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THE NATIONAL HEALTH SERVICE CONSULTANTS' DISTINCTION AWARD SCHEME - HISTORY AND PERSONAL CRITIQUE*

I. J. T Davies, North of Scotland Institute of Postgraduate Medical Education, Raigmore Hospital, Inverness

The starting point for review of the Distinction Award Scheme is the *Spens Report* which was presented in May 1948. This report was heavily biased by the opinions of Lord Moran and by the Minister of Health, Aneurin Bevan, who knew it was important to attempt to divide the medical profession at this crucial time. He needed to persuade the most influential group of specialists in the country to accept the National Health Service. He and Lord Moran, one evening, in Prunier's Restaurant, St James Street, London, devised the system of rewarding the most senior and influential members of the profession.†,[2] Moran knew, in the case of the Royal College of Physicians of London, that this would allow him to espouse the introduction of the National Health Service, which would effectively split the Royal Colleges from the British Medical Association (BMA) which, as a result of a series of tortured plebiscites and agonising meetings, was opposed to the introduction of the Health Service. In this Moran and Bevan were spectacularly successful.

The *Spens Report*,[3] even after 50 years, is still cited as significant justification for the continuation of the Awards System which, despite modifications and tinkering, remained essentially unchanged apart from the publication of the names of 'award holders' in 1997 until the recent Government proposals.[4]

Moran was strongly committed to the principles of the 1942 *Beveridge Report* which had cross-party support and was the original blueprint for the Health Service. Bevan's major contribution was to extend the principles of the *Beveridge Report* and by charm, force of personality, tenacity and political acumen to circumvent practical objections (especially those of the medical profession). Bevan was not the originator of the National Health Service but he developed the *Beveridge Report* by incorporating nationalisation of the hospitals into the new National Health Service.

'What we are doing is now being watched by the whole world,' said Bevan to a meeting of the Executive Councils Association at BMA House in October 1948. 'This is the biggest single experiment in social service that the world has ever undertaken.'

> Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical care can provide.[5]

As far as Bevan was concerned the ends justified the means. 'Ultimately,' said Bevan, 'I had to stuff their mouths with gold.' (A remark first made over dinner at the House of Commons to celebrate the Guillebaud report[6] which exonerated Bevan of the charge of extravagance.)

* This paper is based on submissions to the Health Departments and National Audit Office in March 1998 and on a personal response to the Consultation Paper[1] on the proposal to establish a Scottish Advisory Committee on Distinction Awards.

†Brian Abel-Smith further confirmed this to me in a written note before he died.

Moran, was in his early sixties in 1948; he had been President of the Royal College of Physicians of London since 1941 and, as is well known, was Winston Churchill's doctor. Moran was in some financial difficulty; he was careless with money and had no paid employment. He badly needed to find a source of remuneration other than his tiny and sporadic private practice. He had been canvassed for the Regius Chair of Medicine in Cambridge but this eluded him. Moran knew that if the Distinction Award System was established his friendship with Bevan would ensure that he would be selected to be the Chairman of the first Advisory Committee on Distinction Awards (which indeed he eventually became and which he persuaded Bevan to remunerate generously at the level of an 'A' Merit Award).

An additional factor was Moran's need to demonstrate to the Fellows of the Royal College of Physicians of London, his own pivotal role and that of the College in influencing government opinion. The annual elections for President of the Royal College of Physicians were, for several years, contested by Moran (who was in favour of the National Health Service) and by the much respected Lord Horder (who was opposed to the Health Service). Moran desperately needed to be able to pull 'a rabbit out of the hat' and this he did successfully by his domination of the Spens Committee which recommended Distinction Awards for senior members of the profession.

Moran was re-elected President of the Royal College of Physicians at the second ballot by a margin of only six votes (165 to 171) on 22 March 1948 having released previously to the College Fellows details of the Awards System. The *Spens Report* itself was published in May 1948 and in October 1948 Aneurin Bevan appointed Lord Moran to be the first Chairman of the Advisory Committee on Distinction Awards. Moran further stamped his forceful character upon the awards process during his ten years as Chairman.[7]

THE *SPENS REPORT*[3]

'Terms of Reference' of this report were the following:

> To consider, after obtaining whatever information and evidence we thought fit, what ought to be the range of total professional remuneration of registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital and specialist service; to consider this with due regard to what have been the financial expectations of consultant and specialist practice in the past, to the financial expectations in other branches of medical practice, to the necessary postgraduate training and qualifications required and to the desirability of maintaining the proper social and economic status of specialist practice and its power to attract a suitable type of recruit, having regard to other forms of medical practice; and to make recommendations.

These 'Terms of Reference', in effect, asked 'What remuneration and methods of remuneration would be needed to persuade reluctant consultants and specialists to work in the proposed nationalised hospitals?' The Report contains statistical evidence of the remuneration of consultants in many different specialties and the 'Terms of Reference' implied that the differential between different specialist branches of the profession should be maintained. This indeed is what happened and was exacerbated by Moran's known distaste for Psychiatry and Anaesthetics and, to a lesser extent, for the laboratory specialties. Bias continues in the system 50 years after its introduction. The Spens Committee took evidence only from one Royal College - the Royal College of Physicians of London!

Progressing through the report, page 4 states:

> We were instructed in our remit to have due regard to what had been the normal financial expectations of consultant and specialist practice in the past. We considered very carefully at the outset to what extent the incomes of consultants in the publicly organised service of the future should be related to past incomes which had been derived mainly from private practice, and we decided that in accordance with our remit we were bound to have regard to past remuneration from all sources in judging what effect our recommendations were likely to have upon the recruitment of medical practitioners to the consultants ranks.

And page 7:

> Thus the highest remuneration would be open to specialists in all fields although the proportion attaining that remuneration might be less in some fields than in others and might vary with the increasing importance of this or that branch of Medicine.

These paragraphs indicate that the Spens Committee did accept the view that there should continue to be a salary differential between different specialties.

On page 6 there is rather quaint statement which even seems archaic, but it is a significant indication of factors which influenced the Spens Committee:

> It was, for instance, emphasised in evidence that in the past possession of private means often enabled a man to continue as a specialist in spite of a limited private practice, and that lower levels of taxation in the pre-war period enabled some specialists to accumulate sufficient savings to allow them to cut down their practice in the later years of their active life. In interpreting the statistics we have borne such considerations as these in mind.

