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Hospital Career Structure

SIR,—Frustration, even despair, cannot be far from the minds of those who, over the years, have tried to formulate a reasonable basis for the staffing structure of hospitals. This subject has been most carefully reviewed at least six times since the National Health Service came into being: by the Strachan Committee (1955),[1] the Guillebaud Committee (1956),[2] the Platt Working Party (1961),[3] the Brotherston Committee (1967),[4] Panel I (1968),[5] and the Royal Commission on Medical Education (1968).[6] All of these eminent committees (both medical and lay) discussed the subject in much detail, as may be read in their reports.

Two dominant views emerge from these reports: Firstly, that the consultant is the apex of the pyramid, to be appointed with standards that should not be lowered, and, secondly, that in addition to the consultant and training grades a career grade is necessary. To take the first point. The Platt Working Party referred to the consultant in the following terms:

"A consultant is a person who has been appointed by a statutory hospital authority by reason of his ability, qualifications, training and experience to undertake full personal responsibility for the investigation and/or treatment of patients in one or more hospitals without supervision in professional matters by any other person. . . ."

And Panel I, in a somewhat similar manner, states:

"We have discussed at length suggestions that there should be more than one grade of consultant, but found them unacceptable at the present time. The consultant grade should therefore continue as the only grade of hospital staff with ultimate clinical responsibility."

One wonders, therefore, what has prompted the flash of insight which has made the Health Ministers announce: "A solution of the present disagreement about permanent grades of hospital medical staff is dependent upon the definition of responsibilities and function of the consultant grade" (3 August, p. 323). One principle to which the profession has firmly held has been the maintenance of standards and the acceptance of the view that any sudden or uncontrolled expansion of this grade must inevitably lead to dilution and lowering of standards.

A great deal has been said about enlarging the consultant grade, and this is desirable on many counts, but it must be subject to three major conditions. Firstly, the need for the post must be established; secondly, adequate facilities such as beds, outpatient accommodation, and theatre times must be available; and finally, the applicants must be of suitable calibre. Possibly one of the greatest errors in the structural pattern has been the failure of the employing authority to define with precision the duties of the consultant. In the past the newly appointed consultant was content with a few beds and an obligation to undertake duties which are now regarded as the lot of the registrar. His reward came later. Platt emphasized the value of the "firm" system, but there seems to have been little progress along this line. One of the merits of the old "firm" system was that the aspirant might reach his goal earlier, even if its mouth was initially not so wide.

The second point concerns what is now known as the medical assistant or assistant grade. The term is certainly not satisfactory, but if a more appropriate designation could be found it would be welcomed. The fear that a sub-consultant grade could be inflated and misused still exists in the minds of many doctors, but it is remarkable that one section of the profession, when rejecting Panel I's report, seems to have completely ignored the sentence in the preface which reads: "The proposals contained in the Report are now put forward as a basis for further discussion and not in any way as final conclusions, and the Health Departments will in due course seek the views of interested bodies. The Report's proposals will also of course have to be considered in the light of the recommendations of the Royal Commission on Medical Education, when these are known."

One of the main objectives of Panel I was to ensure that the career of a young doctor should be so planned that he should not waste unnecessary time in reaching his objective, and that, having completed his training (give or take a matter of some months), he should not block people behind him. He might therefore be expected to side-step into the assistant grade, which is not intended to be a dead-end for those who have adequate experience and training. To regard it as a "holding" grade for those who aspire to consultant rank would be a much more reasonable concept. The rejection of Panel I's findings has been followed by a standstill in the appointment of further full-time assistants, and what effect this will have on the Service needs remains to be seen.

Surely the time is overdue to settle, for the time being at any rate, some of our problems of structure, training, and education. Is it too much to hope that a satisfactory conclusion can soon be reached and that hopital doctors can get on with their real work—the treating of patients—with some sense of stability and security?—I am, etc.,

London N.W.1. T. HOLMES SELLORS.

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3 *Medical Staffing Structure in the Hospital Service, Report of the Joint Working Party*, 1961. H.M.S.O., London.
4 *Organization of Medical Work in the Hospital Service in Scotland*, 1st Report of the Joint Working Party, 1967. H.M.S.O., London.
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Seat Belts for Lorry Drivers

SIR,—In the great majority of collisions between cars, and in the single car accidents we have studied, the passenger compartment has remained intact or relatively so. Fatal and serious injuries have been caused by the occupants being thrown about this compartment or thrown out of it. Hence the proved value of keeping occupants on their seats and the seats firmly in position.