The BMA's trade union structure—four years on

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Four years ago the BMA took a major initiative to strengthen its regional services when the Annual Representative Meeting in Cardiff decided to appoint industrial relations officers and place-of-work-accredited representatives.¹ This was a significant change of direction for the BMA at a time when the changing climate of industrial relations in the Health Service and the introduction of more complicated contracts were presenting doctors with problems that required expert and quickly available help. The IROs based in the regions provided the expert help; the POWARs were to be the "shop stewards" of the profession, a function that had previously not been a prominent part of the BMA's activities. The POWARs, backed up by IROs, would ensure that doctors could develop the same representation at the place of work as other staff working in the Health Service and resist their challenge to the profession's traditional leadership.

The ARM knew that its decision would be expensive—and it has cost money—but saw it as a cost-effective way of helping members and strengthening the membership. Since then the BMA's industrial relations structure has developed along the lines then envisaged, with 15 IROs in post and two further appointments to be made in the Oxford and East Anglian regions. Over 500 hospital doctors have been accredited as POWARs, and there are also POWARs among community health doctors, general practitioners, and medical academics. The BMA, through its network of POWARs, is represented on numerous local negotiating and consultative committees, and this representation has generally proved effective in putting across the medical viewpoint at an early stage in staff/management discussions. Obviously gaps still remain in the coverage of the POWARs, but these are gradually being filled. The POWARs sit alongside representatives of TUC-affiliated unions and non-affiliates like ourselves; many of these organisations have obtained recognition from local management only during the past decade.

New service to members

The decision to establish this industrial relations structure was a response to the increasing "industrialisation" of the Health Service. As a result of industrial relations legislation passed in 1974² the BMA had to register as an independent trade union to obtain the protection of the law when pursuing its tasks as a trade union, and our industrial relations officers and POWARs were in part modelled on the structure of other trade union organisations. Although these developments were important in themselves, their value has been enhanced because they have served as a base for extending the range of services the Association provides for its members.

Initially the IROs were seen rather narrowly as experts on industrial relations, dealing with issues which doctors were often facing for the first time and about which they were understandably uneasy or unfamiliar. Since then, however, their jobs have greatly expanded to cover a wide range of duties extending well beyond industrial relations. Indeed, we have recently estimated that the proportion of their day-to-day activities that is strictly industrial relations, as for example attending a local joint negotiating committee, is little more than 25%. Perhaps the

title "industrial relations officer" is now a misnomer. Most of their time is now spent assisting and advising members on a wide and disparate range of problems—for example, on junior doctors' out-of-hours payments and on the arrangements for private practice within the NHS.

The new regional services have enabled a personal service to be offered at a local level, replacing the previous somewhat "impersonal" advice given by telephone or letter usually from the BMA's London-based headquarters or one of its national headquarters. For a newcomer to the BMA like myself it was surprising but understandable that the Association has only recently invested in this local service to help the individual doctor. One reason was the centralised Health Service of the past—without an active trade union presence or local industrial relations problems—and another was the nationally negotiated, open-ended contracts which left little room or need for local initiative. Introducing IROs into the BMA's traditional structure was helped by the existing network of regional offices, some of which were already moving towards providing this personalised service to members. But it was the notable successes of the West Midlands regional office in Birmingham, which aggressively "sold" its personal services to members in the region, that provided a model for a similar nationwide service.

GPs the biggest users

The BMA's regional offices are dealing with over 30 000 inquiries a year, and it is surprising to find that a majority of these come from general practitioners. When the industrial relations service was first mooted many GPs were naturally sceptical of the proposal, believing that it would mostly serve the employed doctors, in the hospital service, universities, and community medicine. In their view as self-employed contractors they had little to gain from the BMA's newly acquired skills in such work. But because of the calibre of staff we have been able to recruit the IROs have been comprehensively trained and have broadened their skill to cover many other matters. They are now advising and assisting GPs on such matters as the law governing the employment of ancillary staff, contracts for part-time appointments in hospitals and industry, superannuation and taxation, the rent and rates reimbursement scheme, health centre charges, private practice fees and other items of service payments, partnership agreements, study leave, representation at service hearings, NHS reorganisation and its impact on general practice, and even how to handle the insolvency of a practice.

In the hospital service we have seen a similar expansion in the IROs' work. They are advising hospital doctors on their contracts—for example, on the options available to consultants and on the UMTs of juniors—starting salaries, removal and travelling expenses, private practice and various payments for items of service, allocation of beds and hospital closures, superannuation and taxation, mess facilities and accommodation standards of junior doctors, career problems and study leave, and the handling of grievances and disputes with health authorities.

In community medicine an equally varied range of problems are being handled. In particular, BMA members in this craft are being assisted by the IROs in the difficult and often personally traumatic circumstances caused by the recent reorganisation of the Health Service. At regional and local level the IROs have closely monitored the progress of reorganisation and have ensured that members' interests are protected.

Other crafts have not been neglected. The IROs are helping with the problems arising from the cuts in university funding and are advising medical academic staff on redundancy matters.

