SUPPLEMENT

Examination of the Distinction Awards System

S. BOURNE, P. BRUGGEN

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Summary

When they stopped secrecy, the consultants of an internationally-famous postgraduate teaching centre in psychiatry—not a designated teaching hospital—discovered that they had one-tenth the national average of distinction awards. Subsequent investigation of the whole system suggests that this is not an isolated case. Moreover, official figures are scanty and misleading.

This paper explores the difficulties in understanding, investigating, and influencing the system. The composition of the committees involved, the de facto quota system, the method of collecting information, and the convention of secrecy are examined and criticized.

Introduction

Our consultant colleagues asked us to make recommendations on their behalf to the Advisory Committee on Distinction Awards. It is officially stated (in a letter from the Secretary to the Distinction Awards Committee, June 1972) that the case of every consultant is scrutinized and reassessed every year, irrespective of whether he makes a claim. It is also stated that each case is settled entirely on its merits—without influence of regional or specialty quotas. We question how far it is possible to rely on these statements in the light of our findings. Obviously we have personal and parochial interests and we hope that the gravity of our findings and their implications will not be obscured by the fact that we have had repeatedly to refer to our own "test case"—other facts being so hard to unearth.

Preliminary Survey

We could find very little written information about awards.

There are many ways in which people distinguish themselves, though the advisers must somehow determine those whom they consider to be the top 35%, 14%, 3.4%, and 0.9% of all consultants, which are the strata represented by each class of award. In 1972 in England and Wales 10 813 consultants shared 2258 C awards, 1053 B awards, 364 A awards, and 100 A-plus awards. The 1974 value of these, for full-time appointments, were: C £1506; B £3540; A £6030; and A-plus £7947. The general notion is that C awards might go to people of some local reputation, B awards to people of national reputation,

and the A awards to men of outstanding achievement and international standing. We realized how difficult it must be to devise practical criteria to measure the degree of unusualness (for this is the essence of distinction) in different hospitals, specialties, and age groups.

TWO DECEPTIVE FACTORS AND A POINTS SYSTEM

The most striking disparities emerged only when the higher awards were considered separately from the C awards, which are much more numerous and far more evenly distributed than the others. Moreover, "raw" figures for award holders tended to obscure the fact that B, A, and A-plus awards represented two, three, and four acts of recognition and reward. To clarify this we have used a points system in which a C award was represented by one point—that is, one point of recognition and reward—a B award represented by two points, an A award represented by three points, and an A-plus award by four points. (In fact, the cash value of higher awards is over twice, three times, and four times the cash value of the C awards and the rarity ratios are higher still).

TEACHING AND NON-TEACHING HOSPITALS

About 54% of teaching hospital consultants hold awards, compared with 25% in non-teaching hospitals. The real disparity is much greater, however, because C awards, to 19% of non-teaching hospital consultants and 24.4% of teaching hospital consultants, serve to mask the pattern for higher awards. Thus, B awards are held by 19% of teaching hospital consultants but by only 5% of non-teaching hospital consultants. A awards go to 8.2% of teaching hospital consultants but to only 0.9% of non-teaching hospital consultants. For A-plus awards alone the difference is 25 times.

If the points value of the awards are added up the teaching hospital consultants average 0.97 points each, three times the non-teaching consultants average of 0.33 points each. Furthermore, if the calculation is repeated with the exclusion of the C award points, the difference is five times, with teaching hospital consultants averaging 0.72 points each, and non-teaching hospital consultants averaging 0.14 points each.

DIFFERENT SPECIALTIES

General medicine and surgery fare well from awards and cardiology, neurosurgery, and thoracic surgery very well. The worst scores are in mental health, geriatrics, and anaesthetics. Because of our special concern with a psychiatric centre we have compared psychiatry with the overall average and with general medicine, general surgery, and thoracic surgery. General physicians score over twice as well as psychiatrists on the general total of awards. They score three to four times as well in the

The Tavistock Clinic, London NW3

S. BOURNE, M.B., M.R.C.PSYCH., Consultant Psychiatrist
P. BRUGGEN, M.B., M.R.C.PSYCH., Consultant Psychiatrist

higher awards, and chest surgeons score from four to nine times as well as psychiatrists (table I).