Having regard to the veneration, even after 50 years, for the recommendations of the Spens Committee, it is not unreasonable to question how valid these recommendations should remain.

'MERIT' AND 'DISTINCTION'

Paragraph 13 contains the nub of the problem:

> If the recruitment and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward.

'Ability' and 'effort' are not the same thing. By the same token neither are 'distinction' and 'merit'. This is a point which was taken up when Sir Stanley Clayton* was interviewed by the Social Services Committee of the House of Commons in March 1981.

On page 11 this is further expanded:

> In our opinion this Committee should be empowered to recognise special contributions to Medicine in the field of research or otherwise, exceptional ability, or any outstanding professional work (other than administrative) by the conferment on selected individuals of distinction awards in three grades.

*Sir Stanley Clayton, 1911-1986; qualified 1934. Professor of Obstetrics & Gynaecology, Kings College Hospital, London. Past Chairman of the Advisory Committee on Distinction Awards.

This sentence makes interesting reading bearing in mind the current policy of involving employers in the selection of Award holders.

Paragraph 13 (page 12) considers but rejects quotas, either by specialty or by geography, but it does state that awards should not be allowed to gravitate towards a few large teaching hospital centres and 'we wish to stress that in making awards as between those who on other grounds appear to have equal claims, regard should be had to the desirability of spreading such awards over the country as well as over different branches of specialist practice.'

The *Spens Report* was regarded as sacrosanct but contains important internal inconsistencies. This is relevant to the extremely brief review (five lines only) of the Distinction Award Scheme in the Comptroller and Auditor General's Report, 1985 (the National Audit Office) which was tagged onto the end of a report about hospital medical manpower.[8] It is quoted in its entirety:

> In 1984 the health departments told the DDRB that they believed the distinction and meritorious service award scheme has been administered generally in accordance with the Spens Committee recommendation (paragraph 5.2). I have no reason to dissent from these views.

The *Kendell Report* [9] implied that this 'review' by the National Audit Office was of significance.

DISSENT

The *Spens Report* was largely a political document; it was produced in extraordinary political circumstances and its political aim - persuading consultants to join the NHS - was achieved even before it was published. Inevitably there was contemporaneous dissent from the *Spens Report* and a great deal of unease was expressed in the columns of the *British Medical Journal (BMJ)* and the *Lancet*. The most famous letter was that of Sir Francis Walshe, the eminent neurologist; it is quoted in full because of its vigour and style.

> Sir, Few, indeed, would dispute that the Awards Committee has a wholly impossible task, but many will regard it as being so not from any simple matter of lack of local knowledge but from its very nature, and likely to remain so no matter how freely the Awards Committee may farm out its responsibilities to small bodies reporting confidentially. It is one thing to grade a series of posts but quite another to seek to grade professional distinction, and it passes my comprehension that anyone who has spent his working life in medicine - unless as an administrator - could suppose that a grading of this order can be rationally and equitably accomplished. Even the assessment of purely scientific achievement in men of science, such as may be needed, for example, in the matter of election to membership of learned societies, is difficult enough, though here no vexing questions of money values arise. How utterly illusory, therefore, must be the hope of pricing 'distinction' in the profession of medicine, where so many diverse factors of personality and achievement are involved and there are so many red herrings to be drawn across the trail.
>
> It is idle to discuss this question unless we are candid about it. I ask, therefore, What constitutes 'distinction' in medicine? Is it aptitude in the variegated arts of worldly success? Is it clinical wisdom, therapeutic fervour, or the acceptable usage of the forms of sickroom politeness? Is it the gift of training students or fruitfulness in original research? Is it the acquisition of seniority by lapse of years or a flair for planning the activities of one's colleagues? Is it to be a Mary or a Martha in medicine? How are these incommensurables, these diverse qualities of mind, heart, and worldly wisdom, to be comparatively assessed in terms of sterling? What are we to feel about a committee, apparently so unaware of the essential nature of what it is setting out to do that it can suppose no more is necessary for its successful accomplishment than sufficient local knowledge? - F.M.R. Walshe

More letters were critical of the proposed system than in its favour. Portions of only two others will be quoted, the first was from Katherine Lloyd-Williams (Dean of the Royal Free Hospital) and the other from Reginald Murley who, in characteristically forthright manner, expressed his belief that 'the only true award for distinction is distinction'. Reginald Murley became President of the Royal College of Surgeons of England; he died on 2 October 1997 and remained unrepentant about his views on distinction awards.

> Sir, I should like to add my support to Dr E.C. Warner's excellent letter. Lord Moran is certainly mistaken in thinking that the number of uneasy agnostics among consultants is inconsiderable. The idea of 'distinction awards' caused great uneasiness from the outset, though, as a profession, we were perhaps not active enough in our opposition to the suggestion.
>
> Nevertheless, many committees as well as many individuals, as a protest against the system, refused to help in the invidious task of grading their colleagues. They presumably took this course because they felt that the principle of secret awards was wrong, and surely a principle, once it has been accepted, should stand above financial considerations.
>
> The hospital consultants have nevertheless been graded, whether they wished it or not, into classes A, B, C or Nil. Many individuals do not wish to profit by a system for which they have shown their dislike by refusing to assist in recommendations to the grading committees. Some of them have merely refused the awards; to others the suggestion of transferring the money to a benevolent fund appeals as being more practical. An annotation in the Journal shows how welcome contributions to these funds would be.
>
> It is surprising and most undesirable that secret awards of this kind can be made from public funds. In the eyes of many of us they confer no distinction on the recipient. - Katherine Lloyd-Williams.

> You, Sir, in your editorials and correspondence columns have published various views on the distinction awards, and I do not wish to enlarge on this subject now. I find myself in complete sympathy with those ideas which have been expressed in such eloquent and masterly fashion by Dr F.M.R. Walshe and I regret that our profession has suffered so seriously from lack of wise leadership in these difficult times. While members of the public and our general practitioner colleagues watch our undignified scramble for these pensionable additions to the basic salary, I shall prefer to stick to my old-fashioned belief that the only true award for distinction is distinction. - Reginald S. Murley.

