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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522

From the Minister for Health

DN.

The Rt Hon Viscount Whitelaw
Lord President of the Council
68 Whitehall
London

29th November 1985

NBPM

Dear William,

SOCIAL SERVICES SELECT COMMITTEE FOLLOW-UP REPORT ON MEDICAL EDUCATION

I enclose a draft reply to the Social Services Committee's follow-up report on Medical Education which was published in June.

The Committee's original Medical Education Report, published in 1981, dealt with the chronic problems of medical staffing, in particular the imbalance between the large numbers of hospital doctors in the junior training grades and the number of fully qualified doctors, and the consequences of this imbalance for patient care. The Government, in its response to the 1981 report, accepted most of the Committee's recommendations and has been pursuing a policy of consultant expansion to ensure that an increasing proportion of NHS patients are treated by fully-trained doctors.

The Committee's follow-up report is critical of the Government for failing to achieve the changes it had recommended. After analysing the possible reasons for failure to make further progress, the Committee calls on the DHSS to "issue unambiguous guidance on how they are to fulfil Government policies" and on the Minister to develop "operational plans" to implement agreed policy.

I am broadly in sympathy with the Committee's approach to medical staffing and in particular with the view that improvements in patient care must be the paramount consideration; and I accept that progress in implementing policy has been slower than originally envisaged. But I do not accept the Committee's recommendations on how to proceed. I believe that the reasons for slow progress may not be due solely to resistance on the part of vested interests in the medical profession or lack of energy by health authorities; rather it may point to defects in the policy itself. I have therefore decided to launch a review of current policy with the aim of finding why implementation has been so slow and how it can be improved. This new initiative is at an early stage, but has so far been well received by the medical profession and the NHS. The draft response therefore does not directly break new policy ground, although it does indicate that we must find new ways of implementing policy and that policy itself may be modified in the process.

Previous responses to the Committee's reports have been published as White Papers and I feel that would again be appropriate in this case. I would also like to clear the reply in correspondence. The draft has been agreed by officials in the Departments most concerned, Scotland, Wales and Northern Ireland.

E.R.

I would like to publish the reply during this session and so I would be grateful for any comments you may have by 10 December.

I am sending a copy of this letter and enclosure to members of 'H' Committee, the Prime Minister and to Sir Robert Armstrong.

BARNEY HAYHOE

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RESPONSE TO SSC FOLLOW UP STUDY ON MEDICAL EDUCATION

Introductory Chapter

As the Committee noted in its 1981 report on Medical Education [1], concern with the hospital medical staffing structure has a long history. It is already over 15 years since the First Progress Report [2], an agreement between the Health Departments and the profession, enunciated the principle that "the training of doctors should take only as long as the needs of training require and should lead without undue delay to a [consultant] post". This implied careful control of the number of training posts. A subsequent agreement [3] suggested that the problems of medical staffing could be solved by a sustained process of differential growth, with consultant numbers growing at a faster rate than training grade numbers. The problem was looked at afresh in [1976] by a working party under the auspices of the King's Fund [4] and the Royal Colleges have also published several important contributions [5] to the debate. Only a year before the Committee's 1981 report a conference [6] chaired by Sir Henry Yellowlees, at that time Chief Medical Officer of the DHSS, reached a substantial measure of agreement not only on the nature of the problem but also on the preferred solutions.

2. The Committee's 1981 report stands out amongst these other reports, by its insistence that the fundamental issue in hospital medical staffing is not the career prospects of doctors, nor even the requirements of medical education - important as these objectives are - but the quality of patient care. The Committee's central diagnosis was that too much patient care was given by doctors who were inadequately trained or supervised for the work they were given to do, and all the recommendations of the report flow from this. Despite their different starting point, however, the Committee reached broadly similar conclusions to those of the manpower studies referred to above. The major reform required was to increase the ratio of consultant to training posts - by consultant exapnsion and, "in most hospitals and most specialties" by a reduction in training posts. Reform of the career structure itself, in the sense of reconsidering the nature and responsibility of the grades, was considered unnecessary and undesirable.

3. The Government welcomed the Committee's report [7] and proposed changes in the ratio of consultant to training posts and, for England and Wales,

specific national and regional targets [8] for the expansion in consultant numbers and for the consultant:junior ratio. The leaders of the medical profession also welcomed the general objectives set out by the Committee, albeit with certain reservations. The need for a measure of consultant expansion was almost universally agreed [9] and there was also widespread agreement that the number of training posts should be reduced to some extent, provided adverse effects on doctors' workload and on patient care could be avoided [10]. The evidence given to the Committee in its follow-up study [11] shows that the leaders of the profession still maintain their qualified support for the Committee's recommendations.