TABLE I—Distribution of Awards in Various Specialties (from D.H.S.S. Annual Report*, some specialties not shown).

Award	General Medical (n = 1130)		General Surgery (n = 1037)		Psychiatry (n = 1222)		Chest Surgery (n = 109)		All Consultants (n = 10 813)	
	%	No.	%	No.	%	No.	%	No.	%	No.
A-plus	2.3	26	1.3	13	0.6	7	5.5	6	0.9	100
A	5.7	64	5.1	53	1.9	23	15.6	17	3.4	364
B	15.5	175	15.8	164	5.1	62	22	24	9.7	1053
C	27.3	308	27.9	289	16.2	198	36.7	40	20.9	225
Total	50.7	573	50	519	23.7	290	79.8	87	34.9	3775

*Department of Health and Social Security, Annual Report 1972, D.H.S.S. London, H.M.S.O., 1973.

GEOGRAPHICAL DISTRIBUTION

There are noticeable variations from one region to another, but less than the variations between different specialties and between teaching and non-teaching consultants. In 1972 the regions with the lowest overall percentage of award holders were Leeds, Birmingham, Manchester, Sheffield, and Newcastle upon Tyne. If awards points are added up, the order changes slightly. The high scorers are London, Oxford, and East Anglia. The total awards ratio is 1:1.32, between the lowest and highest regions, and the awards points ratio is roughly 1:1.44. If the higher awards are considered separately—that is, excluding C awards—the Leeds region scores 24.2 points per 100 consultants and London scores 42.2 points per 100 consultants, so that the ratio then becomes 1:1.74. On A and A-plus awards London scores nearly three times as many points as Sheffield and well over twice as many as Leeds (table II).

TABLE II—Number of Award Holders in Each Region Expressed as a Percentage of the Total Number of Consultants in Each Region*

Award	Leeds (worst scorers) %	Wales (average scorers) %	Oxford (high scorers) %	All Metropolitan Regions (best scorers) %
A-plus	0.2	0.7	1.9	1.5
A	2.6	2.7	3.3	4.4
B	7.8	9.7	9.1	11.5
C	19.7	19.3	22.5	22.6
All awards	30.2	32.4	36.7	40.0

*Department of Health and Social Security, Annual Report 1972, D.H.S.S. London, H.M.S.O., 1973.

AGE

The age of a consultant when he receives an award is significant. It may, for example, be rarer for a C award to be gained at 34 than for an A-plus at 64. On the other hand, the age of a consultant is crucial in considering what sort of award he might deserve, for the system operates on a promotional basis. Consultants are appointed first to a C award, may later be promoted to B and A, and then to an A-plus. While 35% of all consultants hold awards at any one time, 60% of consultants will receive an award before retirement.¹ In general, the earlier a consultant gets his C award the more likely he is finally to reach a higher award. And C awards are allocated at all ages with an average of 50, while the average age for receipt of a B award is only two years older.¹

During the last three years no new A or A-plus awards were given to a consultant under the age of 45 and two-thirds of these new awards were allocated to men over 55. Only about 16% of the current A and A-plus awards are new so most of these higher awards belong to the older one-third of consultants. It is, therefore, misleading, in examining the distribution of A

and A-plus awards, to include those consultants under 45 who virtually never hold them. Whereas A and A-plus awards are received by about 1 in 23 of all consultants, the figure for men over 55 must be more like 1 in 8 or 10, rising still further as retirement age approaches. Moreover, in view of the differentials previously described, probably A or A-plus awards are held by a figure in the region of one in three teaching hospital consultants over 55, compared with something like 1 in 30 non-teaching hospital consultants of the same age.

The Task

TAVISTOCK CLINIC

The Tavistock Clinic is not only among the famous psychiatric institutions in the world and one of the principal national resources for postgraduate training and development in psychotherapy; it is also a leading centre in child, adolescent, and family psychiatry. Students at the clinic—over 1000 in 1973—regularly include a proportion of consultant psychiatrists. Some of the present staff are also consultants at designated teaching hospitals and a number are prime international authorities in their field.