Charles Webster[*,9] wrote in his official history of the National Health Service:

> Notwithstanding the prevalent view in the Ministry of Health that there was no escape from distinction awards because of their association with the Spens agreement, the awards system was subjected to a barrage of criticism on account of its secrecy, because of alleged discrimination against certain specialties, because of geographical inequalities, and because of the implied hierarchy of hospital types. Others argued that distinction awards were unsound in principle, because they discriminated against full-time consultants, medical research and university teaching personnel. The Scottish Department of Health only agreed to participate in the scheme on the understanding that it would soon be superseded by a new career structure for specialists and consultants. Distinction awards came under attack from Gaitskell and the Labour NHS Cabinet Committee, from Willink the Conservative former Minister of Health, and persistently from Sir Harold Himsworth, the Secretary of the MRC.

[*]Charles Webster Dsc; FBA 1982; Senior Research Fellow, All Soul's College, Oxford, since 1988; University Reader in the History of Medicine, University of Oxford, 1972-88; Director Wellcome Unit for the History of Medicine, 1972-88; Fellow of Corpus Cristi College, Oxford, 1972-88. Publications: *The Great Instauration* 1975; *From Parcelsus to Newton* 1982; *Problems of Health Care: the National Health Service before 1957* 1988; (ed) *Aneurin Bevan on the National Health Service* 1991; (ed) *Caring for Health, History and Diversity* 1993; *Government and Health Care: the British National Health Service 1958-1979.*

In the Scottish context, it should be particularly noted that the Scottish Home and Health Department only agreed to participate in the scheme on condition that it would soon be superseded.

Subsequent reviews of the Distinction Award System

The first major review (after nearly ten years) was the 1957 *Royal Commission on Doctors and Dentists Remuneration* (the Pilkington Report).[11] According to Webster[10] it was anticipated that the Royal Commission would suggest sweeping changes in the Award System.

> In the Treasury view Distinction Awards should be abolished as a blot on the landscape of public finance and the Scottish Home and Health Department suggested the abolition of 'C' and 'B' Awards with substitution of payment attached to a particular post. The Ministry of Health wanted the status quo. Reluctantly the Treasury withdrew its opposition on the ground that the Awards offered the cheapest means of granting a pay increase and because of support of this system among the 'big battalions' of the profession. It was accepted that 'arguments of expediency outweigh those of principle.

By the time of the Royal Commission the Awards were viewed as a means of rewarding the élite of the profession. The idea of the Spens Committee that they might be used as in inducement for consultants to serve in unpopular areas or in less prestigious specialties was not emphasised. 'Indeed it could be argued that the workings of the system had induced precisely the opposite effect.'

In evidence to the Royal Commission, Sir Thomas Padmore, permanent Secretary to the Treasury, made a statement on behalf of the Treasury. 'It is from our point of view a very curious system. I know of no other public service in which merit is not linked with the post. The present system therefore is quite unique in the public services.'

There have been other significant reviews and commentaries about the Awards System, some of which were indicated in the 1994 *Kendell Report*.[9] However, there were significant omissions from the *Kendell Report*:

1. Peter Bruggen and Stanford Bourne's series of articles in the *BMJ* between 1975 and 1982.

Bourne and Bruggen were two distinguished psychiatrists working at the Tavistock Clinic in London. Their interest in the subject was aroused during a coffee-break in the Tavistock Clinic. A dozen or so distinguished colleagues were discussing the system because one of their number had disclosed that he had recently received a Distinction Award. In the course of comparing notes it was discovered that there was only one Award holder among them. It would have been anticipated, given their eminence and ages, that at least half a dozen should have had Awards. This caused Bourne and Bruggen to examine the published statistics about the system and these were analysed in a series of seminal articles in the *BMJ* which periodically gave rise to considerable debate and animus. It will suffice to quote only from Bourne and Bruggen's seventh and last article.[12]

> Since our first paper we have tried to master our anger and dismay and, in successive studies, to consider how things go wrong. We remind ourselves that most colleagues are fair minded. There is no Machiavellian plan, no crooked conspiracy. But we are disappointed to face finally that group allegiances and prejudices are stronger than rationality.
>
> We have met support, argument, and hostility over the years; we have had our legs pulled. Much remains debatable, but we are back where we came in, with a batch of figures that we can only regard ironically in a rough and ready world. We should like the system abolished because it remains immutably unfair, divisive, and , in its secrecy, contemptible. No other profession would copy this system and consultants would gain respect by scrapping it - especially self-respect. Moreover, we suspect that the dangling carrot has helped to keep the salary of most consultants down.
>
> We feel somehow saddled with this peculiar subject. We do also have other clinical interests which we write about from time to time, and we wish others would take this one over now. The injury to women is flagrant and calls for immediate correction.

2. The review of the system by the Social Services Committee of the House of Commons in 1981.[13]

Interestingly this enquiry into the Distinction Award System was not mentioned in the Hansard title of the Social Services Committee Report. The Hansard title was *Medical Education*; the Distinction Awards enquiry was tagged on to the end of the review of *Medical Education*. It may be for this reason that the drafters of the *Kendell Report* failed to include it in their report.

The Committee cross-examined the Chairman of the Advisory Committee on Distinction Awards (ACDA), Sir Stanley Clayton. Sir Stanley was extensively questioned by the Committee Chairman and other members of the Committee (who included Mr Nicholas Winterton and Mr David Ennals - a previous Secretary of State for Health).

Mr Ennals made the point several times that Awards should be preferentially paid to those who are in unpopular specialties. The point was also made that there should be a clear distinction between Awards for 'distinguished service' and for 'meritorious service' (in this regard Geriatrics and Psychiatry were singled out as needing special help). Sir Stanley Clayton declined 'to make the distinction too sharply'. At one point Sir Stanley got himself into a tangle in that he praised colleagues who sat on committees, especially if these were convened out of hours, having previously asserted that committee work should not be especially deserving of recognition. There was also some difficulty in defining the purpose of Awards: were they mainly to be financial inducements to encourage achievement? If so why could they not be used as financial inducements for doctors to take up unpopular specialties in unpopular areas? The Social Services Committee was aware of the articles by Bourne and Bruggen and chided Sir Stanley with them.

