Doctors' careers

NO subject has provoked more discussion in recent years than medical manpower and the hospital career structure. The questions are what should be done, and how to do it. The first answer is fairly simple: we need to extricate ourselves from the consequences of having restricted our medical school output at the time of the Willink report (Department of Health, 1957) and hence of having become increasingly dependent on overseas doctors. Extricating ourselves will be difficult, but something must be done. The decision to increase greatly the output of the British medical schools was made, correctly, some years ago; we now have to create a future for the young doctors that we so badly need. Medical unemployment is not at present a problem, despite some exaggerated reports, but if we allow all the present number of registrar jobs to fill up with British graduates, instead of half being occupied by overseas doctors who mostly do not seek career outlets in this country, we—or rather the doctors concerned—will face a desperate situation. General practice could benefit from this in terms of recruitment, if it wanted to, but only with the potential risk of flooding the market—and it was this kind of anxiety, that there would not be enough places available in general practice, which led to the Willink enquiry in the first place. Year by year, the number of doctors in general practice has increased very slowly. However, the latest annual figures show a greater growth, which suggest that more positive planning for the recruitment and disposition of staff in general practice may be necessary.

The problems of the hospital career structure will be quite familiar to many doctors who are now in general practice. The common spectacle of 40 to 50 applicants for every senior registrar post in surgery, all highly qualified men in their thirties (very few women) with four or five years' experience in the registrar grade, illustrates the difficulties at their worst. There is now general agreement that, at least in most specialties, there must be fewer trainees at registrar level and more career posts. But the breadth of training must be preserved and extended. Lateral movement has always been a feature of the British system, and many specialties, such as psychiatry, anaesthetics, geriatrics and general practice, have gained valuable recruits in this way: they have benefited from the range and variety of experience these doctors have brought with them. Radiology and community medicine insist on other experience before specialist training begins, and obstetrics and gynaecology requires an elective year to be spent outside the specialty. In 1975, a survey of senior registrars in all specialties (Parkhouse and Darton, 1979) showed that the length of time between qualifying in medicine and becoming a senior registrar could be anything up to 25 years. This is at once an indictment and a tribute to the present system, with its combination of haphazardness, frustration, tolerance and free enterprise. Anxieties are now prevalent about the growing rigidity of postgraduate training programmes and the disincentives to stepping off the beaten track to do something enterprising or unusual. The House of Commons Select Committee on the Social Services (House of Commons, 1981) was much impressed, in its recent enquiry, by the dangers of too narrow a training; it also felt that medical training for the modern world should include more than the standard pre-registration recipe of general medicine and general surgery. Their report urged that all newly qualified doctors should have the chance to gain experience in normal child health and development, the illnesses of childhood, the problems of old age, the role of medicine in the community, the psychological aspects and effects of illness and general practice.

With the introduction of vocational training, general practice is the only specialty to have adopted this concept of general professional training in the way that it was envisaged by the Todd report (DHSS, 1968). Although vocational training is to be applauded in this respect, and in others, it could defeat its own liberal purpose if not carefully integrated into the postgraduate training system as a whole. There are now so many applicants for schemes that two dangers arise: doctors considering general practice are almost forced to make a career choice before the end of the pre-registration year, which is often far too soon, and the competition for places is artificially inflated by doctors applying as an insurance policy, with no real intention of entering general practice. Here is a turnabout indeed: it may be amusing to contemplate the prospect of doctors falling off the ladder from general practice into the hospital specialties, but, in the long term, a broader view is needed.

There is an awkward question here about the right number of places that should be available in vocational training schemes. We should never reach a point where completion of a formal scheme is, in effect, the only route of entry to general practice. Many people would feel that the present balance of training—half through

formal schemes and half through self-constructed programmes—is about right. But as general practice becomes increasingly competitive, will it be possible to give equal preference to all, or will those who have undertaken a formal scheme feel ill-used if they are turned down in favour of 'do-it-yourself' applicants? Also, if an element of general clinical training—at least one year—is to become the rule for the hospital specialties, how can this be fitted together with general practice training, bearing in mind that many of the doctors concerned will not have made a firm career choice?

The essential point is that the total number of SHO posts must be sufficient to allow all British graduates at least two years at this level. In principle, there should be no difficulty about this with the existing numbers of jobs, but a free flow through the system must be ensured. There are now over 9,000 SHO posts in England and Wales alone, compared with a UK total of less than 4,000 qualifiers a year. But, at present, there are substantial numbers of doctors, including many from overseas, who have spent four or five years in one or more SHO posts before obtaining promotion. This is the problem which has to be eased: and it is no answer to make a panic move towards reducing the output of doctors. The recommendation of the Short Committee, and of others, is that the number of SHO posts should no longer be allowed to rise—the situation needs watching and there are no plans for actually reducing the number of posts at this level.

Perhaps, as things evolve, vocational training could be based on a 'second year entry', thus adopting the principle of a probationary year to be recognized, if appropriate, retrospectively as suggested by the Short Report (DHSS, 1981) for other specialties. Conversely, it is to be hoped that one year spent as a trainee in general practice would be given recognition as an 'elective' part of the total training requirement for a hospital specialty. With this kind of arrangement there would be a pool of available posts for graduates at the end of their pre-registration year, in the hospital specialties, community medicine and general practice, after which career paths would begin to form themselves more or less clearly. Completion of vocational training would then require two further years, planned in such a way as to complement the experience already obtained. Such a system would imply that virtually all SHO posts, with the necessary educational status and relevance, would be selected for vocational training purposes, whether they were included in schemes or not, and this is surely the right approach. It would also imply that traineeships would be available in general practice for many doctors who later enter hospital and community medicine.

