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Providing specialist care in the modern NHS; a "consultant" led and "specialist" delivered service. Sub consultant versus Specialist. A discussion paper

Introduction

The Executive Committee of the ASGBI fully support the concept that the end point of surgical training is the attainment of a CCT/CSER and the opportunity to then apply for a consultant post in a surgical speciality of choice. Nevertheless, we recognise that, in the current NHS climate, the required expansion in Consultant numbers has not occurred and has certainly not matched the recent increase in surgical trainee numbers. This is resulting in a large number of post CCT "trained surgeons" unable to progress to consultancy immediately and looking for alternative employment.

Many of these "trained surgeons" are already being offered "non-consultant" posts within Foundation Trusts; they have CCT and are allowed to be "on call" with no additional consultant back-up These "sub consultant" posts are rightly much derided by many organisations and the ASGBI, the Colleges, the BMA and many trainees associations, not least the ASIT, have all repeatedly expressed their implacable opposition to such a grade. We share this view but, if trained surgeons are going to be recruited into these "less than" consultant grades, it is imperative that, the posts are carefully monitored, workload controlled and suitable pay scales and employment terms defined. These posts must be recognised by the ASGBI, SAC's, BMA and Royal Colleges and a structure developed whereby such "trained surgeons" can subsequently apply for definitive Consultants posts when they become available.

We recognise that an increasing number of clinicians committed to patient care and the well being of trainees, have repeatedly expressed the opinion that service provision, particularly of specialist services, will have to be provided in different ways in the future. This could result in much clinical care not being provided by "consultants" in the future. We also recognise that the issue of consultant versus non consultant provision often generates much heated debate. The purpose of this discussion paper is to examine how the provision of surgical service may be achieved, if the required consultant expansion does not occur, as is looking likely. We wish to inform that debate rather than to promulgate one particular direction of travel.

One thing, however, is certain; if the profession fails to reach agreement on how best to provide specialist care then inevitably we will see a piecemeal approach to this issue dominated by the financial constraints of Trusts and Government. If this occurs then the interests of our patients will be subsumed into political expediency and the career aspirations of our trainees ignored. In our view, this is already beginning to happen.

Background

Historical precedent: there is nothing new in the concept that there needs to be a grade of doctor who is trained, but not necessarily a consultant**.** Sir Heneage Ogilvie writing in 1954 said "n*ow that surgery has become a nationalized industry, the nation must surely recognize that it is one in which skill and wisdom are acquired slowly, progressively, and by apprenticeship. The two grades at present recognized in surgery, registrar and consultant, do not recognize the progressive nature of surgical training and the gradual release of supervision and assumption of responsibility that is necessary in any surgical service. There is need for an intermediate grade, one comparable to that of a surgical specialist with the rank of major in the Army, an assistant surgeon of specialist rank, responsible for his own beds and his own out-patient sessions, but advised to some extent by consultant colleagues and remunerated on a scale intermediate between that of registrar and consultant. Such a grade would absorb many of the senior registrars who are in fact doing the work, and give them the security of tenure that they now lack".*[1] Plus ca change, plus le meme chose!!

Manpower: there is a looming manpower crisis in many specialities, but most particularly surgery, whereby there will soon be a surfeit of "trained" individuals (i.e. those in possession of a CCT, CESR or who are on a specialist register as a consequence of European reciprocity) seeking a dwindling number of consultant posts.[2,3,4] Within 2-3 years we face the unwelcome prospect of there being individuals with a CCT/CESR who are unable to obtain a consultant appointment. This has already happened in ENT and cardiothoracic surgery.

The reasons for these discrepancies are numerous and include a massive increase in medical school numbers, an appreciable increase in training numbers (particularly in the late 1990s), increasing specialisation which constrains the numbers of posts for which the Calman style trainee can apply and finally a significant increase in eligible candidates for consultant posts as a result of Article 14 applications, CESR and recognition of European qualifications. The problem is compounded by a falling number of consultant vacancies. In the present financial climate with such massive constraints within the public sector it is improbable that there will be significant consultant expansion in the next 5-10 years.