Sir Stanley, incidentally, stated also that he did not personally approve of the secrecy of the system. Mr Ennals made the point that the system was rather incestuous - a matter which may have relevance to the suggestion of involving general practitioners in the selection of local Award holders.

Another interesting comment made by Sir Stanley concerned quotas for different specialty groups; Sir Stanley was speaking about administrative and public health doctors and he suggested that there should be quotas for this group because it was so difficult to compare their achievements with those of consultants in other specialties.

Sir Stanley (who had been the Chairman of ACDA for over five years) was invited by Mr Ennals to provide his reflections on the system in writing but he declined to put in writing his views about reform of the system.

Some interesting issues arise from this Social Services Review, namely:

- the clear recognition that secrecy of the system was wrong,
- the importance of trying to draw distinction between 'distinction' and 'merit',
- the validity of quotas,
- the possible value of positive discrimination,
- the importance of trying to define whether Awards were mainly to be 'incentives' and the extent to which they were 'rewards' for previous meritorious or distinguished service.

Clearly there is an element of competition between these two reasons for Awards. In a region if more doctors are deemed worthy of 'incentives', this will encroach on the number of Awards available as 'rewards'.

This conflict is responsible for the experience of many consultants who have been involved in selecting Award holders that there is a finite 'window of opportunity' for some consultants to be seriously in contention for an Award. Older, deserving and worthy consultants sometimes become relegated because of the influx of several younger, high-achieving consultants. Sometimes, 15 or so years of steady and continued achievement become eclipsed by consultants (or academics) whose activities in a few years appear to be more spectacular. The paradox is that the 'meteors' may partially burn out (but continue to hold their Awards) whereas the steadier but less charismatic Award-less colleague continues his/her previous pattern of worthy but lower profile progress.

3. The University of York, Centre for Health Economics Report.[14]
John Appleby (economic correspondent of the *BMJ*): commenting[15] on this report says:

> A typical holder of a merit award is likely to be a man (38% of all eligible male consultants hold awards compared with 21% of all eligible female consultants); to specialise in pathology, paediatric surgery, nuclear medicine, neurosurgery, or neurology (over half of all consultants in these specialties hold awards); to be aged around 47; and to work in one of London's special health authorities (nearly 6 out of 10 consultants in these special hospitals hold awards).
>
> Since the Spens committee introduced merit awards in 1948 there has been continuing criticism of the process. A letter in the *BMJ* in 1989 called it an 'antiquated system of patronage and secrecy based on "local soundings" and subject to...personal prejudice'. Indeed, the York economists go so far as to intimate that the secrecy of the central advisory committee on distinction awards suggests a degree of conspiracy, with awards made to 'the boys' to 'inflate their income whilst in practice and their pensionable earnings after they retire.' This, they argue, is unsustainable, especially in the changed economic environment in which the NHS now has to operate, in which there is a greater drive for efficiency in all types of spending.

4. In 1985 I conducted a survey on behalf of the UK National Association of Clinical Tutors to establish the Distinction Award status of current and past clinical tutors throughout the United Kingdom. Although circulated to all clinical tutors the results of this survey were not published. Two of the questions of that survey are still relevant.

Question 7: Do you think there are anomalies or surprises in your Region? The replies were:

Gross anomalies	61
Mild anomalies	183
No anomalies	56
Don't know	45
Other	0

Question 8 - How are C Award holders chosen?
Answer:

By existing Award Holders	175
By a combination of Award Holders & Non-Award Holders	56
By a cabal of Senior Award Holders	45
By some other system	9
Don't know	76
Some combination of systems	14

The interest is that in 10% of Regions, non-award holders were participating in the selection of 'C' Awards. This is a policy which has been extended in many hospitals in the selection of consultants for the new 'discretionary points'.

This survey gave rise to considerable debate and discussion. While I do not wish to weaken the arguments in this submission by unverifiable anecdotes, it is appropriate to mention a few comments which were made in the course of these discussions, especially as there is some corroboration from a senior Award holder.

Dr Bryan Williams had written to the *BMJ* in 1978[16] in the following terms:

> Sir, My experience of the working of the distinction awards system as a one-time member and chairman of a local committee is so much at variance with that of Mr B.H. Price that I must state my opinion. As I have now been long retired I have no axe to grind except for the purpose of trying to chop down a system which I think has been dishonourable and discreditable to British public life, on account of its corruption and secrecy.
>
> While it is common knowledge that awards have been given to those of high professional attainments, I am convinced that the system is also used to ensure amenability and docility towards the establishment. A consultant who is doing good work and who is thought worthy of an award by his colleagues may be denied one because he has stood up against authority because of what he considers to be the interests of his patients, while another consultant who is prepared to be a 'yes-man', willing to toe the party line and spend his time in so-called 'administration' instead of with his patients, may be sure of an award and other privileges.
>
> Few can deny that the atmosphere of secrecy conflicts with the principle of 'justice appearing to be done'. The linking of a high award with the remuneration of a university chair or a senior clinical appointment would be acceptable to most and might attract more competition than has been the case in the past.
>
> Surely the time has now come for professional opinion to be tested again, not by the kind of unsuitably worded and valueless BMA questionnaires of the past, but by asking a simple question such as, 'Do you consider the present system of giving distinction awards should be continued?' - Bryan Williams.

Some clinical tutors reported that the system in their hospitals tended to promote docility and conformity to the views of the senior Award holders. At a local level the senior Award holders are always present at meetings at which the names of prospective Award holders are discussed. This inevitably means that Award holders hoping to be

progressed to a higher Award are expressing their opinions in the presence of the more senior Award holders (who will be responsible for promoting their candidacy for a higher Award). This is not a situation which tends to complete frankness or to the expression of opinions contrary to those known to be held by the senior Award holders present. Examples were given of Consultants deliberately displaying themselves to the local senior Award holders by hanging around their hospital and hospital car park so that they would be seen to be in the hospital at unusual times.

The system tends to produce sycophancy in those determined to progress up the Award system. I do not claim that this is widespread, only that the system can bring out baser characteristics. Recently, some trust chairmen were appointed largely because of their party political allegiance in order to promote the controversial, doctrinaire policies of the 'internal market'. The lead that they gave to their managers effectively suppressed a good deal of internal unrest about these politically contentious changes. Many consultants felt constrained to accept management decisions because managers and their board chairman were given an enhanced role in promoting candidates for Distinction Awards. In some instances the involvement of managers and chairmen has been disadvantageous to worthy consultants who were unwilling to accept the excesses of the reforms without expressing their distaste for them.

