Consultant physicians in the UK

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Introduction

On 30 September each year the Medical Workforce Unit of the Royal College of Physicians of London (RCP) undertakes a census of consultant physicians on behalf of the Federation of Medical Royal Colleges of the UK. The 16th census collated responses (online or hard copy) and confirmed or supplemented data from other sources including specialist societies and Human Resources departments within trusts. 8,476 questionnaires were sent out encompassing 26 medical specialties.[1] There was a 56% return rate (4,746 questionnaires: 28% online, 72% paper) with a further 3,609 posts validated from other sources. These data inform discussions on workforce planning in the UK.

Consultant numbers, specialties and academic medicine

In the year covered by the census (1 October 2004 to 30 September 2005) the number of consultant physicians in the UK was 8,541 – a small increase of 3.2% from the last census. This is lower than the rate of expansion in previous years: 5.4% expansion in the year 2003 to 2004 and 3.6% in 2002 to 2003. It is unlikely that the target consultant workforce, identified by the RCP to deliver prompt and high quality care,[2] will be achieved in the near future with expansion at such a low rate. If this trend continues then proportionately fewer of the increasing number of medical graduates will achieve consultant positions.

There are particular concerns for nine specialty groups: there has been minimal expansion in clinical neurophysiology, endocrinology and diabetes and paediatric cardiology, and suboptimal expansion[3] in allergy medicine. The small decline in consultant numbers in clinical pharmacology and therapeutics, immunology, nuclear medicine, metabolic medicine and intensive care medicine is important since a reduction in the smaller specialties can have profound and long-term effects in respect of their ability to provide clinical care, expertise and training for the future. Clinical pharmacology and therapeutics has been under such pressure for some years[4] and raises concerns about the viability of this specialty.

Academic medicine and research-related consultant posts have also recently been under pressure. The 2005 census showed a decline in those holding purely academic and research posts from 8.8% in 2004 to 3.4% in 2005 but an increase in those holding joint NHS and academic contracts (4.5% in 2004 to 7.9% in 2005). The absolute figures, however, suggest a 17% reduction in those with any academic or research component to their work. This threat to academic medicine has been identified by the Federation of the Royal Colleges,[5] the Department of Health and the Government; hopefully the mechanisms being put in place to support academic medicine and research[6] will be successful in regenerating this key area of clinical medicine.

Appointments and retirements

The last two censuses have identified failure to appoint candidates to consultant physician posts in about 35% of cases (varying by specialty, and up to 56% in some). This year the average is 28%. Unfilled posts represent 2% of the consultant physician workforce but remain a concern because of the very high impact on the delivery of local services when they occur.

The age distribution of the consultant workforce shows that 23% (more than 2,000 posts) are older than 55 and are likely to retire in the next 10 years. Physicians typically retire between the ages of 62 and 63. Of those currently working, 78% indicated an intention to retire before the age of 65. It remains a concern that so many consultant physicians intend to retire early; the most frequently cited reasons are work pressure and dissatisfaction with the NHS. This represents a large number of consultant years of expertise and service lost to the NHS.

Gender of the consultant workforce

The number of women consultant physicians rose by 7.5%, from 1,869 in 2004 to 2,010 in 2005. Women now represent 23.5% of physicians in the UK. This welcome increase will continue since 43% of specialist registrars in the medical specialties are women. The ratio of male to female consultants varies greatly by specialty, but generally women are under-represented in the acute medical specialties. Part-time consultant physician posts are also increasing; currently they represent 11% of the workforce.

Working time and continuing professional development

Consultant physicians continue to work hard. Sixty-eight percent of consultants work more than 48 hours per week, although only 14% have formally opted out of the European Working Time Directive. Half of all part-time consultants report working more than 40 hours per week. The average agreed contract of 10.5 programmed activities (PAs) for the 90% of consultant physicians on the new contract (7.4 clinical PAs, 2.3 supporting PAs and 0.8 other activities) falls short of the time actually worked (11.9 PAs) and surprisingly varies little between specialties.

More than 90% of the consultant physicians who responded to this survey regularly undertook continuing professional development (CPD) and were registered with, and monitored by, one of the Royal Colleges.

Acute medical services

Over the last two decades, with the rise in specialisation and the remarkable increase in acute medical admissions (which has led to the development of a new specialty of acute medicine), the broad training of consultants has provided the flexibility to maintain acute medical services at the current level. Just under 45% of consultant physicians still contribute to emergency on-call commitments, the proportion varying widely by specialty but with proportionately large input from endocrinology and diabetes (86%), geriatric medicine (86%), acute and general medicine (85%), respiratory medicine (84%), clinical pharmacology and therapeutics (82%) and gastroenterology (80%). The RCP has set standards for care in several areas of acute medicine,[7] including the time spent with patients by consultants on ward rounds. These data show that almost all of the large acute medical specialties reported ward rounds exceeding this work rate. In addition to acute medical take, more than 50% of consultant physicians report being on-call for other duties including advice, specialty consultations or specialty specific tasks (eg endoscopy).

Medical admission/assessment units (MAUs) are now the mainstay of delivering acute medical services. Consultants report that 75% of patients are preferentially admitted to MAUs, 18% admitted directly to specialist areas and only 7% admitted to general medical wards. Admissions are supervised by the take consultant during morning, afternoon, and rolling rounds as required in 76–81% of units, and by the MAU's acute physician in 8–20%. Consultants and their juniors are relieved of other duties to provide a dedicated acute service and most units now provide at least twice-daily consultant-led ward rounds.

Conclusion

The expansion in consultant numbers this year has been disappointing; some specialties and academic medicine are under particular pressure. The increase in women consultants, specialist registrars and part-time posts is progressing well but needs further support since these groups will form such a large proportion of the future workforce. Consultant physicians continue to work long hours with heavy workloads to deliver care to patients. The early retirement of highly experienced consultants remains a challenge for the NHS. Consultants have shown their flexibility by adopting new working-patterns to improve the organisation and delivery of acute medicine.

The RCP believes that highly trained consultants optimise the long-term flexibility of the workforce.[8] The current and future workforce needs to be fit for purpose and able to deliver high standards of medical care to patients. The RCP is committed to encourage training and supervision for juniors and CPD for seniors, and to promote the delivery of professionalism and clinical excellence in care. To deliver care at the expected standard requires an adequate workforce both in number and in level of skill.

References

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