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Powars, Iros, et al

The BMA has been a registered trade union only since 1971.[1] Yet for most of this century the BMA, though a voluntary professional organisation, has functioned as a de facto trade union, democratically representing doctors at national level. Indeed, according to a recent sample poll of BMA members conducted by BUPA, 80% of the 1000 or so respondents put central negotiations as the most important function of the BMA.

With a full-time secretariat concentrated mainly in London and a local divisional network of voluntary officers the BMA has inevitably been a centralised organisation—some doctors might say overcentralised. The combination of local medical committees looking after GPs' "workplace" needs, the simplicity (until recently) of hospital doctors' contracts, and individual doctors' powerful influence in NHS hospitals meant that there was no great pressure for the BMA to strengthen its voluntary infrastructure. But times have changed, inside and outside the NHS, as the Representative Body overwhelmingly recognised at Cardiff this year when it approved a deceptively simple looking motion from Bedfordshire "that this meeting supports the early appointment of accredited workplace representatives."[2]

This resolution stemmed from the conclusions of Dr A A Clark's Working Party on the Functions and Priorities of the Association,[3] which made a realistic assessment of what services the BMA should offer to its members in an age of variable individual contracts, complex trade union and employment legislation, and the growing local and national power of other NHS unions. The ARM made two other, complementary decisions. Firstly, that "the BMA should appoint in each region, as a matter of urgency, a member of staff with experience in employment legislation and industrial relations," and, secondly, "that this meeting would welcome more whole-time regional medical and non-medical BMA staff." There was no question that despite the high cost the Representative Body wanted these changes urgently. So the central BMA secretariat has written to divisional secretaries explaining the plans for action (14 October, p 1103).

The BMA has now appointed a senior industrial relations officer (21 October, p 1170), and some divisions have already nominated place of work accredited representatives. The aim is to develop a nationwide network of POWARs, starting in the hospitals. It would be premature to define too rigidly what these new-style BMA representatives will do. As their main function will be to provide help in hospitals the way they work will undoubtedly evolve in response to members' local needs. But in some informal notes of guidance (p 1243) the BMA has sketched out the broad pattern of the POWARs' work. These workplace representatives—shop stewards in industrial parlance—will work in close co-operation with divisional secretaries and hospital doctors' representatives, caring for the needs of BMA members, as well as recruiting new ones. They will also be acting for the BMA locally in a trade union capacity, with expert support from industrial relations officers (full-time regional BMA staff who are to be introduced over the next year or so) and from provincial medical secretaries. NHS general practitioners are self-employed, so that initially they will not come within the ambit of the POWARs unless working part time in a hospital post. GP members of the BMA will, of course, be able to seek the advice of the IROs. POWARs will, however, appreciate the value of maintaining a good liaison with local medical committees.

While many people instinctively equate shop stewards with industrial action, this is an erroneous reflex: the shop steward's main job is helping individual members with their workplace problems. This will be the most important activity of the BMA's accredited representatives, but, in the unhappy event of the profession's contemplating militant action centrally, the POWARs will be responsible for organising it in their area, for only they, as official union representatives, will be protected in law when undertaking this function. All this is new territory for the medical profession. The NHS already puts a heavy administrative and advisory burden on doctors, so will a sufficient number of them be willing to take on yet more duties? After all, some divisions are even now hard pressed to attract active members. Perhaps the success of the Royal College of Nursing's stewardship scheme will encourage would-be volunteers. The RCN launched its stewards in 1972 and now has 2000 of them. Over the past 18 months or so, with the scheme in full working order, the college's membership—which, like the BMA's, is voluntary—has risen from 86 000 to 110 000. A proportionate surge in the BMA's membership would greatly strengthen its local and national negotiating powers.

Further "unionisation" of the profession will not please all doctors. In the "real politik" of today's unsettled NHS, however, doctors would be naive to gather their professional skirts about them and pretend no interest in the constant jockeying for power. The profession's ability to influence decisions in the Health Service is vital—not just for the doctors' good but in their patients' interests as well. POWARs, IROs, et al will enhance this influence.

[1] *Industrial Relations Act 1971*. London, HMSO, 1971.
[2] *British Medical Journal*, 1978, **2**, 301.
[3] *British Medical Journal*, 1978, **1**, 1001.