THE *KENDELL REPORT*

The foreword of the *Kendell Report* makes an astonishing admission:

> In view of the limited time available to it the Working Party considered it impractical to undertake a formal consultation exercise, but did seek evidence from the current Chairman and Vice Chairman of the Advisory Committee.

It goes on to say 'in addition a number of organisations and individuals submitted comments' although nowhere in the report are these individuals' organisations and comments identified.

As a result of professional, public and media pressure following the *Kendell Report* there was a minor variation in the criteria for awards. Criterion Number 6 in 1996 read 'Outstanding and sustained service to the NHS in an exceptionally hard pressed post. This criteria would not normally be the sole grounds for an Award and would not apply above the B Award level'. In 1997 this criterion was modified to read 'Outstanding and sustained service in the NHS in an exceptionally hard pressed post.' There is an implication in this changed wording that outstanding clinical service is now thought to be more worthy of an Award than previously and could be the sole grounds for an Award even higher than a 'B' Award. However, such alterations in the wording of the criteria take years, if not decades, to significantly impact on the selection of worthy consultants for a higher Award. Furthermore, there is no definition as to what constitutes a 'hard pressed post' and this qualification may mean that no consultant will receive a 'B' or 'A' Merit Award principally on the grounds of years of clinical excellence in a non-university hospital.

'APPEALS' AND 'SPECIAL REVIEWS'

There is no appeal against failure to receive an Award; however, consultants can request a 'special review' which will be considered only the following year. As Treasury officials have indicated in the past, the Awards process is 'unique in the administration of public finances'. The ACDA recommends to the Secretary of State each year the names of suitable persons to receive an Award. It does seem most unusual that those

who feel overlooked have no redress to the Secretary of State who is ultimately responsible to Parliament for public expenditure. The request for a 'special review' is made to the same body whose decision of the year before is being 'appealed'.

Consultants who have participated in Regional Award meetings are aware that an 'appeal' often does not reflect beneficially on the appellant; 'appeals' can give rise to feelings of irritation at least at a local regional level. They suggest an inflated ego, and unmanly and unsporting arguing with the referee's decision. They question the wisdom of the local senior Award holder, the relative worth of the recent successful candidates and they impute error.

THE SUPERANNUATION ANOMALY

> For whosoever hath to him shall be given but whoever hath not from him shall be taken away even that which he hath.
>
> *Matthew, Chapter 13, verse 12*

Award holders receive pensions and 'lump sum' payments on retirement which are based on their salary in the last year or two of their working life, like all consultants. The increased superannuation contributions paid by higher Award holders are never commensurate with the enhanced pensions which they receive. Over two-thirds of consultants receive no Distinction Awards and are therefore, by implication, subsidising the pensions of higher Award holders. Take the example of two consultants who started work in the National Health Service at the age of 25, they have both bought five 'added years' and therefore at the age of 60 will no longer have to pay superannuation contributions. Their pensions are based on 40/80 of their final salary. Assume that both of these consultants received 'B' Distinction Awards at the age of 55 but at the age of 60 one of them received an 'A' Distinction Award s/he will receive at the age of 65 an enhanced pension equivalent to half of the difference between the 'A' and the 'B' Awards (about £8,000 per annum). Both of these consultants will have contributed exactly the same amount in superannuation.

Pensions actuaries will argue that there is always an element of 'rough justice' in superannuation payments, and pensions calculations and superannuation contributions are based on an average for the group as a whole. There is a degree of roughness about this justice which, were it widely known, the consultant body as a whole would find objectionable. This inequity in superannuation contributions applies no matter how early a Distinction Award is gained. It is impossible to hold a Distinction Award for long enough for the increased superannuation contributions to equate with the enhanced pension arising from holding a higher Award. This should be an anomaly which will soon be addressed by the National Audit Office.

INVOLVEMENT OF THE ROYAL COLLEGES

Since the *Spens Report* the Royal Colleges have had the main influence in running the Distinction Awards System; representatives from the Colleges constitute the majority of ACDA and of its Scottish sub-committee. The Colleges also promote candidates for Awards - these are chosen *in camera* and the names of those being promoted are not vouchsafed to the Fellowship of the Colleges.

There is the irony in that the Colleges affirm that they do not deal with 'Terms and Conditions of Service' issues; they say they are only concerned with promotion of the highest standards within the specialty that they represent. Their Distinction Award interest is clearly an anomaly because, from the beginning, Distinction Awards have

been part of the terms of service of employment of consultants. Furthermore, the Colleges' active involvement in the process means that they are *de facto* involved in issues of 'Terms and Conditions of Service'. With the involvement of Lord Moran, the Royal College of Physicians of London was the dominant and most influential of the Royal Colleges. The Royal College of Surgeons of England and the Royal College of Obstetricians had far less influence over the Minister of Health because of the less focused and less worldly-wise personalities of their Presidents in the crucial years 1946-1948. The Scottish Royal Colleges, as is clear from the acrimonious correspondence at the time, felt themselves to be effectively disenfranchised.

There is a sustainable argument that the Distinction Award System has proved incredibly harmful to the Royal Colleges. With increasing specialisation and increasing numbers of consultants, it was inevitable that larger specialty groups would no longer feel themselves to be fairly or adequately represented by the long-established Royal Colleges of Physicians, Surgeons and Obstetricians. However, the fact that several major specialties have been so disadvantaged (and continue to be disadvantaged) by the Awards system played a part in precipitating the formation of many of the new Colleges, particularly Psychiatrists, Pathologists, Radiologists and more recently the Royal College of Paediatricians and, on the surgical side, the Royal College of Anaesthetists and the Royal College of Ophthalmologists. It has not been a seemly process given the efforts sometimes made by the older Royal Colleges to discourage specialty groups such as the Paediatricians and General Practitioners from forming their own Colleges. Attempts were made (through correspondence with the Privy Council) to block the conferment of Royal patronage on the new Colleges. The older Royal Colleges have been much weakened by the splits and are now financially dependent on their large numbers of overseas Fellows.

