unlikely to yield any dramatic improvements in the quality or efficiency of general practitioner care. This is not to suggest that we disagree with the government's objective of making general practitioner services more responsive to the needs and wishes of consumers or of raising standards of practice.

We believe that these objectives will not be realised by simple reliance on individual consumer choice, at least within the confines of the present system. There are other ways in which the collective wishes of consumers of health care can be expressed and in which the quality of care can be improved. In this context we welcome proposals to increase the role of medical audit in ensuring high quality care.

It is unfortunate but perhaps not surprising that the white paper contains no proposals to enhance the power of consumers collectively to influence the service through community health councils or increased representation on family practitioner committees. There are no solutions which will solve all problems at a stroke, and it would be naive of ministers to assume that the application of market principles will achieve major improvements in primary health care.

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Doubtful gains from tighter consultant contracts

W J Appleyard

A deputy editor of the *BMJ*, Dr Tony Smith, interviewed Dr W J Appleyard on the working paper on consultant contracts and distinction awards. Dr Appleyard is a member and former deputy chairman of the Central Committee for Hospital Medical Services.

Let's talk first about the sensitive matter of contracts. Consultants are worried on two counts: who will really control their contracts and how flexible these will be in form and in daily operation.

We are told that as the trust hospitals evolve consultants' contracts are going to be held by these hospitals and not by the regional health authority. Traditionally, NHS contracts have been held at the regional level (except for the university and postgraduate teaching hospitals). So in some ways the trust hospital might follow the pattern of the university hospital.

The advantage of contracts being held at region in terms of consultant work is that most of the specialist services that consultants provide are confined to one district. True, general medical and surgical services may be based in a single district, but most subspecialties are provided on a multidistrict basis and have a regional structure.

Increasingly, the pattern of patient services is of primary care by general practitioners, referral to the secondary consultant care service—in the hospital and in the community for the maternity, paediatric, psychiatric, and geriatric services—and then a further layer of tertiary care for the subspecialties and for those topics that require more intensive research in teaching centres. It is important to plan those services both nationally and regionally. If we allow the growth of trust hospitals to be totally independent and based on market forces any planning will be extremely difficult to sustain. The new trust hospitals may not be interested in the difficult cases, and they may be more concerned in getting rid of their waiting lists as a political or as a financial objective.

There are, however, certain advantages in independence—for example, for raising money and developing some services faster. But the risk is that the trust hospital may decide to offer only limited services. In recent years we have seen some important and cost effective changes in the integration of secondary care services within the community and the hospital. One example is geriatric services; the consultant geriatrician must be appointed to the district—not just a hospital—and run the community sector as well. Mental health is the same. And of course in paediatrics we have for far too long been inefficient, keeping two service arms—the child health service and hospital paediatrics—though we are now moving towards integration. It is not spelt out in the white paper whether trust hospitals may take on these services and if so how. And if they take some bits on and not others that would create a disorganised service. It is also difficult to see what incentive would be provided for a trust hospital to keep beds available for emergencies. Currently we are being asked in the south east region to keep our intensive care beds filled 100% of the time. Now that is absolutely impossible to do in any acute service.

. . . A London trust hospital might say "we are going to pay you half the amount because you are bound to earn a lot in private practice."

Until now the regional status of consultant contracts has meant two things: firstly, we have had good specialist services, and secondly, the specialists have been prepared to work outside the big teaching centres. One important feature of the health service has been its even spread throughout the country. If we come to have just a few trust hospitals which concentrate skills we might destroy that concept of overall service.

Experienced staff

Another point about the contracts being held at regional level—a system, incidentally that Alain Enthoven supported—is that regions have staff who are able to cope with such complexities as complaints by patients, and so on. Ideally, I believe that contracts should stay at regional level, but some aspects could be delegated to the district. Of course, to some extent that happens now, with the district deciding the content of the contract and seeking approval from the region. One more important safeguard is that it is desirable

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professionally that a contract is overseen by the royal colleges and the universities so they should be represented on the appointments committees. We would certainly wish that system to continue in order to guarantee the high standard that is required of the consultant grade.

The government is proposing that the general manager should be on the advisory appointments committee. These are important meetings for deciding distinction and overall professional competence of the candidate. Usually all the candidates are well qualified, and it is a question of sorting out with local interests what special talents might bring to the post. Now if we are going to require a major input of management skills that might militate against the care of patients. Existing appointments committees comprise seven people, one of whom is a representative of the district health authority. We would prefer to have any management input at that level rather than from the chair. Clearly in future some further training in management will be part of the consultant's education. I believe that the existing training teaches them to manage rather well; we shall have to look carefully at what other elements they are going to have to learn. But we shall also want to know what criteria the manager on an appointments committee would apply to the candidate. Furthermore, we should insist on being on the appointments committees as managers to ensure that they will command the profession's confidence.

