and Director of Regional Postgraduate Institute for Medicine and Dentistry, University of Newcastle upon Tyne, asked to disagree slightly with the tenor of Mrs Short's comments on overseas doctors. He stressed that they are in fact a very important factor in the medical career structure and the manpower structure of the Health Service, constituting a very large number of doctors, something like a third of the medical workforce. While it is possible to say that they should go home after training, it is not practical and realistic nor is it a sensible attitude to take. Overseas doctors do the worst jobs and many of them have given years of valuable service to the NHS, largely keeping it going. Professor Parkhouse went on to suggest that the profession does owe them something although some of them are not going to make consultant grade and indeed it would not be right in terms of maintenance of standards of health care that they should so do. He suggested that what is really needed is the availability of an ad hoc arrangement of posts at sub-consultant level. However, he agreed with Mrs Short that the establishment of a sub-consultant post would be unwise and unnecessary. He went on to remind the Conference that the present medical school intake was in fact based on the Todd Report [3] recommendations which had suggested a level which provided a self-sufficient health service rather than one dependent on overseas doctors. Medical School intake had now reached Todd's recommended level

and there was a commitment to the philosophy of re-stocking the NHS with UK graduates. As the re-stocking takes place, the situation will change and it has to remain constantly under review.

Professor Parkhouse said that he greatly enjoyed Dr Maddocks' paper and applauded her suggestion that change should start at clinical unit level, looking at what doctors are doing and how the service is going to be provided. This must be done by trying to get districts to form some sort of idea about the range and volume of clinical services which are going to be provided over the next five years, how they are going to do it and what the medical manpower implications of that are mainly from the service point of view. The changes have to be started at district level looking at the specialties as they fit together and then pieced together at Regional level. The whole thing has to come together with the training side of the manpower equation being looked at with the help of the Colleges and the Region. This means looking at which posts are needed for training, how they are going to be linked together and how many should be set aside for overseas doctors at any one time. Professor Parkhouse then said the next question is how to integrate service planning and general strategic planning at district level. This sort of exercise can begin right now given good co-ordination and information systems.

Dr Michael Rees asked to continue the debate on overseas doctors. He stressed the need to oppose a sub-consultant grade but proposed that the profession should look to increased personal appointments to the associate specialist grade for overseas doctors who cannot proceed to consultant status and may find themselves unemployed after years in training posts. If a permanent personal post is created, then the junior post previously occupied could be closed down.

Dr Maddocks replied briefly on overseas doctors reminding the conference that the average age of overseas doctors is currently between 40 and 45 years. However, she could not agree with Dr Rees that the posts held by the overseas doctors could invariably be closed down as they are vacated. At district level in the short term it may be necessary to hold the posts open as substitution of individual posts is wrong in medical manpower terms. The distribution of posts should be planned at a junior and senior level then a decision could be made on how many training grade posts are needed so that they can be re-distributed to get the best training.

Mrs Violet Rushworth, Nursing Officer from the DHSS, hoped that it is now recognised that a shift in the balance of medical staffing will have major implications for other health professions, particularly nursing, and emphasised the need for nurses to be involved in consultations at the local levels on any changes proposed. It would not only enable their views to be taken account of but also help to enlist their cooperation.

Dr C Godber, Consultant Psychogeriatrician, Southampton, added a final comment on the sub-consultant grade suggesting that the profession must accept the need for this grade not to accommodate overseas or women doctors but because not every medical graduate will be fit to take a consultant post and work independently. In the past, the bad doctors have tended to drift off into general practice. That is not to say that general practice is bad - rather the reverse. However there are some doctors going through the training grades who shouldn't reach either principal grade in general practice or consultant grade in the hospital service. These are the people along with those who would rather not commit themselves as fully to medicine as the consultant role implies, for whom there is a need for a sub-consultant grade. This grade should not therefore be thrown out of the window.

CONCLUSION

Lord Richardson summed up briefly by suggesting that it probably did not come as a great surprise to the assembled gathering that no new conclusions had been reached. Although the substance was familiar, things that were said had been said rather differently. He thanked the King's Fund for their hospitality and drew attention to Mr Malvern's disappearance during the afternoon to do some emergency work demonstrating in a practical way "continuity of care and avoidance of the shift system".

Mr Cannon thanked Lord Richardson for his contribution as Chairman and the Conference ended.

PD/DMH:nmd
December 1982.

REFERENCES

1. GREAT BRITAIN. PARLIAMENT. Fourth Report from the Social Services Committee. Session 1980-81. Medical Education with special reference to the number of doctors and the career structure in hospitals London H.M. Stationery Office 1981.

2. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Government Response to the Fourth Report from the Social Services Committee, 1980-81 Session (Cmnd 8479) London. H.M. Stationery Office 1982.

   See also DHSS Circular HC (82)4: Health Services Management Hospital Medical Staff: Career Structure and Training. February 1982.

3. Royal Commission on Medical Education 1965-68 (Chairman, Lord Todd). London. H.M. Stationery Office 1968.

4. The Organisation of Hospital Clinical Work. Report of a King's Fund Working Party (Chairman, Prof T J H Clark). Project Paper No. 22 London 1969 - available from the King's Fund Centre price £1.50 plus 29p p & p.

5. DAY Patricia Women Doctors: Choices and Constraints in Policies for Medical Manpower. King's Fund Project Paper No. 28 - available from King's Fund Centre price £2.30 plus 26p p & p.

MEDICAL MANPOWER - THE OPPORTUNITY FOR CHANGE ?

CONFERENCE ON FRIDAY 14 MAY 1982

List of those who were present:

DR M E ABRAMS	Senior Principal Medical Officer	DHSS
MR D ADSETT	Senior Personnel Officer	East Yorkshire HA
PROF A R BUCHAN	District Medical Officer	Leicester
DR D BURMAN	Consultant Paediatrician (Consultant Member D.M.T.)	Bristol & Weston HA
DR P S R BURRELL	District Community Physician	North Tees HA
DR G D CARROLL	District Medical Officer	North East Essex HA
PROF T J H CLARK	Sub-Dean	Guy's Hospital Medical School
DR J CONNOLLY	Senior Lecturer, Westminster Medical School	Queen Mary's Hospital, Roehampton
DR M COTTER	District Community Physician	South Glamorgan HA
DR D CULLEN	District Medical Officer	Plymouth Health Authority
MR G I B DA COSTA	Consultant Orthopaedic Surgeon	Representing Hospital Consultants and Specialists' Association
MRS P DAY (RAPPORTEUR)	Research Officer, School of Humanities and Social Sciences	University of Bath
MRS P DIXON	Regional Manpower Planning Officer	Wessex RHA
MR R DOBSON	Assistant Regional Personnel Officer	Mersey RHA
MR F S A DORAN	Consultant Surgeon (Retired)	Mid-Worcestershire
MISS A H ELDER	Personnel Officer	North West Thames RHA
* DR S ENGLEMAN	Senior Lecturer in Health Economics	University of Edinburgh
MISS J ENGLISH	Reporter	"Hospital Doctor"
DR P W FISHER	Consultant Physician	Representing NHS Consultants' Association
DR G R FORD	Deputy Chief Medical Officer	DHSS
MISS M FRASER GAMBLE	Honorary Secretary	Association of Nurse Administrators
MR F W GASTON	Acting for SCM (Medical Staffing)	West Midlands RHA
DR F N GARRATT	District Medical Officer	Wolverhampton HA
MR J A GIRLING	Consultant Surgeon (Consultant Member D.M.T.)	South East Kent HA
MR P L GIROLAMI	Consultant Surgeon	Medway Hospital, Gillingham, Kent
DR W J GLOVER	Consultant Anaesthetist	The Hospital for Sick Children, Gt. Ormond Street
DR C GODBER	Consultant Psychogeriatrician	Moorgreen Hospital, Southampton