The spirit and letter of the secrecy convention over awards had been observed at the clinic until 1972 when the consultants decided to end it. The lifting of the veil disclosed that, of the 19 eligible consultants, only one held an award—a C. This represented about one-tenth of the national distribution, or about one-eighteenth that for teaching hospital consultants. This low level suggested to us that an oversight had occurred, in view of the standing of the clinic as a whole, which could not be said seriously to be a centre of medical mediocrity.

It was at this point that the clinic's consultants' committee asked us to act as a distinction awards advisory subcommittee to study the question and to make recommendations.

PREPARATION

Following our preliminary researches we began to collect opinions and data. We obtained curricula vitae and soon realized that, even within a small group of familiar colleagues, it was possible to be startlingly unaware of precise activities and achievements.

The task was difficult. Our colleagues were reluctant to put themselves forward or to supply data. Nevertheless, there seemed to be two pre-eminent consultants, prime international authorities, both aged nearly 60. We thought they qualified for A awards according to every criterion. There were two others of international standing who were in their early 50s. We thought they should have been of B award level for some years and on the threshold of A awards. We also recommended C awards for six other consultants. If accepted, these recommendations would have placed the Tavistock Clinic "score" somewhere between the general average for all consultants and for teaching hospital consultants.

We sent our list to Sir Hector MacLennan and the Regional Advisory Committee. Sir Hector confirmed that it was possible, in the case of someone who had been neglected in the past, for a higher award to be granted immediately—though he implied that this would be extremely rare.

"REALISTIC" NUMBERS

In 1973 the chairman of the medical committee of our hospital group received a letter from the North West Metropolitan Regional Advisory Committee (a so-called "C award committee") inviting nominations for awards. It was stated that it would be realistic to put forward not more than one or two names for the entire group which, at that time, employed 85

consultants in all specialties. The Regional Advisory Committee itself had been asked to put forward 12 nominations for C awards for the North West Metropolitan Region, which had about 800 consultants.

In contrast, we learned subsequently⁴ that London undergraduate teaching hospitals had each been asked to submit five or six nominations for C awards, for an average of around 100 consultants (a range of about 85 to 130). Thus, the invitation to the teaching hospitals was on a scale three or four times as high as the invitation covering consultants outside the teaching hospitals. (The teaching hospitals were, of course, also invited to submit nominations for higher awards at the same time.)

NEW AWARDS 1973

When the 684 awards for the whole country for 1973 were announced our C award holder had been promoted to a B and three other consultants received C awards. Table III sets out the incidence of the new awards in some different professional groups.⁵ According to our "points rating" for 1973 the Tavistock Clinic now receives five points between its 19 eligible consultants—an average of 0.26 points each. This places these consultants at half the national average rating of 0.54 points for all consultants, and one quarter the rating of 0.99 points for teaching hospital consultants.

TABLE III—Incidence of New Awards 1973 (England and Wales)

	No. of Consultants	No. of new Awards	Average Incidence of New Awards
All consultants	11 282	592	1 in 19
Teaching hospital consultants	3744	280	1 in 13
Non-teaching hospital consultants	7538	312	1 in 24
General surgeons	1068	70	1 in 15
General physicians	1164	61	1 in 19
Psychiatrists	1303	47	1 in 27

Discussion

We have found the system not working as it should or, at worst, unworkable. We have found massive anomalies at one centre and these have been only partially corrected. We think that the Tavistock Clinic offers a crucial test case in regard to the hypothesis that teaching hospital consultants have special priority given to the recognition of their claims and that psychiatrists outside designated teaching hospitals are at a particular disadvantage compared with other privileged specialties. The Tavistock Clinic is a main national postgraduate teaching centre but, before the N.H.S. reorganization in 1974, it was not officially designated as a teaching hospital; it does not have an autonomous board of governors nor does it have its own distinction awards advisory committee consulted by the chairman of the central committee each year.

