Doctors in uniform

“Apart from £459 a year what can the Army offer medical students?” Certainly not the opportunities and remuneration of Ex-Empire, and the emphasis in recruitment advertisements these days is on professional training and a good career in medicine. The Forces recognise that they will not attract officers on short-service commissions or persuade some of them to stay on as regular officers unless they offer training and work that is at least as good as that in the NHS. Nevertheless, the financial inducement of the cadet scheme helps, and medical officers are attracted to the armed services by much the same aspects as other officers—mist, social life, adventure, and service traditions.

The Forces have not always been able to boast of their professional opportunities. Throughout most of the nineteenth century Army and Navy doctors earned little pay, had unceasing duties within their regiments, and had few facilities for treating their patients. In the Crimean war the BMA and BMJ campaigned against the inadequate treatment given to soldiers and sailors because of the lack of equipment, facilities, and authority accorded to Army and Navy doctors. Even though the shortcomings of the medical services were widely acknowledged afterwards, not until 1898 and the formation of the Royal Army Medical Corps did the organisation of military medical services become properly established. Since then the BMA has maintained its interest in the medical services of the three Forces, resisting several suggestions to amalgamate them, and taking a keen interest in recruitment and its incentives.

Recruitment is a perennial problem in each of the Forces and has been particularly difficult since 1948, when the establishment of the NHS removed one advantage that a Forces career had previously had over most civilian practice—that of pay, promotion, and secure employment. The NHS gave this without the disruptions of service life.

Two problems have underlain the long-standing recruitment difficulties—pay and professional prospects. Pay remains a recurrent grouse, but the services have recently put greater efforts into improving their professional training and opportunities. Although medical officers all have to undergo some general postings, the services claim to offer postgraduate training comparable with that in the NHS, with posts approved by the royal colleges. Indeed, they pride themselves on their general practice training schemes, which offer 18 months in hospital jobs and 18 months in general practice and which they can offer to doctors on short-service commissions. A doctor joining the services for five years may thus leave with a highly marketable qualification.

The medical services of the Army, Navy, and Air Force aim at maintaining the health of servicemen and coping with the medical problems of their respective organisations that are either preparing for or engaging in combat—often highly technical forms of combat. Thus Forces doctors provide general and specialist services similar to those in the NHS, with a bias towards preventive medicine, and concentrate on the medical aspects of work peculiar to each Force. The expertise of service doctors in some of these specialist subjects is such that civilians also rely on it—for example, civilian divers use the Royal Navy’s decompression chambers and benefit from its research into deep sea diving.

Scope of medicine

Servicemen and women are essentially fit, but the scope of medicine is broadened by the emphasis on surveillance and prevention and by the need to look after servicemen’s families. The Navy does not look after families, except overseas, but the general practice component of vocational training is done in civilian practices that serve the naval families clustering around major bases such as Portsmouth. General practitioners in the Forces also tend to do more than just general practice. A regimental, RAF station, or ship’s medical officer is also an adviser to the commander on the health of his men and will look after occupational health and safety at work provisions as well as providing primary care.

All three services provide specialist services in their own hospitals. The pace of work differs from that in NHS hospitals because servicemen cannot be discharged until they are fit to return to their units. Nevertheless, most service hospitals also treat NHS patients and some provide the accident and emergency service for a health district. For the smaller specialties that the services cannot offer themselves they refer patients to NHS units or call on their panels of consultant advisers.

The particular activities of each service have also produced medical specialties. The RAF has pioneered work in aviation medicine, aeromedical evacuation, and mobile dialysis, while the Navy’s environmental specialties are concerned with the health of men who spend long periods in artificial atmospheres on the surface or under water. Practice and research in occupational medicine is also important in the Navy because of the many civilians working in the royal dockyards.

Whatever their specialty, medical officers are supported by the normal range of ancillary staff—both civilians and servicemen and women. All three services also train ordinary soldiers, airmen, and seamen to provide basic first aid and emergency care and assist medical officers on ships, submarines, and field ambulance units. On some ships a medical technician may provide all medical care.

Recruitment

The basis of recruitment in each service is the medical cadet scheme, introduced after the end of National Service with the active support of the BMA. Students are recruited once they have passed their 2nd MB, and in return for a generous grant (which reaches £450 in the third year) they promise to spend five years as a medical officer once they have fully registered.

To become an eight-five-year short-service commission a newly registered doctor could expect to undergo some postgraduate education and if he chose general practice vocational training generally complete it. A doctor who wanted to start specialty training could do so only if his service had room for him in its specialty, and within a five-year commission he could usually expect to do the general professional component of his training. Though progression through training is similar to that in the NHS, a medical officer’s first year or so—up to 21 years in the Navy—will be spent doing a variety of general medical jobs throughout the service. The Forces rely heavily on the general skills of their doctors, who might be isolated in a ship or the middle of a jungle, and are expected to strengthen these skills by a short initial period of officer training and courses in subjects such as tropical medicine, surgery, and avigation medicine.

Despite the useful work that each of the services gets from its ex-cadets and others on five-year commissions the existence of these commissions makes manpower planning difficult. The effort that goes into postgraduate training for short-service officers also represents an investment for which the service may see little return or at best an uncertain one, since many of these doctors will not go on to regular commissions. Many of those who do their vocational training in the Army, Navy, or Air Force leave to enter civilian practice (some come back), but the requirements of the training scheme have reduced the officer’s flexibility. A regimental medical officer undergoing vocational training may no longer accompany his regiment to different parts of the world, as has been the tradition, but will instead stay in his practice and look after the next regiment that moves in.