4. Despite this reasonable degree of consensus across time and between different groups, progress in reforming hospital medical staffing has been very limited. Figure 1 shows how the overall ratio of consultants to junior grades has changed since 1971, and compares this with the targets set in 1971 and 1982. Only in the very last year has the ratio marginally improved (for reasons that are not yet fully clear); for most of the period the imbalance actually worsened. Why?

5. The Committee's latest report considers two possible reasons: the reluctance of health departments or authorities to give priority to reforming the staffing structure; and resistance by some consultants. On the first factor, the Committee notes that no additional funding had been made available by Government specifically for consultant expansion, and that hospital medical manpower had not been the subject of detailed consideration at the annual reviews between DHSS and regional health authorities. They conclude that health authorities will not act unless given positive directions to do so. The Government cannot accept this conclusion: the facts prove otherwise. Resources for the NHS <u>have</u> been growing in real terms, and this growth is available for consultant expansion where health authorities judge that this will further their plans for service development. Some regions have been making determined efforts to improve the balance between junior and senior doctors and to increase consultant numbers. However change cannot take place overnight and indeed should only proceed at the pace which causes the least disruption of patient services. The Government believes moreover that health authorities must, within broad national policies and priorities, have a large measure of freedom to manage their own affairs and to determine the pattern of service locally. Earmarking money for consultant expansion, or detailed directions on the levels of

hospital staffing,* could distort service priorities and hinder the integration of manpower planning and service planning which the Committee rightly calls for in another context [12]. The Government also notes the reservations of the National Association of Health Authorities [13] over the "desirability or practicability of [reducing imbalance of junior to senior posts] simply by increasing the numbers of consultants".

6. The second possible factor considered by the Committee is resistance by some consultants. The Committee notes the reluctance of some consultants to reduce tiers of cover, to undertake on-call duties and so on but concludes that "the extent of consultant resistance can be and is exaggerated. There is consensus behind continuing expansion of the consultant grade, associated with some change in the ratio of consultants to junior posts". The Government accepts that in many districts additional consultant posts, even without additional junior support, would be welcomed by existing consultants. However, experience shows [14] that where health authorities have attempted to combine additional consultant appointments with the loss of junior posts, such changes are usually resisted. It is far from evident that - given any rate of increase in resources which could conceivably be made available - the needs of patients for continuous, safe, 24-hour cover can be reconciled with present agreements on the career structure without significant changes in the nature of consultant work which many consultants would strongly resist. The problem is particularly severe for acute specialties like general medicine and general surgery which have traditionally relied on junior grades for much of their out-of-hours cover. Moreover, the argument that a major reduction in levels of junior support would, by reducing caseload and changing case mix, lead to a loss of expertise amongst the consultant workforce cannot lightly be dismissed.

7. There appears, therefore, to be an impasse. There is broad agreement nationally on the need for changes in hospital medical staffing, both in the interests of patient care and of doctors' career prospects. But at local level, many people are unpersuaded. Such resistance cannot be simply disregarded or written off as ill-informed. On the contrary, the opinion of those most directly concerned with patient care must be taken seriously.

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* Because of the smaller size of Scotland and wales, and in Wales the absence of a regional tier, the SHHD and Welsh Office are inevitably closer to the detail o local service planning than would be possible or desirable in England. The SHHD and WO therefore exercise some functions which in England would be found at regional level; for instance, the Welsh Office, like some English regions 'topslices' to encourage consultant expansion in priority specialties.

8. The Government therefore believes that there is a need for a fresh examination of hospital medical staffing and of the reasons for lack of progress. It may be that the answer cannot be found in attempts to alter merely the relative numbers of the present grades; it may be necessary to examine again the logic of maintaining the existing career structure. The Joint Consultants Committee has accepted the Health Minister's invitation to join in such an examination and health authorities have welcomed the opportunity to participate in it. The Government is confident that a successful outcome would result in an improved service to patients and a more certain future for doctors wishing to make a career in the hospital service.

