TALKING POINT

Re-examination of the distinction awards system in England and Wales, 1976: the new advisory committees

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Economies have shortened the DHSS's 1976 annual report¹ and curtailed the published data on distinction awards. More information was readily given on request and we have been particularly concerned to examine the new advisory committees.

The 1976 awards were announced in 1977 and for the first time their total (4418, including 516 new ones or promotions) was the same as for the previous year. The number of consultants continued to rise so that the award holders fell from 35.3% to 34.6%. Thus, the awards points* fell from 54.2 per 100 to 53.2.

The trend towards a reduction in the disparity between "rich" and "poor" regions has not progressed. The ratio of average awards points in three northern regions to that for the three most successful regions in the south (which includes so many teaching hospitals) fell from 1:1.35 in 1974 to 1:1.26 in 1975 but remained unaltered in 1976.

Teaching and non-teaching hospitals

From 1975 to 1976 the number of consultants in the teaching areas rose from 4771 to 5076, whereas the number of consultants outside the AHAs(T) fell from 7204 to 7115. The actual number of awards held in the teaching areas rose from 2173 to 2231, while those held by AHA consultants fell from 1991 to 1930. So, though the "teachers" lost 1.6 awards points per 100 consultants and the "non-teachers" lost only 0.5 awards points per 100, in both number of consultants and number of awards the teaching areas have gained relative to the others (despite RAWP).

There are now no separate figures for the teaching and non-teaching hospitals in the AHAs(T) but we have found separate ones for the London postgraduate teaching hospitals (administered by boards of governors). In 1976 the consultants at postgraduate teaching hospitals had an awards points rate of 114.7 per 100 consultants. This is 16 points per 100 higher than the 98.1 awards points per 100 that we noted for teaching hospital consultants in 1973, which was the last time figures were shown separately for them. It is over three times the awards points scored in the non-teaching AHAs.

Age

The fresh data supplied by the DHSS since our 1975 paper show that over 10 years the average age for allocation of a C award has been 48; for a B award, 50.5; for an A award, 54.5; for an A+ award, 57.1. The Review

Body's Seventh Report stated: "There is some evidence that, at the lower levels in particular, *distinction in the sense of excellence is no longer the only consideration* [our italics], and the system has been operated as if it were a promotional system." From recent figures and from the calculations we presented in 1975 it seems likely that the same is true for A and A+ awards within the favoured specialties in the teaching hospitals. These groups may be more talented on average than some others, but over a third of these consultants probably retire with at least an A award. This makes nonsense of the proposition that A awards might represent the attainment of unusual eminence. They are commonplace for many older consultants who are well placed. Indeed, recently more than 60% of consultants have retired with awards of which half are B awards or higher.⁵ About one in five are A or A+ awards.⁶

Differing specialties

In previous papers we tabulated figures for various groups of consultants with a range from some of the specialties. In this paper we have tabulated all the specialties for which separate figures are available. Table I shows the figures for 1975 and 1976 and gives the rise or fall of awards points per 100. The average fall was one awards point per 100 consultants, and those groups scoring around the average have changed least. Since some of the specialties are much smaller than others in numbers, the figures should be interpreted cautiously. Even so, in a shortage year, the neurosurgeons increased their awards rate by an astonishing 20 points per 100 consultants. Cardiologists dropped 8.3 points per 100, and thoracic surgeons 7.5 per 100. The geriatricians (at the bottom of the table) lost a further 6.4 points per 100.

There were 516 new awards or promotions in 1976 shared by 12 879 consultants (one in 24.9 compared with one in 16.3 for 1975). The community physicians seem to have lost all the impetus of their entry to this scheme and their new award rate fell from one in 11 in 1975 to one in 37.9 in 1976. The high scorers this year have been the plastic surgeons (one in 13.3), neurosurgeons (one in 16.4), neurologists (one in 17.4), general physicians (one in 17.5), and paediatricians (one in 17.7). With most awards the thoracic surgeons and cardiologists have scored around the average number for new awards this year, but, at the bottom, the psychiatrists (one in 36.5), the anaesthetists (one in 37.9), and the geriatricians (one in 34) have done badly. One in 52 venereologists received a new award or promotion, even worse than the previous year, but their total position for awards is still five places from the bottom. There were no awards

to the specialists in infectious diseases in 1976, but their position is still in the top third.

Advisory committees

The Distinction Awards Advisory Committee for England and Wales receives advice from 15 regional C award advisory committees and 15 higher award advisory committees. The teaching hospitals, including London, are now included in the same system as the others and we welcome this as a development which may slowly change the balance. (Advice is also obtained from other bodies, including the royal colleges and the Medical Research Council. There are subcommittees for dentistry and community medicine, but we have not studied these.)

We regret the continuation of two factors which must promote error and bias. Firstly, the advisory committees consist entirely of award holders, and, secondly, there is a persistent bias of committee membership towards physicians, surgeons, and gynaecologists. An analysis of the regional committees (see table II) shows that consultants in general medicine and general surgery occupy roughly twice the number of seats on advisory committees than would appear fair pro rata. Even if larger bands of specialties related to medicine or surgery are taken together, these enlarged groups still have around 140% of the fair number of seats their numbers warrant. The most eloquent fact of all is that the top seven specialties—that is, with most awards—are together represented over three times as strongly, per caput, as the bottom seven specialties. On the higher award committees the disparity is just short of four times. It is not surprising that the distribution of awards stays the way it does and that the committees sincerely believe that it is about right.

