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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Challenging the victim narrative about NHS doctors

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In July, I posted some tweets arguing that doctors still have high professional status, public respect, secure and relatively well paid careers, and a great deal of hard power and soft influence. I said that doctors shouldn't describe themselves using the language of hapless, impotent victims of the state.

Plenty of doctors agreed with me, often those who had taken on difficult service leadership roles with all of the challenges those entail. And plenty disagreed vehemently.

Years of below-inflation pay rises, the mistreatment of whistleblowers and the inefficacy of mechanisms to protect them, and the government's indefensible, demoralising attitude to junior doctors during last year's contract stand-off were all cited as evidence of our disempowerment. They certainly contribute to doctors' sense of being less influential than we once were—or were expecting to be when we entered training.

If more doctors really are feeling this way it may damage recruitment, morale, and retention and reduce engagement in medical leadership and patient advocacy, with consequences for patient care.

In any case, none of these examples proves that the entire profession is powerless or has earned victim status. Feelings are running high and shouldn't be dismissed, but I'd challenge the hyperbole. Unlike some celebrated examples of very clinically led US organisations,[1-3] NHS doctors work in a tax funded, politically accountable system—a principle that most of us still strongly support. But this comes with consequences.

As a national public service the NHS is influenced by macroeconomics, government allocation, and trade-offs in the use of finite public resources, as well as pressure from a range of stakeholders well beyond medical professionals, not least from patients and the voting public. Doctors will never get everything we want or call every shot. It's the same for the military, police, fire service, prisons, and schools.

Pay? The whole public sector has taken an austerity hit. We do better than most and have relatively more security, guaranteed career progression, pension entitlements, and paid leave.

Public respect? Doctors and the wider NHS still repeatedly top polls about trust in professionals,[4 5] despite some horribly disrespectful attitudes we all sometimes encounter and some hostile media. Online reaction to recent television documentaries about doctors and hospitals has been incredibly supportive—often awed.[6 7]

Power? We control undergraduate and postgraduate curriculums and exams (yes, the General Medical Council and Health Education England have a statutory stake, but they employ senior medics too). We are the training supervisors and examiners.

We lead our own clinical teams and set the tone. We make the clinical decisions that determine how most non-pay NHS resources are spent.[8] We develop and lead the research, evidence base, guidelines, and quality standards for best practice. We lead clinical audit and quality improvement programmes to help implement it. Our specialist medical societies and colleges provide clinical, communications, and policy influence in their fields.

In every service some doctors double up as managers,[9] from departmental leaders right through to board level medical directors, and they foster the culture—good or bad. If doctors feel unfairly treated, bullied, or unsupported or don't like certain service changes and implications for their job, their line managers are generally fellow doctors.

Doctors at the BMA were influential at every turn in the contract stand-off, strike, and eventual imposition.[10] Tactical and communications decisions by BMA doctors were central to how events played out.

Of course, doctors have serious, legitimate concerns about the future of the NHS, as well as our own working lives and conditions. And we often disapprove of decisions made or imposed in our name.

This doesn't make us hapless victims. We have to be realistic about what we can achieve, but we must also use our considerable hard power, soft influence, and status to the best effect to preserve and improve patient care.

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