Federation of the Royal Colleges of Physicians: Census 2000

WR Burnham

Last year saw the publication of the first UK-wide census of consultant physicians[1]. There are 6,343 physicians (5,612 whole time equivalents) in 23 medical specialties. Previous data are not available for Scotland but in England, Wales and Northern Ireland, consultant expansion averaged 6.2% pa between 1993 and 2000 (4.6% from 1999 to 2000). The rate would have been 7.1% in 2000 but some advertised posts were unfilled. The consultant workforce is mature; 73% were appointed at or after the age of 35. The majority (75%) work for the NHS alone. A further 17.5% have an academic role, often combined with NHS work, and about 40% of consultants work in teaching hospitals. The average age of retirement remains about 60. Over the next 10 years, 39% of consultants will reach this age. Only 10% say that they intend to work to 65, compared to 16% in 1999, which will exacerbate the current deficits.

Eighteen per cent of consultants in the UK are female, with a much higher proportion in the younger age groups and amongst specialist registrars, suggesting that future working patterns are likely to involve more part-time working[2]. Currently, consultants work an average six notional half days per week over contract, which has implications if they are to be asked to be even more directly involved in acute care. Already, 64% are on call for duties as well as acute take, often entailing personal involvement in the care of patients and urgent practical procedures. Sixty-eight per cent of gastroenterologists provide out of hours endoscopy and treatment of GI bleeding in addition to emergency admissions.

Physicians in endocrinology & diabetes, gastroenterology and respiratory medicine admit an average of 54 general medical emergencies per week and most continue the care of these patients in hospital. Other acute specialties admit on average 40–49 emergencies per week. Two-thirds of geriatricians admit all ages on take. The average rota remains at 1:8. 17.5% of consultants are on call at more than one location, 20% are single-handed at one of their sites and 10% are single-handed specialists within their Trust, without cover when on leave.

On average in each week, consultants providing an acute medical service work 11 hours in general medicine, 24 hours in their main specialty and 23 hours in generic general duties, mostly related to patient care. For example, administration mainly consists of reviewing results and communications to patients or general practitioners; management of the service, attending meetings and travelling between hospitals enables the service to function; training, keeping up to date and doing academic work maintains the quality of the service. Eleven per cent of consultants undertake an additional specialty (mean 8.6 hours per week) and 37% perform duties in management or work for the post-graduate dean, BMA or Royal College of Physicians (RCP).

The consultant workforce in medicine provides acute and elective services, both general and specialist, to the NHS and is therefore cost effective. It is committed to the management and improvement of the service. In the future, adequate numbers of trainees are required so that expansion can continue. More part-time working seems inevitable with increasing numbers of female doctors qualifying, but what other changes are on the horizon?

The consequences of the European Working Time Directive[3] suggest that, by 2004, all trainees will be working shift patterns. Many physicians will have seen problems with a lack of continuity of care and non-identification of sick patients by junior doctors on the night shift who do not have the experience to recognise them. A pilot audit into medical deaths by the RCP showed that patients admitted between midnight and 9 am had the highest mortality rates; this was not due to them being more ill[4]. Changes in working practices for consultants in order to provide better training and supervision seem to be required, but this cannot be achieved without addressing the current difficulties first. Simply talking about 'new ways of working' may not convince consultants that the problem has been grasped. Two things are needed. Firstly, a clear national commitment to increase and fund many additional National Training Numbers in acute specialties is essential. Secondly, a central directive to purchasers and Trusts to ease existing consultant workload is vital, coupled with a long-term guarantee that consultant expansion in those specialties will occur. Then patients, current trainees and consultants can face the future with confidence.

WR Burnham
MA MD FRCP,
Director, Medical Workforce Unit, Royal College of Physicians of London

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Address for correspondence:
Dr Rodney Burnham, Director of Medical Workforce Unit, Royal College of Physicians, 11 St Andrews Place, Regent's Park, London NW1 4LE