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Draft IV (22.11.85)

SOCIAL SERVICES COMMITTEE REPORT ON MEDICAL EDUCATION
DRAFT COMMENTS ON INDIVIDUAL RECOMMENDATIONS

Recommendation 1

In view of the Government's commitment in 1982 to a radical change in the ratio of consultants to junior doctors, we cannot but deplore the plain fact that little has happened to change that ratio over the past three years. In the final analysis, the changes proposed are sought by the Government, and it is to the Minister that we are entitled to look for operational plans to bring those changes about.

Recommendation 2

The essence of the problem is agreed to be that, in many specialties, there are too few consultants and too many registrars and SHOs; and that where there has been consultant expansion, it has generally been accompanied by an increase in the number of junior posts. The imbalance in the career structure of hospital doctors cannot be rectified simply by an increase in consultant numbers: some reduction of junior posts is essential. Few junior posts have apparently been closed or replaced by consultant posts following a loss of recognition for training purposes, and it is clear that review of junior posts on educational criteria is unlikely to lead to any significant reduction in junior posts. We reiterate the two central recommendations of the 1981 Report, to the effect that a much higher proportion of patient care should be provided by fully trained medical staff and that in most hospitals and most specialties there should be an increase in the number of consultants. A faster rate of consultant expansion must be accompanied with some reduction of junior posts. We recommend that the Department develop models, based on local experience, for the replacement of junior by consultant posts.

The Government accepts that change has been slow, but the numbers of consultants are increasing each year and the number of juniors has begun to decline. However, given the difficulty described in the Committee's report in making rapid progress with the policy formulated in 1982 it may be timely to review the policy itself, and in particular the targets set at that time. It is clear that many doctors are deeply concerned at the radical change in medical practice implied by these targets. Moreover the development of health services can only take place within the limits of available resources. Indications coming to us from health authorities are that consultant expansion on the scale originally envisaged is not seen either as affordable or as

necessarily providing best value for money for patients. The specialties with the severest problems of grade imbalance are not in general those of the highest priority for service development. And health authorities are not convinced that the replacement of junior staff by consultants can be achieved without additional costs, or that it always represents best value for money.

The government remains committed to the principle that a greater proportion of patient care should be given by fully-trained doctors - and indeed that all doctors should be adequately trained for the work they are given to do - but sees the need to examine the reasons for lack of progress towards this end. The Minister for Health, with the agreement of the other Ministers concerned, has therefore written to the chairman of the Joint Consultants Committee proposing a fresh look at the problems of hospital medical staffing. In particular, the government believes that it should be possible to evolve new arrangements that can be more readily adapted to the needs of different specialties and localities. The possibility of creating a further career grade at a level of full clinical autonomy, and of the wider use of non-training grades below this level, must - as Mr Clarke said in his evidence - remain an open question.

Recommendation 3

Authorities cannot realistically be expected to take the initiative in correcting the medical profession's career imbalance unless specifically directed to do so. We recommend that, based on evaluation of the recently received strategic medical manpower plans, the NHS Management Board now issue to Regions unambiguous guidance on how they are to fulfil Government policies on medical manpower, and on how they are to deal with the financial consequences; and that the DHSS, together with NAHA, now identify those districts or hospitals where significant shifts in the consultant:junior ratio have taken or are taking place, with a view to evaluating the reasons for and effects of different patterns of staffing.

The primary role of health authorities is the provision of services to patients; in order to achieve this they must be able to make effective and flexible use of all the resources, including finance and medical manpower, available to them. The government does not believe that the DHSS can or should prescribe in detail how this should be done*. On the contrary, it believes that health authorities must remain responsible for detailed manpower planning within national policies and arrangements, which should be sensitive to varying local needs. The Department will ensure that regions are developing manpower plans consistent with their planned service developments and that the

*See the footnote to paragraph 5 of chapter 1.

regional plans add up to a coherent national strategy for medical manpower in which the number of training posts is adjusted to expected career openings. Where problems arise, they can be taken up with regions through the accountability process.

The government agrees that evaluation of the different types of staffing patterns that already exist within health authorities will provide valuable information. The DHSS is therefore considering the commissioning of a research study which would examine different patterns of medical staffing and responsibilities in a range of specialties and health authorities. In addition the Department will again write to RHAs inviting them to submit evaluations of any significant shifts in hospital staffing patterns.

Recommendation 4

We continue to reject the idea of two consultant grades, but renew the proposal that further examination be made of the feasibility of separate salary scales, and recommend that further consideration be given to regularising the terms and conditions of those individuals who have been in training posts for many years without prospects of becoming consultants.

