

Why we are where we are

by Nitin Shrotri

The modern shaping of medicine and how politicians and doctors leaders can guarantee a successful future for the NHS

Location: UK International Published: Friday 28 January 2022



A discussion this morning and an article in a newspaper today set me thinking about why the health service was in the situation it found itself in.

When I came to England in 1989, we had long waiting lists which patients did not seem to mind. Quite content waiting for their hernia and hip operations for months and years,

even cancer patients were sometimes known to wait a long time. This was the situation in the '80s and '90s.

Private practice flourished for consultant surgeons. They were apparently spending time on the golf course or in private hospitals during their NHS sessions. The colleges did not do anything and turned a blind eye. In fact, it would be these same people from the colleges who would be getting knighthoods for spending time on the golf course. It mattered who you knew.

Foreign medical graduates and senior registrars slaved away and kept the NHS running. By the mid-to-late 90s the situation for foreign graduates changed to an extent, and some became consultants.

With the election of a Labour government in the late '90s, NHS funding increased. But the consultant contract changed and tightened up. In return for the increase in salary, consultants had to be present in the hospitals during their working hours and be available.

A tiny number, caught out, inevitably got the sack. The contract for general practitioners also changed and they were no longer required to be on call. Money was thrown at the NHS to deal with waiting lists and consultants found themselves in a good financial position earning from waiting list initiatives on weekends, but this also benefited patients as waiting lists went down to an all-time low.

The millennium also saw Europeans come into the UK with visa changes leading to a lack of opportunity and career progression for doctors from the subcontinent.

But as the subcontinental countries became richer, some doctors who might have otherwise come to the UK, stayed at home as it was possible to have good local jobs without bureaucratic governance, management interference, mandatory training, appraisals and e-learning, all the bane of the NHS, and plenty of freedom to practise without encumbrance, and occasionally, governance. They could be their own masters without having to play second fiddle to anyone.

The European working time directive led to the effective decrease of working hours in the UK. But the workload continued to mushroom for a number of reasons. From the 1990s, when many doctors would work 90 hours a week, these came down to 56 hours a week.

Junior doctors in some units had 30 days of study leave, 30 days annual leave and pre- and post-night days off totalling perhaps another 30, leaving them available for work for the remainder of the time, some of it for training, some on call.

There were also an increasing number of female doctors in the system. Work life balance became the buzzword and people realised that working long hours was not good for their health and quality of life.

As these factors started affecting the system the effective number of working hours available for patient facing work

decreased rapidly without adequate workforce planning. There was no right way of saying this, but it is likely that with better work life and gender balance, more study leave and increasing involvement in management, the number of patient-facing doctor hours decreased.

There were other factors responsible for this too. There came improvements in technology and sub specialisation which continue to this day. Partha Kar – an eminent consultant in diabetes and endocrinology – calls it ‘The Rise of the Machines’.

While this benefits patient care hugely, in different ways the advance of technology has outpaced the abilities of many a human brain. To use any computer program, and many instruments, extensive training is often needed, so much so that when the routine operator is absent, that gap becomes difficult to fill. Take new generation scanners, robots and lasers as simple examples.

There was rapid improvement in technology in both areas, diagnostic, as well as therapeutic. Diagnostic improvements led to more suspicious lesions being diagnosed, requiring peer review of reporting, further investigations, follow up or treatment.

This used up clinician time with often little useful clinical yield. Therapeutic improvements were expensive, and the privately funded technological advancements such as scanners, the robot, lasers and the cyber knife had to claw back money for their investors. Another problem with

extremely expensive technology is that it can be fragile, breaks down very easily and is difficult to replace swiftly.

This development in technology also led to a lack of generalist doctors and one would often find children and unusual cases being transferred to larger hospitals in London or another hub as subspecialist doctors for some conditions were not available in adequate numbers.

Doctors, referred to the GMC, were learning that the only person who would look after number one was themselves, not their medical directors. Referring the patient a hundred miles away for a simple condition, treated locally in previous years, was more convenient than accepting the chance of getting into trouble.

Working and learning has become classroom or computer based. Everybody who wanted to be good at anything had to first go on a course, face-to-face or online, but you had to do one, because without doing it, you were never good enough.

A certificate made all the difference. The old policy of 'see one, do one and teach one' could not be used any more. Unless you had the correct paperwork you were not the right person for the job.

There was no increase in training numbers but there was a rapid increase in the number of managers and many nurses and doctors were lost to management but not replaced in the clinical setting.

In fact, I would see 50 patients in a two-person clinic in 1999. By 2019, the number had decreased to 24. Somehow the capacity to see patients had halved!

Patient expectations were fired up by the government, with lawyers moving in with ideology from across the pond. 'No win, no fee' lawyers sprung up.

Not their fault, as some criminal barristers were living below the poverty line with massive cuts in Legal Aid. Defensive medicine leading to over-investigation of conditions is also another reason for increased workload.

All these factors have led to the remaining doctors working under massive pressures from all sides. This had led to emigration, doctors leaving the profession or taking early retirement.

The resulting scenario is what we see today with COVID being the proverbial straw that broke the camel's back. The Government's desire to privatise the NHS makes this scenario ripe for cherry picking services, music to the ears of the vultures waiting in the wings.

As the government and NHS bosses clash on how to deal with the huge backlog, we must first recognise what has gone wrong over the years. Medical workforce planning over the last three decades has been non-existent owing to a number of reasons.

It could be because of a lack of vision, the expense of training doctors, the ease of poaching, a self-serving

profession, a government unwilling to invest, or a desire to make the NHS go under. Decades of postage stamp solutions haven't worked and a combination of innovation, vision and imagination are required. Workforce morale, low as never before, needs a massive boost.

Till then, possible solutions could involve improved joint working between primary and secondary care with nurses, physician assistants and doctors in joint clinical settings to avoid time-wasting inter referrals.

[The Getting it Right First Time programme](#), colleges and specialty associations must work together to minimise bureaucracy and unnecessary defensive investigations.

We must also work with our patients, and patient representatives must be brought on board to understand the problems and work with our profession. Only by working together, will we find a suitable solution.

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