Consultant physicians workforce: now and in the future

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Introduction

The 17th annual survey of consultant physicians in the UK was conducted by the Medical Workforce Unit of the Royal College of Physicians of London (RCP) on behalf of the Federation of Medical Royal Colleges of the UK on 30 September 2006. The census now encompasses 28 medical specialties following the inclusion of medical ophthalmology and stroke medicine.[1] Of the 8,605 questionnaires sent out 4,966 responses (58%) were returned of which 29% were online and 71% in paper form. Data on 3,620 further posts were verified with specialty societies, workforce contacts and medical staffing departments.

Changing work patterns and provision of care

The census showed increasing feminisation of the workforce (24% of consultant physicians are now women) and an increase in less than whole-time working (13% of consultants). Physicians continue to work intensive and long hours (12 programmed activities equivalent to approximately 48 hours per week) compared with the 10.9 programmed activities contracted (43.5 hours). There is a marked geographical variation of specialist provision of care that is unexplained but may impact on access to, and quality of, care.

A slowdown in consultant workforce expansion

The 2006 survey recorded the smallest annual increase in consultant physician numbers in the UK since the survey was first conducted in 1989. The increase over the year was 1.8% compared with 3.2% in 2004–5,[2] 5.4% in 2003–4[3] and 3.6% in 2002–3.[4] Expansion at such a low rate suggests the targets identified by the RCP to deliver high quality care promptly[5] are unlikely to be achieved in the near future. Some specialties have been affected more than others. A reduction in the numbers of consultants in some of the smaller specialties (eg clinical pharmacology and therapeutics, immunology, and metabolic medicine) is potentially very destabilising for the future. These specialties are now so small that it is becoming difficult to provide sufficient training opportunities to sustain them, let alone to expand them. Disappointingly there were also small reductions in the number of consultants in the larger specialties of dermatology, infection and tropical medicine, rehabilitation medicine and rheumatology. It seems likely that recent financial challenges to the NHS may be partly responsible, but if so there is little hope of improvement over the next few years. There have been concerns that the move towards 'care in the community' might have a negative effect on some specialties more than others including dermatology, rheumatology, rehabilitation medicine and diabetes. These specialties are the ones identified as having reductions in consultant numbers, or for diabetes, a minimal increase (0.02%).

Consultants are required to deliver high quality care to patients and one would expect to see more consultants appointed to, or spending time in, the community rather than in their historic bases in secondary care. The foreseen danger that specialist services may be seriously undermined with reductions in consultants in secondary centres without a concurrent increase in community-based consultant physicians may be beginning.

Future effects of lack of expansion in consultant numbers

There would be a larger and more worrying effect of the reduction in expansion of consultant physician numbers if this were to be mirrored in other areas of medical practice (eg surgery and general practice). The UK has historically employed a large number of 'junior' doctors to provide service work while training as a specialist (in medicine, surgery or general practice). These young doctors were able to progress to senior posts primarily because of the expansion in numbers of consultant posts, since retirements alone provided insufficient employment opportunities. Lack of expansion of the consultant

grade will lead to an increasing number of trainees obtaining a certificate of completion of specialty training but being unable to find a suitable post in which to utilise their skills. There have always been peaks and troughs in the number of trainees seeking such posts but the very small expansion in 2005–6 has had an immediate effect. Worse still, the current system has no brakes since trainees have a six-month period of 'grace' at the end of their training attachment in which to obtain a consultant post, then the next trainee automatically starts on the programme, whether the previous trainee has obtained a senior post or not.

These peaks and troughs in the supply of trained specialists, however, pale into insignificance when the size of the coming tsunami is appreciated. The size of the medical student intake is increasing; a 68% increase from 4,699 in 1996 to 7,898 in 2006. The first cohorts are now moving through the junior doctor training grades. There are currently too few training slots available for all who wish to train, an effect amplified by European economic area and international medical graduate doctors,[6] as the recent Modernising Medical Careers/Medical Training Applications Service debacle has shown. Unless the number of training slots is increased substantially it is hard to see how many of those emerging from UK medical schools will have an opportunity to train to specialist level (including those in general practice). The rigidity in the training times through foundation year (F)1, F2, and specialty training, will continue to churn out specialists at a rate dependent on training slot numbers, regardless of the career opportunities at the end.

The future

A system needs to be developed to regulate the numbers of doctors in the workforce that is responsive to change and to the needs of the service. The most important element is the long-term vision of the sort of service one is seeking to produce, and the steady move towards it without short-term reactionary changes. The model can be gently adjusted as time unfolds. Training posts should be increased in the short-term to give opportunities to all UK graduates. Elements of slight overproduction of doctors and competition will keep standards high and allows some to work for alternative (non-NHS) providers or develop other careers. The time is ripe for the NHS to move towards a consultant-delivered service to raise clinical standards and benefit patients. Ultimately, the number of students and training posts should fall substantially to levels that provide for the replacement of consultant leavers rather than inexorable expansion. Producing excessive numbers of young doctors who are unable to obtain posts is financially wasteful, detrimental to morale and recruitment, right down to medical school level, and politically difficult.

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