The distinction between a two-tier consultant grade, and separate salary scales for (presumably) differing mixes of clinical and management or teaching work, seems a very fine one. As argued above, no option for resolving the present impasse over hospital medical staffing should be ruled out in advance of discussion with the profession.

The government accepts the need to consider solutions for the problems of those doctors in training grade posts who have no realistic prospects of further career progression. This will be one of the issues for discussion with the profession and the NHS.

Recommendation 5

We recommend consideration by all those concerned of elision of the SHO and Registrar grade, based on an effective elimination of the Registrar grade through loss of posts or transfer to SHO or Senior Register.

The structure of postgraduate medical education is a matter for the medical profession and the relevant education bodies, but the government will draw this recommendation to their attention. The Committee's report does not appear to explain how this elision of the training grades would help either to improve patient care or doctors' careers. If the thinking is that doctors in the SHO grade would not be so firmly committed to a particular specialty

as those in the registrar, this appears an over-simplification. A doctor who has a higher qualification in a particular specialty is committed to it, whatever the title of his grade.

Recommendation 6

We recommend continued monitoring by the Department of the clinical assistant grade to ensure that clinical assistant posts are not used as a substitute for consultant expansion.

The government accepts this recommendation.

Recommendation 7

We recommend that the Government, in the course of discussions on the forthcoming Green Paper, take steps to establish a more integrated manpower planning system for hospital and family practice medical staff both centrally and at local level.

The government continues to accept that the balance between primary, community and hospital medical manpower is a vital consideration in NHS manpower planning. At national level there is continuous appraisal of the aggregate supply of and demand for doctors, taking into account the manpower needs of general practice as well as of the hospital and community health services.

As to planning at local level, it must be remembered that Family Practioner Committees are independent bodies, accountable directly to the Secretary of State for the provision of family practitioner services; and that the local distribution of general medical practitioners, in such a way as to achieve an even spread of manpower across the country, is the responsibility of the Medical Practices Committee. In planning levels of manpower and service provision, health authorities do of course take account of the contribution of the family practitioner service towards primary care, and of its manpower requirements. For example, most regions consider explicitly the training requirements of future general practitioners in planning the number of SHO posts required in the various specialties popular with vocational trainees. To that extent, there may already be said to be integrated medical manpower planning at local level.

Recommendation 8

We recommend a more vigorous effort to establish effective manpower data systems on the numbers, occupants and status of all medical posts and commend the progress in Scotland as an example worthy of imitation.

The government considers that the data on the number of doctors in training are already adequate for the purpose of national manpower planning. Data on training posts will be available in detail at regional level, and in summary at national level, when the recommendations of the Third Report of the Health Services Information Steering Group (the "Körner committee") have been implemented. The government are not convinced that the benefits of a national information system on posts (over and above the separate regional systems) have been demonstrated, or that they would justify the likely costs involved.

The DHSS is aware of the West of Scotland system, which appears to be similar in scope to systems being developed in other parts of the United Kingdom.

Recommendation 9

We deprecate the delay of 14 months between completion and publication of the Report of the Advisory Committee for Medical Manpower [Planning]

Ministers judged that the appropriate time for publication would be in the context of the announcement of other linked initiatives such as the changes in the immigration rules for doctors and dentists, announced to Parliament on 26 March.

Recommendation 10

It is not clear that the prospect that the sponsored postgraduate training programmes must mean some UK graduates being obliged to take on training jobs in the less glamorous specialties and that many training posts in popular specialties will be occupied by overseas trainees has been fully appreciated. It is now time to thrash out the details of the sponsored training scheme, so that a halt can be called to the exploitation of overseas doctors.

The government agrees that it is important to ensure that overseas doctors have the opportunity to gain the sort of postgraduate training and experience that will be of value of them on return to their own countries. However, it should be noted that even in the 'popular ' specialties, many posts are already occupied by overseas doctors. It has been agreed with the profession that schemes for sponsorship of suitable overseas

graduates will be worked out specialty by specialty and based on Colleges and Faculties. The Royal College of Obstetrics and Gynaecology is already operating such a scheme, and details of a further pilot scheme in general surgery and orthopaedics are now being worked out between the DHSS and the Royal College of Surgeons.

Recommendation 11

We recommend that the target figure for UK medical school entry be maintained.

The government does not intend any immediate change to the target levels for UK medical school intake, but will review the position in the light of the effects of the changes in the immigration rules described above on the inflow of overseas graduates, and of a further review of medical manpower to be undertaken in 1986.