An important factor in the manpower equation is the massive increase in medical school output in recent years which was justified to make the UK self sufficient in doctors and independent of overseas graduates. It is an indisputable fact that the NHS has been completely reliant on overseas graduates for most of its existence. Many of these doctors worked in non consultant posts. Now that this government has legislated such that IMGs (International Medical Graduates) are discouraged from working in the UK, then inevitably the work previously done by non consultant IMGs will, in future, have to be done by "home grown graduates". Either this will be done, as previously, in non consultant posts, or we can take this opportunity to create a new grade of doctor who is recognised as trained, senior, and capable of independent practice and with further career opportunities (see specialist grade, below)

Cost efficiency: Consultants are too expensive. There is increasing disquiet that the recent consultant contract has resulted in significant pay increases without commensurate increases in productivity. Some may argue that comparisons of consultant costs in the UK with our continental neighbours are flawed because in reality continental countries have significantly more doctors (and surgeons) per head of population and that therefore consultants in this country generally work harder. Surgeons need to be aware that sympathy for their position is significantly weakened by frequent press reports describing the colossal salaries earned by carrying out waiting list initiative work and operating on

NHS patients in private institutions. Consultants demanding a private tariff for this work are unsustainable in the long term. The fact that this work has been generated by government policy and a target mentality does not detract from an increasing perception that consultants are overpaid. This provides a colossal incentive for politicians and health service managers to seek alternative means of delivering services that are not dependant upon consultants.

EWTD and specialisation: The consequences of implementation in full of the EWTD are well known. Before 2004 the average exposure of a trainee during their 6-8 year training programme was 21,000 hours [5]. It is estimated that by August 2009, when the working week will be restricted to 48 hours, that the average trainee will receive a total of only 6000 hours during training. It simply does not matter how one tries to "square the circle" the fact of the matter is that trainees in the future (n.b. this does not necessarily apply to current trainees, particularly those in year 4 or above) will be "less trained". This will occur irrespective of attempts to increase exposure by modular training, simulators, dedicated training lists or more dedicated trainers. These developments may well prove invaluable assets to training but will not compensate for such a significant reduction in clinical experience.

Therefore, it is highly probable that possessors of a CCT in the future (those entering training now or in last couple of years) will not be equivalent, in terms of clinical experience, to todays' trainees. We appreciate that Colleges, SACs and others have repeatedly stated that the curriculum will be competency based and not time limited, and that as a consequence, they argue the CCT will remain the same. We consider this improbable.

One is forced to conclude, therefore, that future trainees will require more training after they have gained their CCT. This is already beginning to occur.

Receiving supplemental training after appointment to a permanent post is not new. Prior to "Calmanisation" in 1995 the general surgical senior registrar was trained in all aspects of what was then "general surgery". He or she then developed additional specialist skills after appointment. It is really only since "Calmanisation" that our training programmes have produced "specialists".

Increasing specialisation creates a paradox for the provision of all surgical care. Emergency surgical admissions comprise the largest numerical group of patients but, with a few exceptions, without dedicated specialists. CEOs are rightly concerned about the adequate provision of emergency care as all hospitals which function as a DGH have a statutory duty to provide this care. It is inevitable that specialisation will continue. It is only a matter of time before vascular surgeons and those with an interest in breast diseases develop their own training programmes and cease to participate in the "general" on call.

Inevitably, therefore, the future provision of "emergency general surgery" will be provided by "gastrointestinal " surgeons. This was cogently argued recently in a paper by Shorthouse et al on behalf of ACP, AUGIS and ALS [6]. They recognised the different needs of different hospitals whilst accepting the need for all gastrointestinal surgeons to be on call. They proposed a "specialist gastrointestinal surgeon might be appropriate for smaller hospitals providing on call and level 2 colorectal and upper GI provision. Larger hospitals might appoint specialist upper or lower GI surgeons many of whom may have had specialist training post CCT. These authors emphasised the importance of mentorship of recently appointed surgeons.

The combined effects of EWTD and specialisation make it increasingly likely that some reconfiguration of services will be necessary. Whilst politically unacceptable this will inevitably result in smaller DGHs no longer providing an on call service.

