SUPPLEMENT

Two views on medical unionism

The BMA as a trade union

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The development of the BMA's union role has stimulated both controversy and curiosity. For some, its decision to obtain a certificate of independence as a trade union is regarded as incompatible with its status as a professional body. But for others there has never been any doubt that the BMA has always undertaken the functions of a union, albeit in association with other professional activities.

In this debate about whether the BMA should or should not be a trade union, the term "trade union" itself has had an emotive significance, conjuring up an imagery of the closed shop, picketing, and industrial action. It is sometimes assumed that these are necessarily integral features of any organisation which has the legal status of a trade union. In practice only a few trade unions (and a minority of union members) are ever associated with these aspects of industrial relations. Indeed, if the term "trade union" is to be of any use at all it must be given greater precision and separated from these particular phenomena.

Since its formation in 1832 the BMA has continually sought to promote the corporate interests of its members. So it can be properly described as having untaken the functions of a trade union though the Association has had other functions besides these, notably those of a professional and scientific body. The BMA has continued ever since to negotiate collectively with those bodies which have funded medical care, whether publicly or privately sponsored—that is, the State or the insurance agencies. Indeed such union functions started as far back as the 1830s, when the Provincial Medical and Surgical Association (as the BMA was then called) acted to raise the remuneration and standing of poor law medical officers. Furthermore, these functions have been undertaken on behalf of both those doctors whose status is that of an independent contractor—for example, general practitioners—and those who are employees—for example, in the hospital service and other disciplines.

So, if the BMA has always undertaken union-type functions it may well be asked why so much significance is now being attached to the development of this side of the Association's activities. To answer this we need to consider several factors which have recently emerged and combined to give a new perspective and prominence to the trade union role. These same factors have also made it more difficult (if not impossible) to sustain the traditional view of the BMA's activities as being wholly professional.

While the BMA was able to persuade others (and the profession) that its active defence of members' corporate interests was no more than an extension of its professional functions, there was no pressing need to adopt the legal status of a trade union. Until 1975 the BMA retained a restrictive clause in its Articles which specifically prevented the Association from pursuing trade union objectives. Whenever the BMA found itself in dispute with Government over the pay and conditions of service of members, any possible constitutional and legal difficulties were avoided by adopting the guise of the British Medical Guild, which was established in 1949 for the purpose of taking union-type action. The guild was a phantom body formed for the purpose of raising and administering funds (drawn from the defence funds of the craft committees) to support a threat of withdrawal from the NHS. As recently as 1970, after the resignation of the Kindersley Review Body, the BMA used this technique to avoid its status as a limited liability company being put at risk by trade union action.

Industrial relations legislation

This advantageous arrangement was able to continue unhindered until 1971 when the Industrial Relations Act was implemented. However, in order to strengthen the legal control over trade union affairs, this Act made it unlawful for any organisation to act as a trade union unless it was properly registered as such. The BMA persuaded the Government to set up a special register to deal with the difficulties which it and other professional bodies would have experienced in registering as trade unions. But this Act had so fundamentally altered industrial relations law, by seeking to codify in legal terms the status of trade unions and their actions, that it removed for ever any possibility of reverting to the convenient and relatively uncomplicated arrangements formerly available to the BMA.

In 1974 the Industrial Relations Act was repealed and replaced by the Trade Union and Labour Relations Act. The special register for professional organisations was abolished, and the BMA was by definition a trade union. (A trade union is defined in the Act as an "organisation consisting wholly or mainly of workers whose principal purposes include the regulation of relations between workers and employers and employers' associations.") The BMA was obliged to register as an independent trade union if it were to be protected by law in any action it might take as a trade union, and also to obtain certain benefits accorded to trade unions under recent legislation.

Alongside these legal developments there are other factors which have added impetus to the expansion of the BMA's trade union role and peripheral structure. The acquisition of this new status had a catalytic effect by initiating a reappraisal of the Association's structure and services to the member. Moreover, once the psychological hurdle of the BMA registering as a union had been overcome there seemed to be no reason why the Association should not take full advantage of the benefits that were now available to it. Hence the introduction of the place of work accredited representative (POWAR) scheme and the positive decision that representatives should participate in the range of industrial relations machinery being established in the NHS.

But it is perhaps those factors that are beyond the BMA's

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control which have had the major influence upon the development of its peripheral structure. There has been a fundamental change in the industrial relations climate of the NHS. This reflects a growth in trade union membership over the last decade from around 25% to an estimated level today of over 80%. During that time the number of accredited work place representatives—or shop stewards, in the terminology of other unions—has risen from no more than a handful to an estimated 150 to 200 in each health district. This growth in trade union organisation has led NHS administrators to look for ways of formalising industrial relationships by introducing codified procedures and new machinery for processing disputes and grievances instead of the previously informal, ad hoc arrangements. So health authorities are developing new procedures for consultation and negotiation at a local level (district, area, and region), new disciplinary and grievance procedures, and are also establishing other joint bodies—for example, safety committees. Because these developments have been mostly undertaken without any effective formal guidelines being laid down at national level we are faced with a plethora of different procedures and approaches to industrial relations. Indeed, viewed from the centre each area and region seems to have adopted its own distinctive industrial relations policy. It was surely never intended that each health authority in the NHS should be free to develop a wholly independent and separate approach on a wide range of personnel matters, including discipline and grievance procedures, safety committees, the provision of facilities for trade union representatives, and consultative and negotiating arrangements at a local level. These developments in the NHS, in particular the devolution of personnel policies to the local level, have led if not propelled the BMA to develop its peripheral structure. Only if the BMA is equipped in the regions with industrial relations expertise can it hope to handle the issues and problems that affect members at the local level. It is simply not practicable to expect to be able to deal with these from the centre.