Recommendation 12

We recommend that the Metropolitan and Provincial Deans formally consider the recommendation made by the Committee in 1981 on the recruitment of a higher proportion of mature students, particularly those from the 'caring' professions.

This recommendation is primarily for the Deans, and will be drawn to their attention. The comments made in the government's response to the 1981 report are still relevant.

Recommendation 13

We recommend continuing Departmental monotoring of the process of doctor-substitution.

The government will continue to assess developments in the substitution of doctors by other professional groups and in the development of multi-disciplinary teams.

Recommendation 14

We welcome the General Medical Council's initiatives on postgraduate training and look forward to a constructive outcome. We recommend that the Minister and the Department ensure that they are fully abreast of developments in the pattern of postgraduate medical education.

The government also welcomes the GMC's initiatives in this field. While the content of postgraduate medical education must primarily be a matter for the profession's independent educational bodies, the Government accepts that the DHSS should keep itself informed of developments and considers that it takes considerable pains to ensure that it does so. For example, the Department is represented both on the General Medical Council and on the Council for Postgraduate Medical Education, and attends meetings of the Higher Training Committees for Specialist Training and the meetings of Regional Advisors in General Practice.

Recommendation 15

We recommend continuing efforts to fund academic chairs in emerging or less popular specialties.

The government accepts that the establishment of academic chairs in emerging or less popular specialties can be an important step in encouraging the development of these specialties. But it is primarily for the University Grants Committee and for individual universities to judge how the progress of academic medecine can best be advance, within the resources made available to them, and in which specialties new chairs should be establised.

Recommendation 16

We look to the General Medical Council to give active encouragement to more organised and varied rotational training arrangements. We recommend that postgraduate and undergraduate deans should intensify their efforts to provide realistic career advice to medical students and trainee doctors, and to that end we recommend a greater degree of involvement of postgraduate deans in the formal mechanisms of regional manpower planning.

The government welcomes these recommendations and will bring them to the attention of those responsible for taking them up.

Recommendation 17

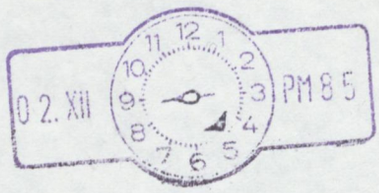
We recommend thorough local examination of the possibilities of extending cross-cover as a means of further reducing onerous rotas.

The government agrees to a further examination at local level of the possibility of extending cross-cover arrangements.

Recommendation 18

We welcome signs that the General Medical Council is showing a broad concern for professional issues in line with its expanded responsibilities.

It is for the General Medical Council to respond to this comment.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PRIVY COUNCIL OFFICE
WHITEHALL, LONDON SW1A 2AT

28 January 1986

Dear Barney.

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SOCIAL SERVICES COMMITTEE: FOLLOW-UP REPORT ON MEDICAL EDUCATION

You wrote to me on 16 January outlining the outcome of your further consideration of the presentation of this report.

I am most grateful to you for looking at this matter again. I fully recognise the difficulties you face in striking an appropriate balance and the importance of securing the co-operation of the profession to the changes you wish. I am therefore content for you to proceed as you propose.

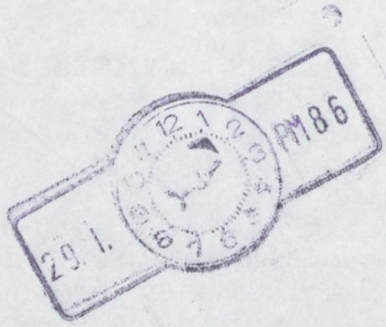
I am sending a copy of this letter to the Prime Minister, the members of H Committee and to Sir Robert Armstrong.

The Rt Hon Barney Hayhoe MP

PARLIAMENT

H/C PROCEDURE

PT 7



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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Minister for Health

The Rt Hon Viscount Whitelaw CH MC DL
Lord President of the Council
68 Whitehall
LONDON
SW1

6 January 1986

Dear Willie,

SOCIAL SERVICES COMMITTEE: FOLLOW-UP REPORT ON MEDICAL EDUCATION

Many thanks for your letter of 11 December conveying the general agreement of H Committee to publication of this Select Committee report.