Job descriptions

The existing job descriptions were agreed about 1979 as part of the new package with the then Secretary of State for Social Services, Patrick Jenkin. One important element was the concept of whole time and maximum part time. Under both contracts the consultants devoted substantially the whole of their time to their NHS tasks. There is a list of duties that we have—the diagnosis and treatment of patients at one or more hospitals, domiciliary consultations, and so on—as well as a continuing clinical responsibility for patients in our charge allowing for proper delegation to and training of the staff. The white paper puts it about that we have 24 hour responsibility. That concept is open to considerable misinterpretation. I think we have continuing clinical responsibility for the patients in our charge, but not for any new patients arriving at the hospital unless we are on the duty rota. We do have continuing responsibility for those people in our care but we can delegate that responsibility to colleagues. This is how it works in custom and practice, and I would not want that to change. The patients know which consultant is looking after them and who is responsible for their care.

The building brick of the consultant contract is the notional half day and this will apply in any future negotiations. This is a three and a half hour period of time flexibly worked and aggregated up to a total of 35 hours for 10 notional half days a week. The key aspect, however, is its flexibility, so that these are not sessions requiring a consultant to be in at 9 o'clock precisely—just as you wouldn't expect a manager to be at his desk at any particular time because his duties may call him away elsewhere.

I come in at around 8 15 am and visit our special care baby unit before I go on to the clinic. So my time of arrival at the clinic is determined by the emergencies that have come in overnight. Of course it is entirely reasonable that a consultant should be expected to be there to run a clinic when everybody is geared up to it. But some of the work is variable, and on a knock for knock basis I think that the health service has gained a considerable amount over the years from this flexible working pattern. A survey carried out by the Office of Manpower Economics showed that consultants were giving the NHS up to 25% extra work above their contracted sessions.

A too rigid contract will work against patients

The concern is that if the new system defines the contract too rigidly it will actually work against the interests of patients. Should the government enclose and encapsulate the doctors' work much more rigidly than now a lot of that extra work is not going to be done unless the health authority pays for it. Certainly there are few doctors who don't fulfil their contract satisfactorily; they are a small minority who are relatively easily identified. When consultants are collectively responsible for running a unit and one of them is just not discharging these responsibilities then the best way to deal with the problem is to sit round a table and the backslider can be shamed in front of the others.

. . . the consultant is in everyday contact with patients. This is the big difference between the consultant and the manager.

The existing job description also includes provision for teaching. We are responsible by custom and practice for teaching the juniors who work for us; that responsibility we enjoy. Any attempt to formalise that more clearly will mean identifiable time will have to be set aside. If it is then formalised as part of our 35 hour week of course it will mean that the service will have to have more consultants doing the other clinical duties. At present many consultants regularly take on students—on monthly and sometimes two weekly rotations. That work is totally unrecognised, but increasingly it will be a necessary part of the students' education because the central hospitals are just not going to have the range of patients they need for teaching students. If this sort of teaching is recognised it will be a bonus for the district hospital. It won't be a bonus for the teaching hospital, however, because part of its budget will be redistributed.

More staff

One other thing about the job description; we have been careful not to box people into their job description and designation of duties simply because the nature of a consultant's work is flexible. I never know when I go into a hospital exactly what will happen that day, everything is totally unpredictable in terms of clinical demands. If audit is introduced we shall all need to have a session or so put aside—perhaps more than the initial one or two sessions—for managing the clinical service and auditing it. So more time will be taken away from patients in that way. Overall more staff will be needed to get through the clinical workload if teaching, audit, management, and those other elements that the government has rightly identified are to go ahead.

I would like to see a basic contract of 10 notional half days which could be built on, so that the more work you did for the health service the less work you could do in private practice. And I am sure it is right that we must have systems which provide a guarantee to the managers that if you are contracted for a particular amount of work you actually do that amount. But outside those duties you should be able to contract to do other things. Consultants working just for the health service would be able to contract extra sessions for their administrative work, their teaching duties,

and so on, building on that contract. It would be helpful for the trust hospitals to have a basic, nationally agreed contract on which they could build to suit local needs.