A change in the career structure leading to a different balance between junior and senior hospital staff raises questions about how consultants are to function. Anxiety must not prevent constructive thinking. There is no slight on the way consultants work at the moment—and most work very hard indeed—but a better service to the patient could be provided if more consultant time were available. Current proposals do not imply, as has sometimes been thought by more alarmist observers, a wholesale withdrawal of all junior staff from peripheral hospitals, but the welcome removal of a few layers, here and there, between the patient and the consultant. This must open up possibilities for a more direct working relationship between the consultant and the general practitioner and a better understanding than has sometimes existed of the nature and purpose of referral. In some cases the management of the patient needs to be transferred to the hospital sector, at least for the time being; in other cases what is wanted is an opinion, or advice; in many cases long-term collaborative effort is badly required. This raises issues such as the carrying of consultations and clinics into the community and further exploration of the best way to serve the needs of childhood, maternity, occupational health, intractable pain, terminal illness, old age and the other areas where family practice and special expertise interlock.

The hospital career structure concerns everyone. The whole question of numbers of doctors, and hence of trainees, is dependent on what doctors actually do, and why. The more one learns of medicine, as Lord Cohen used to say, the more one comes to understand that there are no diseases, but only disease. There are no self-contained specialties, for which a complete package of training and a specialist register can conveniently be provided, but only the practice of medicine as a service to the community, and, through research and teaching, to its future. The Office of Health Economics (1981) commented in its recent briefing on *Doctors, Nurses and Midwives in the NHS* that, "it was automatically assumed during the 1960s and early 1970s that any increase in professional manpower in the National Health Service must bring corresponding improvements in the quality of care". It is doubtful if many doctors were, in their hearts, so naïve; but the OHE Report, like the Medical Manpower Steering Group Report (DHSS, 1980), does give some reminders of the never-ending way that doctors can find useful means of occupying their time. If the number of obstetricians increased during the years when the number of live births was falling, as in fact it did, what does this mean in terms of health care—and how does one measure it? What about the number of midwives, health visitors and doctors engaged in family planning and screening?

There is no field more active than general practice in the study of the relationship between doctors, other health professionals and ancillary staff, and the relationship between medical and social causes of ill health. These are areas in which well-controlled research is desperately needed and desperately difficult. It is here that audit begins to have real meaning, and where the complexity of the numbers game of medical manpower planning becomes fully apparent. Not only must the situation be kept under constant review, as has fre-

quently been emphasized, but the review must be highly competent and backed by an appropriate research effort. We are a long way from being able to measure the value of human life, and its quality, in stark terms of cost-effectiveness. Perhaps we always will be. But we do know that, unless we sustain our medical school output at the present level for a while, we may well have fewer doctors in 10 to 15 years than we have now and we should at least have some idea of whether this would be good or bad, before giving the economists an easy way out. It does us no harm to feel some pressure to justify what we are doing with our jobs and with the careers of the next generation.

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Health education

THE management of chronic disease can be frustrating. Many illnesses have multifactorial causes, they may develop very gradually with unremitting progress and little amelioration from conventional medical treatment. It is easy to see why the medical profession and government are increasingly giving priority to prevention of such illnesses. Unfortunately, prevention is difficult and, as it usually involves major changes in attitudes and behaviour, many doctors and patients opt for the easy way and ignore the possibility of change. With the publication of three documents on health and prevention in primary care within the last year, the Royal College of General Practitioners (1981a, 1981b, 1981c) has indicated its commitment to this whole area of preventive medicine.

One major part of prevention is health education. It should already be considered as a potential part of every consultation in general practice (Stott and Davis, 1979), and is now beginning to have its own professionals as well. These people are in posts in Area and District administration and their function is to stimulate other health professionals in the field of health education, such as general practitioners and health visitors, and to provide material support for their activities. A recent DHSS publication (1981) has attempted to clarify some of the aims of this relatively new health professional and suggests that health education officers should be recruited either from nurses with appropriate post-nursing experience, teachers, environmental health officers or graduates in a relevant discipline. The trainee health education officer would normally have two years' in-service training, followed by at least a one-year full-time diploma course in health education.

We now have a central body, the Health Education Council, which is attempting to co-ordinate national campaigns against such things as smoking, alcoholism and irresponsible sexual behaviour; we have locally based health education officers who, with their growing administrative machinery, are striving towards a greater degree of professionalism; and we have the vast number of health professionals who are expected to include health education in their everyday work.

Perhaps we should be clearer about what this structure is being used for. What do we mean by health education? It is surely more than the simple propaganda put out in the first half of this century. Are we simply to encourage people to stop smoking, to use alcohol appropriately, to wear seat belts and so on, without taking account of the importance of encouraging governments to change their priorities and sometimes the law? We are all individuals who have evolved patterns of behaviour over the course of years, partly as a result of cultural and parental attitudes. If we are to change our behaviour to achieve better health, propaganda is not enough: education is better, but education together with cultural pressure is better still. Government and the profession need to work hand in hand.

We know that general practitioners who advise their patients to stop smoking will have a limited, though significant, impact (Russell *et al.,* 1979). We also know that government (national and local) is dragging its feet in failing to raise the price of tobacco products high enough to actively dissuade people from smoking. Government's two-faced attitude in supporting health education on the one hand and failing to reduce sales of tobacco on the other cannot be condoned, however persuasively the industrialists argue in support of the tobacco industry. The same need for joint action between the profession and government arises in other areas of health care, such as the use of alcohol and road accident prevention.

We all need reminding that health education can be