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Many doctors have also been helped in occupational medicine, where the economic recession has had an immediate impact on the employment of doctors.

Substantial increase in BMA membership

Since the 1978 ARM BMA membership among doctors working in the UK has risen substantially from 42 336 to 50 277, an increase of over 20%. This impressive rise has occurred during a period when the full subscription rate has increased from £40 to £100. There can be no doubt that the work of the regional services has contributed to this growth. Indeed, the demand for assistance and advice is so great that the BMA recently decided that assistance could no longer be provided to a member on a personal problem that predated his or her membership, a common rule in most trade unions but one which the BMA, in line with its previously rather generous approach to non-member doctors, did not embrace.

The IROs have undoubtedly uncovered a latent demand from doctors for a wide range of services. Their presence is becoming widely known among the profession, and knowledge of their successes and the value of their advice generates a seemingly endless flow of work. Indeed, the stage could be reached where limits may have to be imposed on their work and additional services developed to supplement their advice and assistance. For example, the IROs sometimes assist in preparing partnership deeds or practice accounts. This time-consuming work needs its own specialists.

There are many outstanding success stories. The BMA has obtained four- or even five-figure settlements for doctors whose contracts have been breached or terminated improperly. But it is a continual (and increasing) flow of less spectacular cases that provides the bulk of the work of the regional services. Before this service was developed it was widely believed that because doctors were highly educated professional people they were quite capable of looking after their own affairs and did not need this kind of assistance. Unfortunately, because of changes beyond the control or influence of the profession this assumption is no longer valid. The context in which doctors practise medicine has become increasingly complex. The growth of employment law, the "industrialisation" of the Health Service, the emergence of cash limits and the constraints on resources, the introduction of work-sensitive contracts, and the increasing complexity of doctors' terms of service are all factors that have made it more difficult for the individual doctor to handle his own problems in any dispute with a health authority. The principles of the reorganised NHS—flexibility, devolution, and local budgetary control—are bound to lead to even more local variations in the terms of service of the medical profession.

Costs

As I said earlier, the regional services are not cheap to run. Apart from the overheads of office accommodation and regional office staff, each IRO has to travel extensively throughout the region. In part, the additional cost of running this new service has been met by a gradual shift in resources from headquarters to the regions—a policy in line with the following resolution of last year's ARM: "That with the value of the regional structure proven, more resources be directed to the periphery if necessary at the expense of central office." Because more and more queries and problems are being handled by the regional offices it has been possible to reduce staffing levels at BMA House and to redeploy staff on other work.

A cost-benefit analysis of the services would have to take account of the significant growth of membership referred to above, reversing a downward trend that, had it been allowed to continue, would have left us with a membership of some 40% below the present level. The additional subscription income gained also helps to cover the costs of the service. Had the BMA declined this trade union role it would have left the door open for other organisations with little or no experience of the medical profession to fill the vacuum by seeking to represent doctors in NHS negotiating and consultative machinery. Thus representation of the profession would have been divided between a professional body and several competing non-medical trade unions, an arrangement that has been demonstrably unsatisfactory in other countries and in other professions.

A nagging doubt remains among some long-standing BMA members about the wisdom of the BMA's decision to acquire trade union status. They question whether this is compatible with the Association's standing as a professional body and their obligations as members of the medical profession. In their view the term "trade union" is understandably associated with an imagery of the closed shop, picketing, and industrial action. In practice, remarkably few problems have arisen in accommodating this new and untried dimension with the Association's other professional activities.

Association's character not changed

The Association's character as a professional body has not changed. The fears mentioned in the Clark Working Party Report³—that its newly acquired trade union status could harm the profession by impairing the reputation and credibility of doctors as a profession—have not been realised. Indeed, the BMA has evolved for its own purposes a style of trade unionism that meets doctors' needs, takes account of their professional and ethical standards, and is quite distinct from the "industrial unionism" that most doctors have firmly shunned. In short, the development of our trade union activities has not drawn us into the mould of "industrial unionism."

The development of the BMA's regional services has come at an opportune time. Health Service reorganisation has led to the formation of 193 independent health districts in England, each with considerable local autonomy. Similar devolved structures are being introduced in Scotland, Wales, and Northern Ireland. Against a background of stringent cash limits and the curtailment of the real growth to which the Health Service has been accustomed since 1948 there will be increasing competition at the local level for a share of the limited resources between occupations within the Service. The medical profession will need to be vigilant and organised to ensure that these local decisions do not simply maintain employment levels in the Service at the expense of patient care. So that local BMA representatives can be effective in monitoring and influencing local decisions on these crucial matters they will, I believe, be looking increasingly to the regional services staff for advice and assistance. The BMA's devolution, introduced ahead of the decision to devolve the Health Service, has proved a wise policy.

References

- 1 Anonymous. Functions and priorities of the association. *Br Med J* 1978;ii:301-2.
- 2 *Trade Union and Labour Relations Act 1974*. London: HMSO, 1974.
- 3 British Medical Association. Report of the working party on the functions and priorities of the association. *Br Med J* 1978;i:1001-3.