It is inescapable that positions in teaching hospitals do attract most competition and it is possible to recruit teaching hospital staff from some of the cleverest and most creative potential consultants. So, if the principles and ethos of a distinction awards system are accepted, it is reasonable to expect that teaching hospitals will get more of the awards. This must be the result if the distinction awards system operates in the way it is intended to operate.

It is probable that the higher scores in the metropolitan regions are explained by the concentration of medical schools in London. An apparent bias towards London consultants, as such, may simply be an expression of the success of teaching hospital consultants in gaining distinction awards.

Moreover, some specialties may attract more talented doctors. But we see no way of verifying that people in such diverse professions as surgery, radiology, haematology, and psychiatry

are, as a whole, more or less meritorious than one another. If the members of each specialty are ranked in order of merit within that specialty it may be extraordinarily difficult to justify vastly different cut-off points, whereby the top 80% of one group are declared to match only the top 20% of another. Sir Hector MacLennan himself has declared that there is some imbalance, which will take many years to correct.¹ Nevertheless, it is hard to see why this cannot be done quickly since there are nearly 700 awards to redistribute every year, and we have tried to discover the obstacles.

PERPETUATION OF EXISTING SYSTEM

There are certain features of the current process that contribute to error and its perpetuation.

Secrecy

The allocation of individual awards is kept secret, after agreements at the inception of the N.H.S. in 1948. But this leads to a pervasive secretive attitude that is inappropriate and has inhibited the sort of record keeping that might normally be expected in the annual disbursement of £10m. of taxpayers' money.⁶ A senior official at the D.H.S.S. said that much of the data did not exist in a readily accessible form.

There are no sanctions against award holders who disclose their awards, though some believe that their award could be withdrawn or that they would be barred from subsequent promotion. Of course, anybody using an award to advertise for patients would attract the attention of the General Medical Council, just as they would if they misused other distinctions—for example, titles, higher degrees, or other prestigious appointments.

Secrecy inevitably interferes with the process of nominations. Where nobody is supposed to know who has an award it must always be possible that the names most likely to be put forward for nomination will be of people already holding awards. This has the effect of reducing fresh nominations to the realistic figure. It is possible only to guess whether secrecy reduces envy and grievance or whether it increases it. A survey in 1973 showed that 67.4% of award holders favoured continuation of secrecy whereas only 29% of consultants without awards wanted it to continue.⁷ This is the ugliest statistic we discovered. The secrecy is supposed to protect those without awards rather than the reverse and, however it be interpreted, this finding reflects no credit on anybody.

Secrecy facilitates the perpetuation of serious anomalies.

Award Holders on Advisory Committees

A most dubious feature of the present system is the exclusive dependence on award holders for the committees. The present system means that elderly men continue to elect their own successors in perpetuity, and the repetition of existing patterns, right or wrong, is an inevitable consequence.

Representation of Specialties on Advisory Committees

The composition of the main Distinction Awards Advisory Committee at the D.H.S.S. stems from the Spens Report in 1948. The committee is appointed by the Secretary of State, and there is basic provision for a specified number of nominees from the Royal Colleges of Physicians and Surgeons in England and Scotland and from the Medical Research Council. Over the years it has been agreed to add various other nominees, as different organizations become important. There is now a representative from the Royal College of Psychiatrists and the Royal College of Pathologists. There is no representative from the Royal College of General Practitioners—who might, of all

People, be best placed to provide a balanced view of the value of different specialists.

The regional advisory committees are elected by Sir Hector from award holders nominated by the regional committees for hospital medical services. Their composition is not secret and is supposed to contain a balance of district and specialty interests. Their composition closely reflects that of Sir Hector's own committee (table IV) in general pattern, in that physicians, surgeons, and gynaecologists predominate out of all proportion to the number of people in those specialties.

We think this operates against psychiatrists. The staff of general hospitals have ample opportunity for forming shrewd estimates of one another's skills but in general other specialists have little more than an inkling of the comparative merits of psychiatrists.

