Personal views

Medical staffing in paediatric departments in district general hospitals

R NELSON

Queen Elizabeth Hospital, Gateshead

The present situation

In 1978 the Manpower Economic Review established by the Doctors and Dentists Review Body identified paediatricians as one of the hardest working groups of consultants with the highest rate of recall back to hospital out of hours. Now, nine years later, the situation has deteriorated considerably because the workload within many paediatric departments has continued to increase without any significant improvement in medical staff levels. This increase in workload includes inpatient admissions, the increasing intensity of neonatal care, and the greater recognition of physical and sexual abuse of children. Figures published by Her Majesty's Stationery Office show that deaths and discharges for paediatric units in England and Wales increased by 42.5% during the 11 years, 1974–1984.¹ During the same period the increases for general medicine and for general surgery were 21% and 2.7%, respectively. There has been no significant change in birth rate over recent years but the intensity of care provided by neonatal departments is continuing to increase at a tremendous rate. For example, in the Northern Region during 1978, 50 newborn infants received assisted ventilation. By 1985 the number had increased to 375, an increase of 650%.

Hospital inpatient paediatrics and neonatal care is undoubtedly an acute specialty. It should therefore have adequate levels of consultants and experienced junior medical staff to provide an adequate and safe service. In many districts this is clearly not so. For example, within the Northern Region eight out of 16 health districts have no established registrar posts within their paediatric department. Junior medical staff cover is therefore almost totally provided by senior house officers who have no previous postgraduate experience of paediatrics and particularly of neonatology. Many of these doctors are training for careers in general practice where experience in hospital neonatal care is largely irrelevant.

Within these same districts comparison with other specialties can show dramatic differences. For example, within my own district, Gateshead, the paediatric department has an established medical staff of 2.7 consultants and three senior house officers, all with no previous postgraduate paediatric experience. The combined general and geriatric medical unit has six consultants, four registrars, and 10 experienced senior house officers, and the general surgical unit has four consultants, three registrars, and four senior house officers who have had previous surgical experience. The paediatric unit is the only clinical and non-clinical unit in the district that has no established registrar cover.

Opportunities for change

During the past 15 or more years it has been virtually impossible to establish new registrar posts in paediatrics. The present situation is therefore in part a legacy of former consultant paediatric colleagues who failed to achieve adequate junior medical staff levels in paediatric departments when opportunities for expansion were possible. I believe that opportunities for change may occur in the near future and that paediatricians should now make a unified, concerted effort to publicise the present disgraceful level of medical staffing in many district general hospital paediatric departments.

Achieving a balance²

An important objective of the 'achieving a balance' exercise is clearly to try and reduce the tremendous bottleneck that has developed at registrar and senior registrar levels in some specialties. This is not a major problem in paediatrics and therefore although paediatrics is undoubtedly an acute specialty, it was specifically excluded from the limited consultant expansion programme that is funded centrally. Training in hospital paediatrics is relevant for future

general practitioners and for consultants in community as well as hospital paediatrics. Despite the present financial constraints significant expansion of consultant community paediatric posts is likely to continue, funded by individual districts from revenue released by retirement of senior clinical medical officers etc. It is reasonable to argue therefore, that a limited expansion of junior medical posts in paediatrics may be possible without seriously jeopardising the career prospects of paediatric registrars and senior registrars.

If the medical staff levels within paediatric departments in the Northern Region are similar to those of other parts of the country then it will require an enormous increase in the number of registrar and senior house officer posts to implement two important recommendations of the 'achieving a balance' document. They are firstly, that most acute specialties in each district should have at least one regional registrar, and secondly, that there should be a minimum level of 24 hour cover, the so called 'safety net.' If the proposals of this document are achieved then there may be some redistribution of junior medical posts between different specialties. A strong case for improvements in the medical staffing of paediatric departments needs to be made now at national, regional, and district level.

Joint Planning Advisory Committee

The Joint Planning Advisory Committee (JPAC) is at present reviewing the distribution of senior registrar and registrar posts between different regions. To date the situation in paediatrics has not been investigated. From my position in Gateshead I await the deliberations of this committee related to paediatrics with great interest. The Northern Region has already acquired manpower clearance but unfortunately not the revenue to establish 19 additional senior registrar posts in specialties which include orthopaedics, psychiatry, clinical genetics, etc. The Northern Region expects to receive manpower clearance to establish more senior registrar posts as the JPAC exercise continues and other specialties, including paediatrics, are considered. This is clearly an opportunity to improve the junior

medical staff cover of districts which are particularly poorly served at present.

The response of the British Paediatric Association

When I read the paper *Hospital medical staffing*³ outlining the British Paediatric Association's response to the consultative document, *Hospital Medical Staffing—Achieving a Balance*, I was dismayed at the bland response. Surely this is an opportunity for the Association to make a strong statement to the government on behalf of paediatrics and the hospital services provided for children in Britain. My own experience indicates that the medical cover for paediatric departments, and particularly for neonatal care in this country, is at present a disgrace for an allegedly civilised, developed nation. If the situation in Gateshead is typical of a significant number of other districts then clearly members of the British Paediatric Association Council and senior paediatricians are out of touch with conditions in many paediatric units.

In September we were asked to vote on the important question 'Should the BPA become a separate college or a faculty of the Royal College of Physicians?' One of the main arguments for change was the widely held view that the case for child health and for the medical needs for children needs to be voiced more strongly. The document 'Achieving a Balance' provides the Association with an opportunity to pronounce upon an important aspect of child health in this country—that is, the medical staff levels within hospital departments. If the present response is an example of the Association's attempts to improve the child health services in this country then I believe that September's vote was irrelevant.

References

- ¹ Anonymous. *Health and personal social services statistics for England*. London: HMSO, 1986;74–5.
- ² DHSS/JCC Manpower Initiative. 'Hospital Medical Staffing—Achieving a Balance,' *Br Med J* 1986;**293**:147–51.
- ³ Jackson ADM. Hospital medical staffing. *Arch Dis Child* 1987;**62**:872.

Correspondence to Dr R Nelson, Queen Elizabeth Hospital, Sheriff Hill, Gateshead, Tyne and Wear NE9 6SX.