Feminisation of work force : a majority of graduates from medical schools in the UK now are female, and in the future it is quite possible that both male and female doctors will wish the opportunity to spend part of their career in a post which does not have the high level pressure of a consultant post, yet allows flexibility, security of employment and the possibility of career development at a future date.

Routine surgery : much hospital work is routine, and can be easily and safely performed without the need to have the work directly undertaken by extremely specialised consultant staff. This already occurs to a large extent throughout the UK, but in a somewhat inconsistent and variable fashion. Medical staff with a CCT working to specific protocols could be the mechanism whereby we can start to eliminate variation, thereby starting to address the safety agenda [7]. This applies to much routine General and Orthopaedic Surgery, and to many conditions within medical hospital practice. The cancer reform agenda has led to the centralisation of major cancer surgery, such as oesophagogastric and pancreatic resections , into high volume units where the outcomes are better. This leaves other General Hospitals (DGHs) to perform equally essential and often challenging acute and elective surgical procedures.

EWTD and the consultant: the consequences of implementation of EWTD to consultants have been largely over shadowed by its' effects on trainees. A recent paper in the Bulletin by our President reminds us of the consequences to consultant practice, particularly if the "opt out" is withdrawn [8]. It has been! On the 18th December 2008 the European Parliament voted to abolish the ability for individuals to opt out of the 48 hours work per week. A further debate concluded by a large majority (512 for and 127 against) that all hours of on call are to be classified as work, although subsequently it appears that hours spent at home, on-call and not working will not count! The consequences of this to the provision of emergence care, by consultants, are huge. It means that every hospital receiving an emergency general surgical take will need a minimum of 8 GI surgeons to be compliant. In reality, when one takes into account annual leave, study leave and sickness the figure will almost certainly have to be closer to 10 or 12. Take Yorkshire as an example. A population of about 7 million is served by 15 hospitals. A number of interesting observations can be made:

1. Most hospitals will need consultant expansion to fulfil EWTD requirements (assuming a minimum of 10 consultants on a rota). All will if breast &/or vascular surgeons withdraw from the emergency general surgical rota.
2. There are still appreciable numbers of both vascular and breast surgeons doing on call. Clearly, their withdrawal from rotas will exacerbate the problem.
3. A separate upper GI and lower GI rota only exists in Leeds where they are on different sites.
4. Hull has a limited provision from dedicated emergency surgeons who provide daytime care of emergency admissions.

The inevitable conclusion is that if consultant surgeons in Yorkshire are to be compliant with EWTD (assuming decision by European parliament re "opt outs" is not reversed) then this county alone requires an expansion of consultant numbers of between 10-50% assuming all hospitals will continue to provide an on call service and assuming that senior cover is provided by consultants. These problems are, of course, exacerbated for smaller specialities.

There is a caveat to these comments relating to consultants and EWTD. This relates to a little known, indeed largely neglected paragraph in the EWTD legislation. Specifically, under the heading "Derogations", paragraph 17.1 (a) states that this legislation will not apply to *"management executives or other persons with autonomous decision making powers"*. In other words if consultants are recognised as equivalent to management executives we will be exempt from EWTD legislation irrespective of EU law on opt outs. In this situation consultants may rejoice at their continued independence but should be wary because it means that they will increasingly be expected to plug the gaps in service provision which result as a consequence of reduced numbers of support staff. Alternatively, our Government may decide that consultants are not equivalent to management executives. In this scenario, consultants will have to abide by EWTD legislation and, in addition, come to terms with the fact that they are mere pawns to be moved about at will by hospital managers and politicians who are deemed "management executives". Either way, continued provision of service is going to require more trained doctors.

Proposal : " the specialist" grade

- The proposal is to accept the establishment of a new grade of senior clinician termed "specialist" with a prefix denoting area of interest. Hence, specialist colorectal surgeon, specialist oncologist etc.