On 11 January 1952, Sir Russell Brain, President of the Royal College of Physicians, writing with the effective support of Sir Cecil Wakely for the Royal College of Surgeons of England and Dame Hilda Lloyd for the Royal College of Obstetricians and Gynaecologists wrote what he intended to be the final put-down:

> ...I think I ought to make it quite plain that this College, and I am sure I can here speak for the other two Colleges as well, would not be able to support in any way an organisation which aimed at establishing another college or which it seemed to us might seek to do so at some future date. I can say this with confidence because this very point has just been settled by the three Royal Colleges jointly in connection with another matter. I want to make this plain now because, while, as you know, the three Royal Colleges would view sympathetically the establishment of a Joint Faculty of General Practice, I do not want those now considering the formation of some institution of general practice to go forward feeling that the three Royal Colleges would be likely to support an independent body without very stringent safeguards against its ever becoming a College. - W. Russell Brain.

Legal advice was taken by those wishing to found a College of General Practitioners; the advice was that it would be possible to found a College as an unincorporated association privately. In effect, the Royal College of General Practitioners was founded in secret, prior to its inception being announced in the *BMJ* in December 1952.

On 20 September 1994 the President of The Royal College of Physicians of London wrote to the Privy Council about the proposal by the British Paediatric Association to form a College of Paediatricans:

> The ability to speak from the perspective of this College, as well as for Paediatricians alone had an advantage over that which might have been the case if a College of Paediatricians alone had made the case. The combination of the BPA and the RCP should be capable of providing a stronger case for improvements in care than a smaller paediatric college on its own. In a broader perspective, the splintering of the College's role in relation to medical specialities weakens medicine as a whole....You will see that my aim in stating the case against a separate college is predicated on a desire to ensure that adult physicians and paediatricians work closely together in the best interests of children. The application before you will do nothing to further this aim.

These schisms have affected the Scottish Royal Colleges as much as the London-based Colleges. It has debilitated the older Colleges which have now been compelled to collaborate with all the newer Colleges under the umbrella of the UK Academy of Royal Colleges and Faculties.

THE ROLE OF THE CHIEF MEDICAL OFFICER

The administration of the Distinction Award Scheme is closely related to 'Terms and Conditions of Employment of Hospital Medical Staff'. The Awards Committee has the responsibility of recommending to the Secretary of State those worthy of Awards. Although the rules of the system do not allow appeals against decisions by the Scottish Subcommittee it must soon come to pass that direct appeals to the Secretary of State against recommendations made in his name will be allowable. It is not impossible that there will be a legal challenge by individuals who feel themselves to be aggrieved. Under these circumstances the Chief Medical Officer would be expected to advise the Secretary of State; there would be a conflict of interest if the Chief Medical Officer himself, was a member of the Committee whose decision was being appealed or challenged.

IMPLICATIONS FOR PROFESSIONAL SELF-REGULATION[17]

It will be recalled that both the cases of Anthony Goldstein and Wendy Savage caused intense media and public interest to the considerable discomfiture of the medical profession. The Goldstein High Court verdict (1991), only parts of which were overturned by the Court of Appeal a year later, demonstrated the ability of a single dedicated individual to successfully challenge decisions made by an august medical body (the JCHMT).[18] It demonstrated the need for the United Kingdom to harmonise with European law. The judgement was also extremely critical of the secrecy which surrounded the references about Dr Goldstein from the previous hospitals in which he had worked, criticising the process of obtaining opinions about Dr Goldstein which were not in writing and so not available for challenge by Dr Goldstein himself.

In Dr (now Professor) Wendy Savage's case (1986), she too exposed the system of secret and confidential unwritten opinions about her which had been solicited. She was entirely vindicated in her appeal against the decision to suspend her from her consultant post.[19]

These cases are significant for the Distinction Award process. Meetings *in camera* (at which no minutes are kept) and at which the worth of individuals to receive public funds are discussed without their ability to rebut adverse comments - are contrary to natural justice, as well as European (and Scottish) Law. Secondly, the cases are significant in relation to consultants who may have their Awards discontinued in the annual review process. Were such consultants to challenge the decision in the Courts, it is most likely that the whole Award process would be exposed to adverse media and public scrutiny which is likely again to prove uncomfortable and degrading for the profession.

The matter of racial bias has recently been referred to in an article by Sam Everington[20] and the figures for gender differences in Awards are available in the 1997 report of the Advisory Committee on Distinction Awards.[21] These may be other matters which may be put up for formal judicial review.

Further self-regulation questions need to be asked about doctors struck off the Medical Register for conducting fraudulent research. Those most relevant are the recent cases of Mr J.M.F. Pearce (the St George's gynaecologist who fabricated case reports),[22] Dr John Anderton of Edinburgh (a physician who fabricated research results)[23] and Dr P.G.F. Nixon (the retired Charing Cross Hospital cardiologist who admitted in the libel action which he lost against Channel 4 that his reported research errors were 'more than an honest slip of the pen').[24] Nixon's case would have been referred to the General Medical Council but for the facts that he undertook to discontinue medical practice and that he had retired from his NHS post. These doctors held Distinction Awards which would have been awarded partly on the basis of fraudulent research. The Distinction Awards which they held will have resulted in them receiving enhanced pensions. If self-regulation of the profession is taken seriously, as it now must be, then these enhanced pensions, which had their origin in fraudulent research, should have been withdrawn and curtailed, and it should also be expected that the recipients would be made to repay the Distinction Awards which they received prior to retirement or resignation. Drug dealers and fraudsters, like tax evaders, are not allowed by the courts to keep the fruits of their misdemeanours. These were not victimless malfeasances. What of the consultants who did not receive Awards because these consultants instead received the available Awards on the basis of their fraudulent publications? However, none of the offending consultants was convicted of a crime by the Courts and they continue to benefit.

It will now be the Advisory Committee on Distinction Awards (which recommends to the Secretary of State the names of consultants to receive awards) which will advise the Secretary of State to take steps to have the previous awards (and enhanced pensions) of offending consultants returned to the public purse.

