Clinical Medicine 2012, Vol 12, No 3: 195–6

From the editor

The shape of things to come

The survey of young diabetologists reported by Cheer *et al* in this issue[1] does not make particularly encouraging reading, with the headline that one-third of physicians who had achieved their CCT (Certificate of Completion of Training) more than six months previously were not, at the time of survey, in substantive consultant posts. The RCP's own surveys indicate a similar result across all physicianly specialties.[2]

Some adjustment should probably be made for potential bias in the survey sample – for example, those who feel hard done by may be more likely to fill in and return a survey form, inflating the headline figure of those who were not in consultant posts. If substantive NHS posts, locum consultants and substantive academic positions are totalled and making optimistic assumptions about 'locums-with-a-view', the figure for 'fulfilled ambition' rises to 85%. Nonetheless, it is clear that the train that leaves the station with a registrar who has just entered higher specialist training does not inevitably disgorge a consultant at the end of the line.

Does this matter? Or does this lack of perfect match between entrants to specialist training and substantive long-term posts actually provide a degree of flexibility – exemplified in the case of diabetologists by those who take up general physician or acute medicine roles? This brings us to the issue of workforce planning.

The specialty of diabetes illustrates rather strikingly the difficulty in planning. As Cheer *et al* point out,[1] there is a forecast rise in the prevalence of diabetes, yet at the same time there is a drive to treat diabetes in the community. The 600 or so diabetologists in the UK work with around 1,300 diabetic specialist nurses, although over 200 of the specialist nursing posts may be currently unfilled.[3] Some might argue for fewer hospital specialists and a recruitment drive for diabetic nurses. Will future developments increase or decrease costs? Only extreme optimists expect the imminent arrival of a pharmacological advance in diabetes analogous to the peptic ulcer treatments that put gastric surgeons out of business, but the current rate of expenditure by the NHS on diabetes – £286 per second, totalling £9 billion a year in 2009 – suggests successful investment towards a cure would be worthwhile.[4] Or will expensive innovation improve outcome, but at greater cost?

Against this background of uncertainty, plans need to be made. How many diabetologists – or nuclear medicine physicians, or cardiologists – does the country need? Indeed – how many doctors do we need? Statistics from the Organisation for Economic Co-operation and Development for 2009 reported 2.7 doctors per 1,000 of population in the UK, a figure significantly below France (3.3), Italy (3.4), Spain (3.5) and Germany (3.6), and 25% below the average of 3.6 doctors per 1,000 of population for the 16 largest west European countries. Does this matter – or are these comparisons so superficial as to be nearly meaningless?

The Centre for Workforce Intelligence (CfWI) is charged with providing intelligence to inform better workforce planning, and now makes specific recommendations on training numbers in nearly 60 medical specialties. Its most recent report concerns training posts over the next two to three years, corresponding to the 'product' of 2020, which will comprise 5,898 full-time-equivalent CCT holders, of which 3,132 will be GPs and 2,766 will be in the remaining specialties.[5] In the physicianly specialties, over the next short period to 2014, remarkably little change is recommended (and incidentally no change for diabetes and endocrinology, although an in-depth review is planned for 2015).

But the real problem lurks just over the horizon. The CfWI's discussion document *Shape of the Medical Workforce*, which specifically addresses the consultant workforce, raises huge issues.[6] Modelling a 'business-as-usual' scenario for recruitment and deployment, 2020 sees an oversupply of fully trained hospital doctors, a 60% increase in fully trained hospital doctor headcount and a salary spend of £6 billion on consultants, over £2 billion more than a decade before. As the CfWI chief executive commented recently, quoted in the *Financial Times*, 'These numbers for 2020 are not notional; they are real people.' [7]

A limited series of alternative – and obviously non-exclusive – options for the consultant career and working patterns has been briefly modelled by the CfWI: options include shifting trainees to general practice, setting the size of the consultant pool at a level to meet the demand criteria of the Royal Colleges, introducing 'a consolidation period' during CCT training (presumably a year or so of service without training), a shift by employers to using a 'consultant-present' service and a graded career structure for consultants. Each alternative presents many different issues.

The RCP's concerns will concentrate on the implications for the quality of the services that physicians can provide and the

quality of training that can be delivered. In respect of both, the nuances associated with each potential definition of the consultant role are subtle but far-reaching. The potential models under discussion include:

- *'Consultant-led'* – the consultant provides leadership but is not present at all times.
- *'Consultant-present'* – the consultant is present (or able to be present quickly) to lead, advise and supervise activity and other staff, but may not see the patient.
- *'Consultant-delivered'*– the consultant is present, directly delivers the majority of clinical services and may have support from a wider team.

These different models have huge implications. The latter two scenarios have the potential to create a service model in which all trainees are supernumerary, which is at odds with the recognition given to experiential learning in reports on approaches to medical education.[8] Not unexpectedly, this is one of the main concerns raised by the Trainee Doctors Group of the Academy of Medical Royal Colleges in response to the *Shape of the Medical Workforce* document.[9] The 'consultant-present' model would, however, mesh well with the development of physician assistants, as Nick Ross and colleagues advocate in this issue of *Clinical Medicine*.[10]

The RCP's Future Hospital Commission, which is currently at work under the leadership of Sir Michael Rawlins and is reviewing all aspects of the design and delivery of inpatient hospital care, including the composition and development of the medical workforce, has a great deal to mull over.

References

1 Cheer K, George P, Grant P *et al.* One-third of doctors completing specialist training in diabetes fail to secure a substantive consultant post: the Young Diabetologists' Forum survey 2010. *Clin Med* 2012, 12: 224–7.

2 Royal College of Physicians. *Survey of Medical CCT Holders Career Progression 2009–11.* London: RCP, 2011. www.rcplondon.ac.uk/sites/default/files/survey-of-medical-cct-holders-career-progression-2009-11.pdf.

3 Diabetes UK and NHS Diabetes. *2010 diabetes specialist nursing work force survey report.* London: Diabetes UK, 2011. www.diabetes.org.uk/Documents/Reports/2010_DSN_survey_report.16-05-11.pdf.

4 Diabetes UK. *Diabetes in the UK 2010: key statistics on diabetes.* London: Diabetes UK, 2010. www.diabetes.org.uk/Documents/Reports/Diabetes_in_the_UK_2010.pdf.

5 Centre for Workforce Intelligence. *Shape of the medical workforce: informing medical training numbers.* London: CfWI, 2011. www.cfwi.org.uk/publications/medical-shape-2011.

6 Centre for Workforce Intelligence. *Shape of the medical workforce: starting the debate on the future consultant workforce.* London: CfWI, 2012. www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce.

7 Furness H. *Glut of NHS doctors by 2020, report warns.* Financial Times, March 31 2012.

8 Stanton F, Grant J. Approaches to experiential learning. *Med Ed* 2002;33.

9 Academy of Medical Royal Colleges. *ATDG response to CfWI Shape of the Medical Workforce Report.* London: AOMRC, 2012. aomrc.org.uk/item/atdg-response-to-cfwi-shape-of-the-medical-workforce-report.html.

10 Ross N, Parle J, Begg P. The case for the physician assistant. *Clin Med* 2012, 12: 200–6.

Humphrey Hodgson