TALKING POINT

Consultant contract: pitfalls and safeguards

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If the Central Committee for Hospital Medical Services is as representative of consultant opinion as it ought to be, the enthusiastic welcome which it gave to the final draft of the proposed new consultant contract[1] will be reflected in the current ballot. Lest the possible financial benefits of the contract overwhelm an analysis of its implications, we should consider the defects which will have to be remedied before it is acceptable.

For most consultants the most important aspect of the new contract[2] was that remuneration would be related to work done (albeit through a mix of sessional payments, on-call payments, recall payments, etc, rather than the item-of-service system) and a work-sensitive contract would result in substantial improvement in remuneration. But its introduction at a time of rigid pay restraint carries well-known risks. As the basic contract is for 10 sessions (NHDs), existing salary scales must be paid for these 10 sessions alone; all extra work must be paid in addition. If the average consultant has, for example, 12 NHDs in his new contract, and if existing salary scales were to be related by the Review Body to this average figure then the consultant who worked only 10 NHDs of the standard contract —and many consultants may fall into this group—would receive only 10/12 of his present salary.

Such a calculation would be valid if when pricing the contract the Review Body proposes that the total cost of consultant salaries under the new contract should not exceed the cost under the old contract. Consultants would then be put into the same "no detriment" predicament that precipitated the junior hospital doctors' industrial action in 1976.[3] Adequate pricing is a prerequisite for acceptance of the contract, but the portents are not good. Discussing the new contract in its *Eighth Report*, the Review Body says that "consultants with the heavier duties and responsibilities would receive higher remuneration, and those with the less heavy would receive lower remuneration than under the present contract arrangements"[4] and that "protection of an individual consultant's position is envisaged through . . . an option to retain their present contract."[4] In my view the Review Body's treatment of the juniors also bodes ill for the new contract. A relative decrease in their basic salaries is seen as an inevitable consequence of their being paid for work done outside the basic contract, as the Review Body takes average total earnings as the basis for evaluating salary relativities.[5] It also believes that work done outside the basic contract should not attract "the premium rates paid to . . . workers in industry for overtime work. . . ."[6]

While Mr A H Grabham was reported as saying that the CCHMS would decide whether a second ballot was necessary before final acceptance,[7] many consultants believed that there had been a definite commitment to a second ballot after the Review Body had priced the contract. The BMA's ballot form makes it clear, however, that "*final acceptance* by the profession of the new contract will be *conditional upon satisfactory pricing* by the . . . Review Body. (If necessary a further ballot may be held when the pricing is known.)" Even so, the CCHMS must give a firm assurance that a satisfactory pricing of the new contract will mean that the salary scales extant at the time of implementation are applied only to the basic commitment. This concept is also vital in the long term. Unless future salary negotiations are conducted with an agreement that the scales are for the basic commitment of 10 NHDs, the value of the NHD will gradually be eroded. Consultants will find themselves on an accelerating treadmill, having to work ever harder to maintain their financial position.

The attempt to remove the private practice issue from the contract has failed and will not be further discussed here. It should be a less important source of division among consultants as its effects will be restricted to work done outside the basic contract. Only those consultants (and there should be few) who work 14 or more NHDs will be barred from private practice.

The Negotiating Subcommittee of the CCHMS has assured us that the terms of the draft contract are the best that can be obtained at present. There can be no further improvement before implementation, though I would like to see improvements in the future. For example, the inadequate solitary NHD allocated for the basic on-call commitment means being available for recall without additional payment for 26 hours each week. Presumably the discussions on the terms and conditions of service will ensure a much more precise wording than is the case with the draft contract. Furthermore, the machinery necessary to resolve disputes between consultants and their employing authorities must be agreed. In addition, the implementation circular which the DHSS will issue to employing authorities as their bible in contract matters needs careful drafting so that it is a clear exposition of the spirit of the agreement. Consultants should then avoid many of the problems that juniors have experienced with their contract.

Possible pitfalls

The draft of the new contract contains many imprecisions. Even fair-minded administrators will tend to interpret ambiguous phrases in favour of the employing authority, and a minority will seek out phrases that can be used

In brief . . .

EEC doctors meet in Denmark

The Heads of Delegations of the Standing Committee of Doctors of the EEC met in Denmark on 9 and 10 June. The BMA's delegation was led by Dr Alan Rowe, chairman of the Association's EEC Committee. Medical demography and the rising costs of health care were discussed and a report will be made later in the year. The EEC Commission had produced a Community action programme on safety and health at work but the Occupational Health Subcommittee, while agreeing with the general content of the programme, was concerned that occupational health doctors were not mentioned. The standing committee hoped that the medical profession would be concerned with the implementation of the programme and the directives on safety and health planned for 1979. The meeting failed to decide on the question of the general practitioner being the normal route of access to a specialist. This will be discussed at the committee's plenary session in November, together with the reservations expressed by the German delegation about whether vocational training for general practice should be obligatory or voluntary. The committee was told that the Italian parliament had recently passed the necessary legislation to implement the provisions in the Medical Directives on free movement of doctors in the EEC.