If a doctor wants to start training for a specialty he can do so only if there is likely to be a place for them as consultants. If a doctor later decides not to transfer to a regular commission the service is left with a gap in that specialty. To become a doctor on permanent commissions (and the Army and Navy most doctors who change to permanent commissions are specialists) then they complete their specialist training, in many cases being seconded to NHS hospitals or to another of service to do so. A few then concentrate on research in one of the various research institutes run by the services. Whatever the career option, however, any medical officer may have to fill a general duties post if necessary and he will have to keep his generalist skills sharp. This is especially so
when there is a shortage of medical officers.

Regular general duties officers can usually study for further qualifications in the occupational medicine of their force. In the RAF, for example, a regular general duties medical officer who passed the diploma in aviation medicine may go on to do a basic flying course, to give him a further insight into the problems that airmen have. Indeed, all RAF medical officers are encouraged to fly (either as pilots or as passengers). Some Royal Navy and RAF doctors may undergo full flying training and join a squadron as pilots for a time before reverting to their medical duties. More conventionally, general duties officers become general practice trainers. The Army has just recognised general practice as a major specialty by appointing a director of general practice to join those of medicine, surgery, psychiatry, and pathology.

In the Army officers who specialise in army community medicine and occupational medicine provide the bulk of medical administrators. Though some may initially concentrate on preventive and occupational health, all do administrative jobs from the rank of lieutenant-colonel. The other two services do not have a separate administrative stream, and doctors may be posted from their clinical work to do an administrative job for a while, especially in the higher ranks. RAF administration is done by higher-ranking general duties officers.

**Promotion and prospects**

Once, specialists had poorer promotion prospects than doctors who switched to administration. Now they can rise in rank as high as any other medical officers while still practising their specialties. Indeed, in the Army and RAF regular officers who are specialists are invariably promoted to colonel and group-captain respectively, while specialists are promoted to those ranks by selection. A doctor who enters after registration may get up to 7 years’ advancement in pay and promotion, depending on his experience.

Medical officers on short-service commissions may reach the rank of major (surgeon lieutenant-commander, squadron leader) if they extend their service to the maximum of 8 years. They will not have earned any pension rights but will receive a tax-free gratuity. A 16-year commission is the minimum eligible for a pension. Since pensions, or retired pay, as the services prefer to call it, are paid immediately on leaving the service, a doctor who joined as a cadet and transferred to a 16-year commission could leave the service in his late 30s, take a job in the NHS, and boost his salary with his retired pay. An officer who stays on until retirement age (which varies from 55 to 65 depending on service and rank) will receive a full pension. The pension is non-contributory, though pay scales are adjusted to take account of it, and is based on the pay of a combatant officer of the same rank and length of service—a matter of contention between the BMA Armed Forces Committee and the Ministry of Defence. Indeed, most aspects of the pay of armed Forces doctors and its relation to NHS pay have long been a contentious topic. Pay has many times been blamed for the unattractiveness of a service career and consequent shortage of recruits.

Since 1962 the pay of medical officers has been based on the average income of general practitioners (after expenses) in the NHS. This comparison and initial lead of 15% over GPs’ remuneration was worked out with the BMA after the end of National Service as a means of overcoming the severe shortage of doctors in the Forces, but the system came unstuck in 1966. Then NHS GPs got a large increase as a result of their charter, and Forces doctors got caught in an incomes freeze. In 1970 the National Board for Prices and Income re-assessed the appropriate analogue and conducted a survey to compare the work done in the Forces with that in the NHS. It found that despite differences in the organisation and content of the work the load and type of work were similar enough to warrant a pay comparison between the Forces and the NHS, and the GPs’ pattern of salary fitted in better with military gradings. It therefore restored the comparison with GPs’ pay but not the lead over it that Forces doctors once had. The comparison is designed to ensure that over a 32-year career from captain to colonel a medical officer will earn much the same as the average GP over that period.

Since then the Review Body on Armed Forces pay has ensured that increases in medical officers’ salaries follow those awarded to GPs by the Doctors’ and Dentists’ Review Body and has also added additional pay. The BMA’s Armed Forces Committee (which includes representatives of the directors of medical services) argues that the analogue is not entirely satisfactory because some earn as much as those in the NHS. It wants the incentive to be greatest for those staying on after five years. In practice this has had the effect of giving doctors on the first point of the major’s scale (most of them officers on regular commissions) an increase of about half that of all other scales and has penalised territorial officers, most of whom are majors on the first point.

**Doctors first and servicemen second?**

Future recruitment, especially of cadets, will have to take account of the increasing numbers of women medical students, and, indeed, the Forces are trying to recruit more women medical officers. Each service has a handful at present, who do broadly the same work as men. The main exception is the Navy, which does not (yet) allow its servicewomen to go to sea. The nearest a female naval medical officer gets to sea service is day trips on ships whose crews are doing their sea training at Portland, to supervise the medical aspects.

All medical officers, men and women alike, have to wear at least two hats—that of a doctor and that of an officer in an armed service. The modifications that this may require of normally accepted ethical principles—for example, over confidentiality—are well known. Nevertheless, potential conflicts remain. Even when pay and professional prospects are good, and despite the traditional attractions of service life, the Forces will always have to work hard recruiting doctors.