Professional self-regulation means that all disciplinary actions by the GMC require scrutiny if the consultant concerned holds a Distinction award or (if retired) a Distinction award-enhanced pension. The GMC, in addition to erasure, punishes by temporary suspension and censure. Consideration must also be given to any punishment by the GMC which involves only a single misdemeanour, for example the case of the paediatric cardiologist suspended because he performed what he believed to be a life-saving procedure on an infant against the explicit wish of the mother. Should this consultant forfeit all his past Distinction awards and his merit award-enhanced pension? What of a consultant punished for a moral lapse but whose professional activities have been exemplary? The puritanical will argue that any punishment by the GMC *ipso facto* means that the individual is not worthy to receive from the State any additional payments (which are denied to the majority of consultants).

The Wisheart case raises yet other self-regulatory issues. Wisheart received an 'A' Merit Award in 1994 when serious questions were already being asked about his conduct (as a Trust Medical Director) and his competence (as a paediatric cardiac surgeon). He voluntarily stopped operating in December 1996 and announced his retirement from the NHS just before publication of an adverse independent report (commissioned by the Trust). Clare Dyer[25] wrote: 'This case breaks new ground in focusing attention on the overlap between issues of competence and those of conduct.'

One solution to arriving at a judgement about returning to the Exchequer past Merit Awards would be to ask the question - 'If the punished offence occurred at the time that the consultant was a candidate for an award, would an award have been recommended?'

In considering these issues it must be right to temper justice with compassion but in this highly competitive system which provides financial reward and professional esteem one always has to remember that one man's Distinction Award is another man's 'vexation, disaffection, disappointment and disincentive'.

As the *Kendell Report* says 'They are not only a substantial financial Award; they are also a tribute to an individual doctor from his/her peers locally and nationally, and valued all the more for being so'.

MISCELLANEOUS SUGGESTIONS

Devolution offers a unique opportunity to review in depth, and in a Scottish context, many procedures which have previously been considered only on a UK basis. As far as the Merit Award System is concerned, it still remains fundamentally as designed by Lord Moran 50 years ago. The system would certainly not be reinvented in its present form today. At the time it was introduced the Scottish Colleges were effectively excluded from the consultation process.

The opportunity given by devolution and the Government's commitment to a further review of a scheme, which by its nature separates the most distinguished members of the profession, who are the main opinion makers, from the majority of the consultants, should mean that the worst excesses will be removed.

The considerable financial advantage of Award holders inevitably meant inertia in producing substantial modifications to ensure greater equity. Human nature is such that the privileged leaders of the profession were inherently unlikely - whatever their point of view when they were younger - to favour radical changes.

No one disputes that the UK system of general practice and primary care is not only unique but one of the most important features of the National Health Service. The recent Scottish White Paper on the Health Service gives general practitioners an enhanced role in determining local health care provision. The selection of consultants for Distinction Awards is still decided in the main by local Award holders passing judgement on the merits or demerits of colleagues across the whole spectrum of specialist practice. Surgeons comment on psychiatrists, psychiatrists on physicians, and physicians on radiologists. The principle, therefore, of different specialist groups expressing opinions about other groups is already clearly established.

The NHS (Vocational Training for General Practice) Regulation 1997 came into force on 30 January 1998. Under the Regulation all hospital SHO posts which are recognised for General Practice training have to be both 'approved' and 'selected' for this purpose. The final decision about every hospital post rests with the Joint Committee on Postgraduate Training for General Practice which has powers to de-recognise hospital SHO posts for vocational training purposes. The vast majority of hospital SHO posts are presently recognised for vocational training in general practice. Hospital posts which are de-recognised will immediately have significant recruitment difficulties. General practitioners are therefore statutorily involved in assessing hospital training posts as well as consultant trainers. The principle of general practitioners assessing consultants (who have SHOs) is now enshrined in statute. Consequently involvement of general practitioners in the selection of consultants for Distinction Awards is not illogical. Lord Moran's unfortunate phrase 'dropping off

the specialist ladder into general practice' was realised by him to be a monumental gaffe as soon as it passed his lips (he quickly tried to repair the damage by an apologetic letter to the Journals). What better way of repairing the lingering animosity caused by Lord Moran's gaffe than to involve general practitioners in the process of selecting consultants for awards?

As one general practitioner wrote at the time:

> Hitherto I have considered myself devoid of superstition. I shall now think twice before walking under a ladder - you see, there may be a consultant at the top of the ladder, and he may drop a brick.

The Government's proposals for reform of the scheme propose that academic general practitioners will also be eligible for Awards if they have made outstanding contributions to the development of primary care.

The question of quotas for different specialties and for different types of hospitals has arisen from time to time. Quotas were recommended for public health doctors (by Sir Stanley Clayton) because of the difficulty in comparing their work with those of their clinical and academic colleagues. Quotas were specifically stipulated in the *Kendell Report* in the form of discretionary points which individual hospital trusts should award purely on the basis of the number of consultants which they employ. The question of quotas has therefore in principle already been breached.

There are models for the more democratic selection of Awards. In some hospitals local non-Award holders have significant input into deciding who among their number will be selected for an Award - often by a process of secret ballots.

In any system in which the privileged try to retain their rewards the underprivileged have redress only to the law, public opinion or political persuasion. It would not be good for the esteem in which our profession is held that it should be exposed to further damaging publicity and adverse judgements in the Courts. There is a danger, unless we are seen to regulate ourselves rigorously, that regulation of the profession will be removed from us.

We need to re-visit the question of whether 'merit' is the same as 'distinction' and whether it should be rewarded in the same way.

Subtle and covert discrimination exists in favour of university-based hospital consultants (and university academics). The curriculum vitae and citation forms used by ACDA still effectively specify and weight the important criteria which will be used to assess worthiness.

Publications and national committee work are undoubtedly deserving of special recognition but research and publication, the cut and thrust of debate and the excitement of academic controversy are rewards in themselves. University hospitals have much more favourable staffing ratios to enable these activities to be pursued. Producing papers is the purpose of academic departments - of itself it is not specially deserving of quality recognition unless it is of above average standard, yet in the Awards process these activities are given particular prominence.

It remains a question of comparing the merits of university hospital racehorses with district hospital carthorses by criteria which emphasise swiftness and sleekness in preference to strength and stamina.