Need for peripheral structure

There are other factors which have added further impetus to the idea of the peripheral structure. Firstly, there has been the introduction of the work-sensitive contract for junior hospital doctors, followed by the proposal that an analogous contract should be introduced for the career grades. Because the detail of the contract is negotiated locally and the BMA member may well require advice and assistance from the Association if any unforeseen difficulties should arise, there is further justification for the peripheral structure since this will enable information to be disseminated through the POWAR scheme.

The second factor concerns the very substantial growth in employment legislation during recent years. Some 10 new parliamentary Acts have been introduced during the last decade and these have defined and protected new rights for the individual employee, established new legal rules for the conduct of industrial relations, and set new codes of practice governing the conduct of employers and trade unions in certain specific areas—for example, the provision of training, health and safety at the work place, and disciplinary and grievance procedures. This new legislation has two particular features which have led organisations like the BMA to strengthen their peripheral structure. Firstly, the new individual rights are concentrated at the place of work, and BMA members, whether employees or employers, need expert advice and assistance on their rights and obligations. If this is to be readily available to any member with a problem, the BMA is able to ensure that his interests are as well protected as those of any other group working in the Health Service. Secondly, all this new legislation is liable to raise even greater difficulties for the employer than for the employee, since the obligations are very largely his, whereas the rights are mostly enjoyed by the employee. Because the general practitioner is usually an employer on only a very small scale, he cannot be expected to monitor closely the various implications of this employment legislation. This is why the BMA peripheral structure and its POWAR scheme for general practice will be providing an advisory service to BMA members on these matters.

There is another point about the legislation I would like to make. Some of those who regret much of this new law wrongly believe that it is largely an artefact of successive Labour administrations and that much of it will simply fade away under a Conservative Government. If it is possible to allot blame as between Conservative and Labour administrations, then the former probably carry a larger share if only because the Tory industrial relations policy in recent years has been heavily influenced by a conviction that reform required a greater use of the law in these matters. This point is well illustrated by an enactment which has already had far reaching implications for the Health Service: the 1974 Health and Safety at Work Act. This Act was largely drafted by a Conservative administration but enacted by the subsequent Labour administration within its first months of office and, moreover, contains the most "pro-union" clause of any general employment legislation so far introduced in this country. It is the only law which has imposed on the employer a statutory obligation to consult with trade union representatives.

All these changes, whether rooted in legislation, in health services industrial relations, or in the doctors' contracts of service, have encouraged the BMA to increase its range of personal services to the member. The simultaneous development of the trade union role and the peripheral structure will enable the Association to represent fully the interests of doctors on industrial relations matters at the local level in the NHS.

In these changing circumstances the profession cannot afford to allow itself to be unrepresented on these matters. In the past, when industrial relations issues seemed less troublesome and less urgent—and before reorganisation of the NHS reduced the influence of the caring professions in its management—it was wholly defensible for the BMA to adopt an essentially abstentionist and agnostic approach towards many industrial relations matters. But the changes that have now occurred require the Association to adopt a much more interventionist and positive approach, if only to ensure that the medical profession retains its independence and freedom from lay control.

Traditionally, the profession has always sought to maintain its independence from lay control, and in particular has firmly resisted any attempt by its "paymasters" (whether administrators, insurance companies, benevolent trusts, or politicians) to direct the conduct of medical practice. Professional self-government is regarded as an essential prerequisite upon which to build the doctor-patient relationship. While its independence remains vulnerable to the encroaching influence of these external interests and parties, the profession is now also threatened by the increased power and influence of other occupations within the NHS which find expression in the growth in trade union membership and organisation. Unless doctors are prepared to participate in this emerging industrial relations machinery, alongside other NHS employees, they are liable to find that it will present a further threat to their professional independence.

The 1978 ARM carried a resolution supporting the appointment of POWARs and industrial relations officers. Nearly 400 POWARs have been accredited in the hospital service and schemes are being devised for the appointment of POWARs in other disciplines. The BMA is not alone in having to develop a new representative system based on the place of work to complement an existing constitution based on place of residence. The various developments discussed here have affected other organisations just as much as the BMA and they have responded in a similar fashion.

The experience of these other organisations has shown that it can take several years to establish fully a peripheral structure based on a system of work place representatives. There is no reason to assume that the task facing the BMA will prove any simpler.