You wondered whether there was scope to strengthen the presentation of the response and I have looked at this very carefully. In agreement with the other health departments, we had aimed to strike the requisite balance between hinting at a possible change of policy without appearing to pre-empt the outcome of the proposed discussions with the profession and with health authorities to review the policy. I have just held the first of these discussions and it is quite clear that very delicate handling will be required to secure the co-operation of the profession, which will be essential to make progress. I think, therefore that it would be counter productive to strengthen the presentation of the White Paper and I would be grateful for your agreement to publication in its present form.

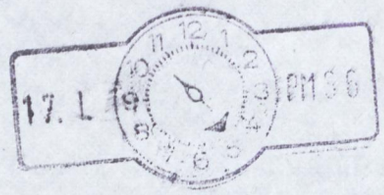
You also mentioned John MacGregor's request that his officials be associated with the review and this has been arranged.

I am sending a copy of this letter to the Prime Minister, the members of H Committee and Sir Robert Armstrong.

Yours ever,

BARNEY HAYHOE

PARLIAMENT : H/C Procedure: Pt 7.



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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522

From the Minister for Health

The Rt Hon John MacGregor MP
Chief Secretary to the Treasury
Parliament Street
London
SW1P 3AG

23 December 1985

Dear John

NBPM.

SOCIAL SERVICES SELECT COMMITTEE
FOLLOW-UP REPORT ON MEDICAL EDUCATION

Thank you for your letter of 9 December.

I fully agree with you that Treasury officials should be involved with the review of hospital medical staffing. Indeed, I believe that our officials have already been in touch and have made appropriate arrangements for this to happen.

I am grateful for your support for the Government response to the Select Committee to be issued as a White Paper.

I am sending a copy of this letter to the Prime Minister, the Lord President, other members of 'H' Committee and Sir Robert Armstrong.

Yours

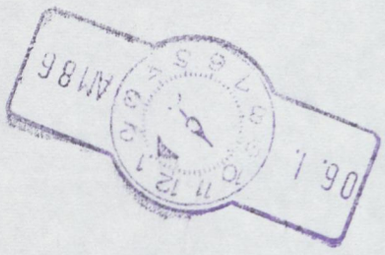
Barney

BARNEY HAYHOE

PARLIAMENT

H/c PROCEDURE

PT7



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PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

11 December 1985

NBPM.

Dear Barney

SOCIAL SERVICES SELECT COMMITTEE FOLLOW-UP REPORT ON MEDICAL EDUCATION

You wrote to me on 28 November seeking comments on a draft of the White Paper you intend to publish giving the Government response to this Select Committee Report.

You will have seen John MacGregor's letter of 9 December welcoming your decision to review our present policy but asking that his officials are associated with the review in view of its possible public expenditure implications. He is otherwise content with the draft. I too am content with the general lines of the White Paper but as, in fact, our reply is such a forthcoming one I wonder if there is not scope for strengthening the presentation of theWhite Paper to make rather more of this.

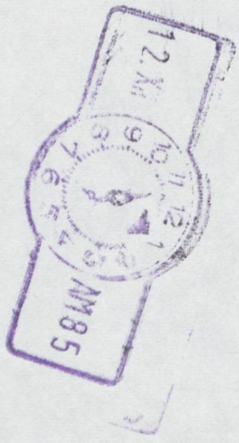
Subject to these points you may take it you have H Committee's agreement to publication.

I am sending a copy of this letter to the Prime Minister, the members of H Committee and Sir Robert Armstrong.

The Rt Hon Barney Hayhoe MP

Parliament Pt 7

H/C Procedure.



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cc BG

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Barney Hayhoe MP
Minister for Health
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London
SE1 6BY

9th December 1985

Dear Barney,

SOCIAL SERVICES SELECT COMMITTEE:
FOLLOW-UP REPORT ON MEDICAL EDUCATION

I welcome your decision to review our present policy of increasing the number of consultant posts. There is now clearly some doubt, particularly amongst health authorities who have direct management responsibility, as to whether that policy represents the best value for money. It would be wrong in these circumstances to press on.

Whatever emerges from the review is certain to have major resource implications (I have in mind the need to tailor medical staffing and duties to cope more flexibly with the changing needs of the health service, as well as direct costs). I should therefore like Treasury officials to be involved with the review.

I have no comment on the other matters covered in the reply, and support your proposal to issue it as a White Paper.

I am sending a copy of this letter to the Prime Minister, the Lord President, other members of 'H' Committee and Sir Robert Armstrong.

Yours ever,

JOHN MacGREGOR


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