- The following "conditions of employment" would be essential if this grade were not to become rapidly tarnished as has occurred with all other non consultant grades:

1. Only those individuals on the specialist register would be eligible for appointment.
2. "Specialists" would have admitting rights to private / independent institutions
3. "Specialists" would admit patients under their own name
4. "Specialists" would participate in "on call" rotas without additional senior cover
5. The upper limit of "specialists" pay scale would be equivalent to lower limit of present consultant scale
6. Specialists would be eligible for discretionary points
7. Specialists would be encouraged to develop their portfolio and speciality interest, or develop educational or research interests
8. Specialists would function as "junior consultants" and be able to apply for "senior" consultant posts when these became available.
9. Specialists would be members of senior medical staff committees with identical privileges and voting rights as with existing consultants
10. Specialists would be encouraged to develop interests out with their clinical commitment such as education, research or management.
11. Specialists would be able to serve as officers in learned societies and be eligible for election to College Councils and Courts of Examiners.

Discussion

- We share the view that many of the problems caused by the introduction of EWTD (increased work load for consultants, limited training opportunities, and a substantial increase in non consultant, non training grade staff to make rotas compliant) would be solved by an increase in consultant numbers together with a reduction in trainee numbers. However, whilst we recognise this as "ideal" it is by no means guaranteed thereby necessitating consideration of alternative solutions.

- It is important to emphasise that creation of any new "specialist" grade will take time. To be successful it would have to have the support of all Colleges as well as BMA.

- Not all trainees would become specialists (some might gain appointment to consultant status from a training grade) and not all specialists would become consultants (many may not want to)

- All trainees appointed in recent years have had as their expectation a consultant post. Fairness would dictate that this expectation should prevail for all SpRs already in the system

- Specialist appointments would lend themselves to "credentialing" of certain procedures

- Specialists are fully trained surgeons. In recognising the views of patient liaison groups which regularly affirm their commitment to a consultant delivered as well as a consultant led service, it is important to emphasise that this new specialist role is to all intents and purposes a junior consultant.
  Why not then just create a tier of staff named "junior consultant"? This solution has much support in the ASGBI executive. It is argued that it preserves the name "consultant", is a natural stepping stone from registrar to consultant, would be easily facilitated by a simple adjustment of pay scales, and that meritocracy could be preserved by establishing "weigh marks" which would have to achieved before progression occurred up the career ladder. This latter would reassure the public that appointment as a "junior consultant" would not necessarily guarantee progression to senior consultant. The alternative view is that the term junior consultant is, as with the term "sub consultant, slightly pejorative. Note that if agreement were reached to establish "junior consultants" then all the proposed terms and conditions of service suggested above would also apply to this grade (which is identical in all but name).

- A new specialist / junior consultant role is "flattens the pyramid" of the medical hierarchy but maintains a competitive meritocracy. Many other countries have similar systems as do many other professions.

- The proposal to create a tier of trained doctor termed a "specialist" is not new or original. However, the suggestions that such a tier is created that is not "dead end", is recognised as part of a career process, that permits additional training/credentialing and deserves the recognition that the individual has achieved a senior and independent position is new.

- Many senior authorities in management already regard the development of this new grade as inevitable [7]. Ursula Ward, CEO writing in a recent ASGBI newsletter stated "a new 'hospital specialist' with a CCT could fulfil "this" role. Indeed, such a grade is the unspoken agenda of

many recent changes, and overtly suggested by the Workforce Review Team. The creation of such a hospital specialist grade, occupying a salary position between the current SpR and consultant grades is, in my view, desirable and inevitable"
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- A paper produced by the NHS employers; November 2008 - Briefing 52 "Medical training and careers – the employers view" clearly states that the employer's view is that a trained, non-consultant grade is inevitable [8]. This paper produced an "MMC like" diagram in which the specialist grade is shown at the end of training. More worrisome, however, is that a brief perusal of BMJ advertisements reveals that many Trusts are already advertising for "specialists". This is alarming because in the majority of cases it appears these posts are simply being used to fulfil rota requirements without any recognition of permanency. If this prevails then the term "specialist" will rapidly be held in the same disdain as the terms, Trust grade, Staff grade, sub consultant and so on.

Conclusion

It is our view that however desirable, significant consultant expansion is unlikely in the foreseeable future. For the reasons outlined in this discussion paper, it is a matter of urgency to agree the development of a new grade of trained doctor who will have appropriate conditions of service, a permanent position as well as the opportunities for career progression.

John MacFie November 2010

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