MR 11
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Dr Kate Gower Thomas BSc, MB BCh, FRCR
Response from: Dr Kate Gower Thomas BSc, MB BCh, FRCR

RE INQUIRY INTO MEDICAL RECRUITMENT

These are personal comments from Dr Kate GOWER THOMAS

Background

I am a consultant radiologist who has worked in the NHS in Wales employed by both Public Health Wales (Breast Test Wales, Cardiff) and at Royal Glamorgan Hospital (Cwm Taf University Health Board) for 24 years.

I qualified in 1985 from University of Wales School of Medicine and have worked as a full time doctor since then.
I am currently the Chair of the Breast Specialist Advisory Group and was the Breast Test Wales QA radiologist for 14 years

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COMMENT

I have long had significant concerns regarding the sustainability of the medical work force in Wales, which has particular difficulties compared to the other UK nations. As a radiologist it is well known that the numbers of radiological examinations far outweighs the capabilities of the radiologist work force for timely reporting. This has been recently acknowledged again publically by the President of the Royal College of

Radiologists , Dr Nicola Strickland. The numbers of radiologists per capita in the UK is amongst the very lowest in Europe and radiology is one of the least appreciated yet most vital hospital disciplines to the smooth running of any care primary or secondary care system. Notwithstanding this there are massive short falls in the numbers of specialist doctor of other disciplines, I can only speak of those I know best, ie the cancer fraternity. There are very many vacant Consultant jobs in this field alone in the UK and especially Wales.

Health Boards give up in advertising for appropriate consultant staff members as there are never suitable recruits and it becomes a waste of valuable time and monies to continue, so posts are only advertised if someone comes forward seeking the role and even then it may fall through. I act as the RCR representative on Consultant Appointment panels and I can list 6 or 7 in the past year in Wales and the South West of England in which I have been involved, which have disbanded due to lack of applicants. At times there are applicants from abroad – mainly the EU, but often the standard of their training falls far short of that expected in the UK, for example recently an Eastern European radiologist applied for a specialist breast radiology post in West Wales who considered themselves to be suitably trained in reading mammograms having read around 300 (I read that number in a normal day's work). In Wales we demand at least 5000 to have been read even before considering someone competent to read them never mind appointable as a consultant responsible for a service. It goes without

saying that it is essential that the standards expected by our workforce should not be compromised in order to fill posts.

The recruitment phenomenon is particularly acute in West Wales to where it seems doctors are increasingly difficult to attract. In certain specialties, again I will site breast cancer as an example, the incumbent surgeons in two hospitals are continuing to work post retirement as there is no one else to take their place. This is non sustainable and leaves the service very vulnerable. Should they leave then there is no experienced senior colleague to mentor the incoming junior consultant, which is an essential aspect of one's development as a specialist post appointment. It also means that training for other members of the team and even medical students is compromised as it becomes the law of diminishing returns, the standard never gets to be greater than the most experienced member of the team.

Indeed this happened in the ABMUHB recently where a newly qualified surgeon consultant took on the responsibility of the breast cancer surgical management the whole area without any senior specialist colleague in the hospital from whom to seek advice.

My own HB has lost four senior radiology consultants in the past two years with none being directly replaced. We currently have very many hundreds of radiology examinations, I will not disclose the actual number, undertaken over recent weeks, waiting for someone to report them – patients are arriving at outpatients to learn of their results only to find that they are not ready. This is contributing to delays in

treatment, poorer outcomes and significant extra personal and hospital costs.

Over the years in Radiology we have developed many individuals (PAMS) into extended practice roles which has served to bolster the service. For example in many HBs virtually all the ultrasound studies are performed and reported by non clinical staff – sonographers. Now the health service depends heavily on such individuals, who then become sought after once they are trained and who can find jobs anywhere. So whilst one HB may have expended many hours training up such a person, it is vulnerable when these individuals leave to another HB which then reaps the rewards, this commonly happens, particularly if the persons expectations are not met with regards to working environment, shift patterns, responsibilities and remuneration. Such issues are also recognized amongst the consultant body; unlike 20 years ago it is common for established consultants to move HB where the grass appears greener for whatever reason.