Pay bargains

I would be very worried indeed if a trust hospital was free to adjust the nationally agreed basic contract. For instance, in London a trust hospital could say, "We will pay you only half the usual amount because you are bound to earn a lot in private practice." So Guy's Hospital might pay only half the salary offered at Canterbury. The other worry about giving a contract to the trust hospital is the fact that the consultant would then be entirely in the hands of the local general manager. General managers are transient beings. Their objectives may be short term, whereas the evolution of a specialist service is inevitably a long term objective. There could be a clash between the consultant trying to build up and develop services over the long term and the general manager who is trying to meet certain short term fiscal targets.

Nowadays when there is such a clash the general manager can't simply say "you're fired" or "we don't need you any more" because he has to go through the regional health authority to do so. But in future he may be able to fire a consultant at whim. And if a consultant is under contract to a trust hospital rather than the region and the trust hospital went broke because, say, of bad management he would lose his job instead of being redeployed. So there may be considerable disadvantages in locally negotiated contracts, mainly arising, I think, from the transient nature of managers and the longer term perspective of consultants.

Finally and crucially, the consultant is in everyday contact with patients. This is the big difference between the consultant and the manager. He sees and he touches and he talks to them, and he's the frontline guy. I know he's supported by junior staff but he's still seeing patients face to face—a real safeguard for them. If the doctor thinks the service is inadequate or in difficulties he knows this from first hand experience and can speak out without fear of being rapped over the knuckles by his manager.

An alternative to distinction awards

Now let us move on to distinction awards. Traditionally they were to reward distinction. Over the past 10 years meritorious service awards crept in. More and more of the B and C awards are being given to people who have borne the heat and burden of the day. My personal view is that I've always found it difficult to be comfortable in a system that gives awards to over 60% of consultants and not to the others. I think that in any system you can always identify the top 10% who are quite outstanding, and probably you could always identify the bottom 10%. But to make arbitrary distinctions within the other 80% has always been a fatal flaw in the system.

A while ago the idea was floated that we should have a seniority payment after 10 years of service in the health service. That would mean an award slightly lower than the C award but recognising long service. The service could redistribute the existing awards money to fund a long service award and on top of that you could have far fewer distinction awards for the truly outstanding consultant. The white paper is proposing a move towards managers having a much greater say in the selection of people for distinction awards, because the health authorities are actually paying the money.

I notice that the trust hospitals are going to pay for the awards for their consultants. That will affect some of their budget decisions. So long as awards are given for consultants' outstanding abilities and research and various national activities that they have performed I think it is quite wrong to require an individual hospital to foot the bill. At present, too, there is an element of equalisation—trying to achieve a reasonable proportion in all the specialties, but unfortunately not all specialties attract doctors with the same degree of merit. That is a fundamental flaw. Under the new system all proposals for awards will have to go through a general management scrutiny first and then there will be a professional decision. Reading between the lines, I think that is what the government wants. If, however, there is to be a real distinction award system for professional merit I don't think that the general manager should have an input into that. And looking back to my comments on the importance of consultants being able to criticise the service provided for their patients, if management has a filtering effect on distinction awards consultants are going to be less likely to speak out on the patients' behalf. But essentially I don't see how a manager could really comment on anything but a consultant's management abilities. If an awards committee wishes to give somebody a justifiable award for research or other professional work I fail to see how the manager can contribute to that judgment. So I come back to my view that we should have seniority payments, which of course managers could influence, with on top of those a few purely professional distinction awards.

Finally, who will pay for consultants attending committees in the new structure? At present if we are representing our colleagues we get payment through an agreement with the Department of Health. The same applies to attendance at royal college meetings or the General Medical Council. Our contracts allow us to do this because of their flexibility; we can make arrangements to see people at alternative times or delegate to juniors and pick up the bits when we come back. The white paper's proposals mean that regional activities of royal colleges will be enhanced and so require more of the profession's time. At present we have an informal knock for knock basis. From the personal point of view I've had difficulties attending some of the Department of Health's information advisory group activities and I've made it quite clear that unless a locum was funded I couldn't attend. And that was accepted.

I said at the start that contracts are a sensitive issue for consultants. If the government and health authorities impose closely monitored inflexible contracts the consequences may well be that consultants will look carefully at how much extra unrewarded work they do for the NHS not just in the wards and outpatients but also in the many advisory and representative committees to which they contribute. Any loss of consultant good will or sense of responsibility as a result of government changes would outweigh any supposed advantages of more tightly controlled contracts.