TABLE IV—*Distinction Awards Advisory Committee 1973**

Specialty	No.	No. of Consultants in each specialty as a Percentage of the Total No. of Consultants %
Physicians	7	20†
Surgeons	4	20†
Anaesthetists	1	12
Psychiatrists	1	11
Pathologists	1	11
Radiologists	1	6
Obstetricians and Gynaecologists	3††	5
Paediatricians	1	3
Lay members	1	—

*Dental Subcommittee not included.

†These figures include all specialties within the rubric of general medicine (for example, cardiology, neurology, endocrinology, etc.) or surgery (for example, orthopaedics, chest surgery, E.N.T., etc.). General physicians, according to the D.H.S.S. Annual Reports, comprise 10% of all consultants and general surgeons comprise 9%.

††Including Chairman.

Scale of the Task

We do not believe the N.H.S. can afford the professional and secretarial resources that would be necessary to ensure that the aims of the system could be honourably fulfilled. We think the job is probably impossible even if more important work is sacrificed to do it.

Quota System and the Queue

Theoretically, there is no quota system since a uniform distribution of awards to regions and specialties might not necessarily reflect the distribution of talent and achievement. In reality, an uneven pattern of distribution from the past has crystallized; and our experience and discussions make it clear that the pattern is very hard to change.

The "realistic number" crops up again and again. It serves to prevent consultants from systematically reviewing the incidence of distinction within their own groups. Instead, there is the recurrent invitation to "put forward one or two names . . ." so that redistribution can only occur, if at all, on a minuscule scale. Nominations from non-teaching hospitals are minimized at source; nominations are invited from teaching hospitals on a scale that is three or four times as generous.

The charge of gross inequity is refuted by the fact that talent is indeed distributed unequally. But, on the other hand, if men of unusual talent and impressive achievement have no corresponding award, the answer is that they must wait their turn in the queue. Sir Hector MacLennan has said that his committee recognizes men who deserve awards but for whom no awards are currently available. This implies that there are men in the top 4% of merit for whom no A awards are available, men in

the top 14% of merit for whom no B awards are available, and men in the top 35% of merit for whom no C awards are available. Who then are the other consultants who do have the awards explicitly meant for precisely those strata of merit? If some consultants are to be paid more for their merit and if doctors agree to this, we are irretrievably involved in the task of deciding who are the top people, so far as price value is concerned.

We believe that the task of deciding may be impossible to perform in a true fashion. Men of indistinguishable merit will have to get different awards and the committee will either have to select them by lot, at that point, or rationalize a choice based on partially irrelevant and inappropriate considerations. We believe that the task of allocating different awards to men of equal claims must compromise the integrity of all who attempt it.

Ignorance

The expectations of people outside prestigious centres are too low. The statements made by Sir Hector MacLennan together with "raw" figures for distribution convey the erroneous impression that an A award is something akin to a Nobel Prize rather than the somewhat commonplace thing it is among well-placed physicians approaching retirement. Modest men are contented with their C awards and this tends to subdue claims they should be making. Many are reluctant to complete their D.H.S.S. forms or, having done so, to follow them up in subsequent years. It is likely that the staff of teaching hospitals, who have their own distinction awards advisory committees, directly consulted each year by Sir Hector, will have been better placed to understand how best to work the system. It is also probable that recommendations emanating from A award holders at teaching hospitals will be more closely heeded—another circular mechanism that perpetuates the imbalance in its present state.

Conclusion

It is stated officially that, in the assessment for distinction awards, every consultant's case is reviewed annually and that awards are made without regard to any regional or specialty quota: our study does not support these claims. The disparities between the different specialties and hospitals is excessive and gross anomalies are corrected only very slowly, even though there are over 600 awards to redistribute each year.

Publication of awards would disclose anomalies and dubious decisions. There are many other political and social aspects of the system and it has effects on staffing, ambition, achievement, equity, and envy, which are beyond the scope of this paper. The present system is unworkable and compromises the integrity of all who touch it: it ought to be abolished.

We are indebted to our consultant colleagues at the Tavistock Clinic for their consent to the disclosure of confidential information. Nevertheless the views expressed are entirely our own.

We are also grateful for the help we received from the officials at the Department of Health and Social Security who provided information and discussed difficult points most willingly.

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