HBs need to become more receptive to the issues of work life balance which may tempt a trained team member away to another trust – this is happening more and more frequently and is very destructive to a team when one person is forced to leave as the HB will not countenance even minor changes in working patterns – eg a reduction in the hours or sessions worked, or no weekend working that an individual may need due to personal commitment with family or

whatever. This has happened to my team very recently and was very upsetting to all concerned. We need to consider annualised hours agreements, out of hours working patterns and more flexibility to working patterns.

For whatever reason we have a problem in attracting doctors to work in Wales – this is not a new phenomenon – we recruited GPs to work in the Welsh Valleys 40 years ago and they have now all but retired. Wales is currently advertising on the London Underground for doctors to come and work in Bronglais hospital, what a sorry state of affairs! Could this be because we do not train enough of our own Welsh born doctors??

I, along with many colleagues have long felt very strongly that the Welsh medical schools overlook scores of very able Welsh school leavers who wish to study medicine in their home country, which they know, love and wish to stay in, and indeed work in once qualified. It is not that these individuals are non appointable – indeed they get offered to study medicine all around the UK and that is where the problem lies. As the medical course in long and intense they strike up allegiances where and with whom they train, frequently meeting a local spouse and they never come back to work in Wales – we are losing our 'life blood' in this way. Surely if Welsh school leavers wish to stay in wales they are far, far more likely to wish to stay here to work afterwards?

I know three school leavers, one a young man who was Welsh speaking with an exemplary CV and all the right qualifications to enter medical school – Cardiff overlooked him and he is now studying in Oxford – surely that says it all? The other two are now qualified, both young women now live in England having met there now partners at English medical schools in the locality of which they now intend to remain. Cardiff medical school needs to acknowledge and appoint these very able Welsh students. Wales is missing a very big trick here, I think it is scandalous this is being allowed to happen.

There also need to be far more sensible dialogue and joined up thinking with regards to work force planning, staff retention and medical student intake. There does not seem to be any dialogue in this regard in my field of work at all, hence the current crisis, which becomes bigger by the month. It is however heartening to learn that there are plans to increased the numbers of medical students in the UK, I am not party to the details of this, what will be happening in Wales? I am concerned that these individuals will need training and that the workforce is so very stretched that this will further add to the burn out so many doctors are experiencing,

Although I trained and have worked fulltime, despite having had four children, it is now very unusual for female doctors who are mothers to want to do this as flexible training is now more widely available. Once they become consultant or trained GPs they will work at less on whole

time contracts. The issue of part time working has of course reduced the number of hours these doctors are available to work from this largely female group. This was not well anticipated by the employers as there is a short fall contributing to the employment crisis.

With the ever increasing demands of training – including the frequent changes in hospitals they are required to train in from one end of the country to another – and often with the father elsewhere in the country this is not conducive to retaining the female work force who may consider it better to just stop working as a consequence. I have GP friends who have done this, with no current intention to go back to work. In addition with very erratic working hours and no provision of child care by HBs out of hours how is a young female doctor supposed to train and ensure her children are cared for at all hours of the day and night, particularly if she is a single parent – as I was? Not everyone has family close by willing or able to accommodate the fickle demands of the health care system. Vastly improved childcare provision will certainly contribute to staff recruitment and retention. I have colleagues who have now considered it appropriate to take several more weeks off work a year as unpaid leave rather than struggle with the child care arrangements, leaving the rest of us to pick up the extra work. If an HB were able to provide 5star childcare facilities for their staff they would surely be the place to work and the hospital would gain in the process.

ON a similar vein, something I have heard several times of late, the rota system is far too restricting with some reporting being unable to alter a shift many months in the future in order to attend important life events like a family wedding. What sort of a health service are we running if this is happening to its staff? It seems the service if becoming increasingly like an dictatorship with little regard to humanity and empathy towards its staff members. This must stop. It is little wonder that these valuable individuals are going abroad – so very many have and others intending to, that we must listen to what they a re telling us before it is too late.

In summary I have concerns that the workforce crisis will get worse before it improves, as it takes far longer then there is time to train competent doctors. The problems should have been more seriously considered long ago when we first raised our concerns. We need to listen to what the doctors are telling us with regards to their needs for work life balance, shift patterns and child care provision and we need to positively discriminate towards welsh students in our Welsh medical schools even if this means the Government pays a tariff to steer them away from the more tempting foreign students who bring more to the coffers of the universities.

If not then future (and even current) Welsh patients will most definitely pay the cost.