Charles Hastings Wine Club

Many of the 7000 members of the Charles Hastings Wine Club have complained about delays in the delivery of recent orders. The club has changed to new suppliers—Saccone and Speed Limited. They have a fixed policy of dealing with all orders within three days of receipt of the order. Furthermore, they have several depots throughout the country to which wine can be sent for rapid delivery. The club hopes that there will be no further delays and that members will receive prompt service. They should hear from the new suppliers before 20 June. Any member who does not should inform the secretary of the club at BMA House, Tavistock Square, London WC1H 9JP.

to the consultant's disadvantage. The proposals state that a consultant's duties "will be set out in a schedule agreed between a consultant and his employing authority, which may subsequently be varied by mutual consent" (paragraph 2). An administrator could interpret "schedule" to mean a detailed timetable which could not be altered without the agreement of the employing authority, even if requested by the consultant because alterations could be made only by "mutual consent." Mr Grabham has reported that the spirit of the agreement did not include timetables, with the spectre of clocking on and off,[8] but this is not made clear in the draft proposals. Paragraph 6(*i*) says: "Temporary additional NHDs may be given . . . to cope with temporary staffing difficulties." What is meant is that temporary additional NHDs *shall* be given to take account of the extra work occasioned by temporary staffing difficulties.

Another example of imprecision is in paragraph 9(*v*), which includes the statement: "Where it can be shown that involvement in an organised vocational training scheme for general practitioners imposes significant additional work upon a consultant, account should be taken of this in determining the appropriate allocation of NHDs in his contract." "Can be shown," "significant," and "should" are dangerous in this context, and the sentence should, perhaps, read as follows: "A consultant involved in an organised training scheme for general practitioners shall have the resulting additional work taken into account in the allocation of NHDs to his contract." The CCHMS will, I am sure, arrange for the contract and the relevant circulars to be scrutinised by a legal expert.

Appeals machinery

However well designed the contract, there will inevitably be disagreements between consultants and their employing authorities. The machinery proposed to deal with these is quite inadequate. For example, the consultant who thinks that he requires extra NHDs to cope with the work load expected of him and whose employing authority disagrees is entitled to "make personal representations to the employing authority." This sounds splendid but is valueless. Does it mean an interview with a local junior official or an emergency meeting of the health authority to hear the consultant's case? The phrase suggests that a consultant in dispute with his employing authority would have neither the wit nor the drive to make forceful "representations" to his employing authority on his own initiative. Failing agreement after "personal representations," the consultant would be entitled to appeal through Whitley. That would take too long. The machinery must be fair and effective, operate locally, and be controlled to a large extent by the profession.

The junior with a problem discusses it first with his local administrator. If he is fortunate, as in the North-west Region, he can call on the expert advice of the HJSC's local contracts committee, which will intervene with the administrator if the junior has a fair case. Most disagreements are settled amicably at this level. If not, the case goes to an intraprofessional appeals committee composed of consultants and juniors, which assesses the case and gives an authoritative judgment. Either party can refuse to accept this judgment and appeal through the Whitley machinery, but this has not happened yet in the North-west. Every appeal has been decided in favour of the junior, and the employing authority has never felt sufficiently aggrieved to appeal to Whitley.

Some kind of intraprofessional appeals machinery for consultants is essential. This machinery could also be used in the reverse direction. For example, it could deal with the consultant who makes many more recall visits than his peers. The contract makes no mention of this problem, which should be dealt with by the profession. It would also be sensible for regional committees for hospital medical services to set up contracts committees to advise local consultants locally. These would help to reduce disagreements by disseminating accurate information. They would also redress the balance in expertise between the administrator with several years' experience of doctors' contracts and the consultant who may be delving into this area for the first time.

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Shortage of consultant locums

CCHMS advice

The CCHMS Negotiating Subcommittee has received several inquiries from single-handed consultants about what to do when employing authorities are unable (or unwilling) to provide them with locum cover for holidays and study leave. After discussion with the Joint Consultants Committee the subcommittee offers the following advice to consultants.

"It would certainly not be in the interests of patients for consultants, confronted with this difficulty, to abandon or curtail holidays or study leave. In such circumstances, each consultant should consider what scale of service can be provided, in his absence, which fully protects the interests of patients. In making this assessment he will, of course, be guided by his knowledge of local circumstances, including the experience and competence of the members of his staff, whether medical or technical, who will be working in his absence and what consultant cover may be available, particularly in emergency circumstances. He should then clearly specify what level of service can be maintained and inform his employing authority and his consultant colleagues accordingly, ensuring that the notice given is sufficient to allow any consequential changes to be made in other departments. In extreme cases it may be necessary to close a department or service completely. Where the restriction or closure of a service, particularly in pathology or radiology, restricts the work of clinical units, it is important that other consultants fully support their colleague in putting the safety of patients before all other considerations."

In brief . . .

Decision making in the NHS

A research report, commissioned by the Royal Commission on the NHS, has drawn attention to the "multiplicity of levels, the overelaboration of consultative machinery, the inability to get decision making completed nearer the point of delivery of services." Professor Maurice Kogan of Brunel University led an 11-man team of researchers who interviewed over 500 people about decision making in the NHS (*The Working of the National Health Service*, HMSO, £3·75.) The team did not believe that wholesale reorganisation would be acceptable or necessary but the regions and areas should see whether they could simplify their structures. The main recommendation was that the health authorities "should begin to make a careful, slow, and reflective attempt to enhance delegation, to remove levels of administration, many of which are known to fail to contribute towards efficient working."

The team emphasised that NHS reorganisation had been an attempt to do too many good things at once.

30th anniversary travelling scholarship

The Welsh Office has established a commemorative scholarship to mark the 30th anniversary of the NHS. It will be tenable in the academic year 1978-9 and is open to anyone between 23 and 30 who wishes to travel abroad to carry out research which will be of direct benefit to the development of health care or the personal social services in Wales. The scholarship will cover costs of travelling, living expenses, research, and equipment, up to a maximum of £7000. Preference will be given to applicants working in the health and personal social services in Wales. Applications should be made to the Welsh Office, Greyfriars Road, Cardiff CF1 3RT by 5 July.

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