* MR R K GREENWOOD	Consultant Surgeon	Leicester
DR L P GRIME	District Medical Officer	Burnley, Pendle & Rossendale Health Authority
DR J A GRÜNEBERG	Consultant Anaesthetist	London
MR S J GUDE	Consultant E.N.T. Surgeon	Burnley General Hospital
DR J D HAILSTONE	Consultant Physician	Royal Free Hospital, London
DR V P HAJELA	Consultant Physician (Chairman MEC)	Burnley General Hospital
DR C E HALL	Senior Medical Officer	DHSS (Northern Ireland)
MR S HALPERN	News Editor	"Health & Social Service Journal"
DR D J HEWETT	District Medical Officer	Winchester HA
MR T HOGAN	Reporter	"Medical News"
DR J HORDER	President	The Royal College of General Practitioners
DR V M C HOLLYHOCK	Regional Specialist in Community Medicine (Manpower)	Wessex RHA
MR M JEFFERIES	District Administrator	Southend Health Authority
DR S A M JONES	District Medical Officer	Victoria HA
DR M D JOY	Consultant Physician	St Peter's Hospital, Chertsey
MISS N KENNARD	Staff Writer	"PULSE"
PROF R KLEIN	Professor of Social Policy, School of Humanities and Social Sciences	University of Bath
DR W LEES	SCM (Medical Manpower)	South West Thames RHA
MRS J M LUCAS	Personnel Officer (Medical Staffing)	Brighton General Hospital
DR J B LYNCH	Postgraduate Dean	Leeds General Infirmary
DR J C LEONARD	Consultant Physician	South Manchester HA
MR G C LUPTON	Assistant Secretary	DHSS
MR R F MACLACHLAN	Consultant E.N.T. Surgeon (Consultant Member D.M.T.)	Croydon General Hospital
PROF I MCCOLL	Professor of Surgery	Guy's Hospital
DR W McMURRAY	Consultant Chemical Pathologist	Wythenshawe Hospital, Manchester
* DR G MADDOCKS	SCM (Medical Staffing)	Trent RHA
* MR J MALVERN	Consultant Obstetrician	Royal College of Obstetricians and Gynaecologists
MR R J MAXWELL	Secretary	King Edward's Hospital Fund for London
MRS P MEACHER	Medical Staffing Officer	Hammersmith Hospital
DR W J MODLE	Senior Medical Officer	DHSS
DR L MULROONEY	Consultant Anaesthetist President	Mansfield, Nottingham Hospital Consultants' and Specialists Association

* DR J D N NABARRO	Emeritus Consultant Physician, Chairman of Joint Consultants' Committee	Middlesex Hospital, London
DR L NEWMAN	General Practitioner Honorary Secretary	London Medical Women's Federation
* MR R M NICHOLLS	Regional Administrator	South Western Regional Health Authority
MR N OFFEN	Consultant General Surgeon and Chairman of MEC	Whipps Cross Hospital, E11
MR C PARISH	Postgraduate Dean	Cambridge Clinical School
MR K E PARSONS	Principal	DHSS
MR R W PARKER	Consultant Surgeon	Hospital of St Cross, Rugby
PROF J PARKHOUSE	Postgraduate Dean & Director of Regional Postgraduate Institute for Medicine and Dentistry	University of Newcastle-upon-Tyne
DR A PATON	Postgraduate Dean	North East Thames Region
MISS A PEARCE	Medical Staffing Officer	South Camden Division, Bloomsbury Health Authority
DR H G PLEDGER	Area Medical Officer	Northumberland AHA
* RT HON LORD RICHARDSON (CHAIRMAN)	Consultant Physician (retired)	Formerly President of the GMC and Chairman of the Joint Consultants' Committee
* DR M REES	Chairman Hospital Junior Staff	British Medical Association
MS J REYNOLDS	Select Committee Assistant, Social Services Committee	House of Commons
PROF P RHODES	Regional Postgraduate Dean of Medical Studies	University of Southampton & Wessex RHA
DR J RICHINGS	Senior Medical Officer	DHSS
DR A B RIDOUT	SCM (Medical Staffing)	South East Thames RHA
MRS V E RUSHWORTH	Nursing Officer	DHSS
MR D SANDBACH	Personnel Officer	Shropshire HA
DR J SECKER-WALKER	Consultant Anaesthetist	University College Hospital
DR F SEYMOUR	Regional Medical Officer	North West Thames RHA
MISS A SEYMOUR	Consultant in A & E	Ingham Infirmary, South Shields
MS J SMITH	Staff Editor	"British Medical Journal"
DR P G SMITH	Consultant Pathologist and Chairman of D.H.M.E.C.	University Hospital, Queen's Medical Centre, Nottingham
* MRS R SHORT	Chairman of the Social Services Committee	House of Commons
MR B STERRY-ASHBY	Consultant Surgeon	Southend Health Authority
MISS J R SWINHOE	Consultant Obstetrician and Gynaecologist, Vice-Chairman of MEC	King George Hospital, Ilford, Essex.

MS L C SYDENHAM	Assistant Secretary, Medical Services	The Hospital for Sick Children
DR J THOMAS	Specialist in Community Medicine	West Glamorgan HA
MR J W THOMPSON	District Administrator	Lewisham Health District
DR J N TODD	District Medical Officer	Sheffield HA
DR J WARREN	Consultant Anaesthetist	King Edward VII Hospital, Windsor
DR D INNES WILLIAMS	Director	British Postgraduate Medical Federation
DR D G WILSON	Representative	Royal College of General Practitioners
DR G WINYARD	District Medical Officer	Lewisham and North Southwark DHA
DR E W WRIGHT	District Medical Officer	Waltham Forest HA

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