It needs to be considered whether the Awards are primarily inducements or rewards. The present criteria for Awards mean that successful consultants must spend time away from their clinical work (doing research, writing papers and attending conferences or sitting on prestigious national or College committees) - there is the paradox that these

activities, by definition, mean absence from clinical work. It is specious to allege that these additional activities are carried out only in spare time.

GOVERNMENT PROPOSALS FOR REFORM[4]

On 10 August 1998 the Government published interim proposals for the 1999 Award round to ensure that the Distinction Award Scheme is fair, open, meritorious and properly geared to the needs of the Health Service. The promised changes are regarded by the Government as an interim measure pending a more fundamental review of the Scheme to ensure that the Awards Scheme meets the needs of the modern NHS.

APPENDIX

Background to the Consultants' Distinction Award Scheme[1] (until 1999)

Distinction Awards were introduced at the inception of the NHS to reward individual consultants for outstanding work of wider benefit to the NHS, and form part of the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine. The scheme is based on a system of peer and employer review, both locally and centrally, arranged through a hierarchy of committees and meetings. This structure consists of the Advisory Committee on Distinction Awards (ACDA), the Scottish Sub-committee, and Regional Awards Committees in England and Wales. The ACDA and Scottish Sub-committee members are appointed by Health Ministers.

The ACDA has 33 members, including the Chairman and Medical Director. Members are appointed for a three-year term by the Secretaries of State and include the Chief Executive of the NHS Executive, representatives of the Royal Colleges and Faculties, the general body of consultants, the Universities, the Medical Research Council and NHS employers. There are 14 Regional Award committees in England and one for Wales. Regional Awards Committees make recommendations on A and B awards and comprise senior NHS consultants and representatives of NHS management. In Scotland, the Scheme is operated by a Scottish Subcommittee which identifies and considers possible candidates for awards and makes recommendations to ACDA. The Sub-committee acts through four regional awards meetings and nominations for awards are considered at these meetings. Shortlists are identified at the regional meetings for the Scottish Sub-committee to consider at its final meeting in July each year, when the Sub-committee decides its recommendations before submitting them to the ACDA.

A number of changes to the Awards system were introduced in the 1996 Awards Round following a review of the scheme by Dr R.E. Kendell, then CMO for Scotland. These changes included greater employer input, central funding of awards and certain changes in the criteria. The changes also included the abolition of the former 'C' award element of the scheme to be replaced by a system of discretionary points to be decided locally by employers with professional input. The names of distinction award holders are now published in the ACDA Annual Report in January of each year. The costs of the Award Scheme are over £100m.

12.6% of all eligible Consultants hold a Distinction Award. The details are:

Grade	Number of Awards (E&W)	Number of Awards (S)	% of total Consultant body (E&W)	% of total Consultant body (S)	Value 1/4/98	Salary + award mix
A+	235	32	1.0%	1.1%	£54,910	£110,720
A	812	108	3.6%	3.7%	£40,460	£98,260
B	1806	236	8.0%	8.0%	£23,120	£80,920
	2,853	376	12.6%	12.8%	-	-

REFERENCES

1 Consultation Paper. Proposal to establish a Scottish Advisory Committee on Distinction Awards. February 1998. Scottish Office, Department of Health.

2 Professor Brian Abel-Smith. *The hospitals 1800-1948: A study in social administration in England & Wales* London: Heinemann, 1964; 486.

3 Report of the Inter-departmental Committee on the Remuneration of Consultants and Specialists, 1948 (Cmd 7420). London:HMSO. (The Spens Report).

4 Guide to the NHS Consultants Distinction Award Scheme. 1999 Awards Round. NHS Executive, October 1998.

5 Foot M. *Aneurin Bevan Vol 2 1945-1960* London:Grenada, 1975.

6 Guillebaud CW. National Health Service: report of the committee of inquiry into the cost of the National Health Service Cmnd. 9663 Session 1955-56. London:HMSO, 1995.

7 Lovell J. *Churchill's doctor, a biography of Lord Moran* London: Royal Society of Medicine Ltd, 1992.

8 Report of the Comptroller and Auditor General. *National Health Service: hospital based medical manpower* (Cmd 373), HMSO, May 1985, 15.

9 Report of the Working Party on the Review of the Consultants Distinction Award Scheme. London: Department of Health, October 1994 (Kendell Report).

10 Webster C. *The health services since the War: problems of health care in the National Health Service before 1957* London: HMSO, 1988.

11 Pilkington WH, Lord. *Royal Commission on doctors and dentists remuneration* London: HMSO, 1960. Session 1959-60 Cmnd 939 xii.

12 Bruggen P, Bourne S. The Distinction Award System in England and Wales. *BMJ* 1982; 284:1579-80.

13 Social Services Committee (Session 1980-81). 'Medical Education' Minutes of Evidence, 25 March 1981. London: HMSO, 3526-60.

14 Centre for Health Economics, University of York. *Rewarding excellence? Consultants Distinction Awards and the need for reform* Bloor K, Maynard A. Discussion paper 100, September 1992.

15 Appelby J. Merit Awards attacked by economists. *BMJ* 1992; 305:863.

16 Williams B. Distinction Awards. *BMJ* 1978; 1:860.

17 Smith R. Medicine's core values. *BMJ* 1994; 309:1247-8.

18 Editorial. Dr Goldstein's victory overturned. *BMJ* 1992; 305:1439.

19 Editorial. All over in five minutes. *BMJ* 1986; 293:340.

20 Esmail E, Everington S, Doyle H. Racial discrimination in the allocation of Distinction Awards? Analysis of list of Award holders by type of award, specialty and region. *BMJ* 1998; 316:193-5.

21 Advisory Committee on Distinction Awards, Annual Report. February 1997, Table 6.

22 General Medical Council, Professional Conduct Committee. Extract of Professional Conduct Committee 5-7 June 1995: Pearce, John Malcolm Frederick. London:General Medical Council, 1995.

23 General Medical Council, Professional Conduct Committee. Extract of Professional Conduct Committee 16-17 July 1997: Anderton, John Leslie. London:General Medical Council, 1997.

24 Editorial. Cardiologist admits research misconduct. *BMJ* 1997; 314:1501.

25 Dyer C. Wisheart begins to give evidence at GMC. *BMJ* 1998; 316:646.