On the central committee (20 doctors and one layman), 14 members are physicians, surgeons, or gynaecologists—though, on numerical grounds, they should add up to less than half the committee. The gynaecologists have three times as many members as their numbers warrant. Pro rata, they have six times the representation enjoyed by pathologists, anaesthetists, or psychiatrists. But the preponderance of gynaecologists on the committee still leaves this group only a little above the average of award holders, whereas some of the small specialties with highest scores of awards are under-represented on the committees.

The imbalance of specialties on committees is a symptom as much as a cause of bias. Far worse is the exclusive dependence on people who have already been successful in the system. Success, age, and experience may sometimes confer wisdom, but not always. To recruit some of the most junior consultants without awards to participate in the difficulties

*Awards points^{1,2,3,4} are used to clarify data that are misleading if all awards are banded together in percentages. C award = 1 point; B award = 2 points; A award = 3 points; A+ award = 4 points.

TABLE I—Distribution of awards in 1975 and 1976

Specialties in descending order of success in awards points 1976	No of consultants in 1976* (total 12 879)	Percentage of consultants with awards		Average points per 100 consultants		Higher awards points (A +, A, and B) per 100 consultants		Higher awards points (A + and A) per 100 consultants		New awards		Rise and fall in awards points per 100 consultants 1975 to 1976
		1975	1976	1975	1976	1975	1976	1975	1976	1975	1976	
Thoracic surgery	112	73.9	71.4	143.2	135.7	115.3	108.0	63.1	56.3	1:12.3	1:28	-7.5
Neurosurgery	82	56.0	63.4	104.4	124.4	84.6	104.9	31.9	46.3	1:13.0	1:16.4	+20.0
Cardiology	103	72.6	68.9	132.6	124.3	101.1	95.1	46.3	38.8	1:13.8	1:25.8	-8.3
Neurology	139	55.1	53.2	95.6	92.8	70.3	68.3	31.2	30.9	1:15.3	1:17.4	-2.8
Plastic surgery	80	53.2	52.5	86.1	81.3	60.8	52.5	15.2	15.0	1:11.3	1:13.3	-4.8
General surgery	1102	51.4	49.4	82.8	79.9	53.7	52.3	23.9	22.9	1:11.4	1:21.2	-2.9
General medicine	1261	50.0	48.4	82.9	79.1	55.8	52.0	25.9	24.6	1:14.0	1:17.5	-3.8
Infectious diseases	32	50.0	53.1	75.0	78.1	44.4	43.8	16.7	18.8	1:13.0	—	+3.1
Dermatology	191	43.6	42.9	72.9	72.3	49.5	49.2	25.0	26.2	1:17.1	1:23.9	-0.6
Radiotherapy	185	45.6	42.7	73.6	68.6	48.4	45.9	20.9	16.8	1:13.0	1:30.8	-5.0
Neurological physiology	39	40.0	38.5	60.0	59.0	40.0	38.5	—	7.7	1:13.3	1:19.5	-1.0
Obstetrics and gynaecology	682	38.1	38.3	59.1	58.8	36.4	35.3	14.8	15.1	1:14.1	1:18.4	-0.3
Pathology	1416	38.4	38.7	57.5	58.5	33.1	34.3	13.1	13.7	1:17.1	1:22.5	+1.0
Paediatrics	442	38.1	36.9	56.7	55.4	32.8	32.8	11.7	11.5	1:17.2	1:17.7	-1.3
Dentistry	450	35.1	34.0	54.6	54.2	34.6	35.3	12.9	13.6	1:12.0	1:26.5	-0.4
Average	—	35.3	34.6	54.2	53.2	33.8	32.1	14.1	13.8	1:16.3	1:24.9	-1.0
ENT	367	34.5	34.6	47.7	48.8	24.1	25.1	6.0	9.3	1:19.2	1:22.9	+1.1
Nuclear medicine	19	40.0	31.6	46.7	47.4	13.3	31.6	—	—	1:15.0	1: 9.5	+0.7
Radiology	757	30.3	29.6	45.5	45.0	26.4	27.1	11.2	10.4	1:20.8	1:29.1	-0.5
Orthopaedic surgery	694	30.3	29.4	44.2	42.8	24.4	23.5	8.8	7.1	1:18.9	1:24.8	-1.4
Ophthalmology	381	29.9	29.7	42.9	42.8	22.9	23.4	7.8	7.6	1:21.8	1:29.3	-0.1
Chest diseases	331	33.9	32.0	45.8	42.6	20.7	19.0	8.8	6.3	1:24.5	1:36.8	-3.2
Venereology	104	30.5	27.9	40.0	36.5	17.1	16.3	5.7	2.9	1:35.0	1:52.0	-3.5
Mental health	1461	26.1	24.9	38.1	36.1	20.5	19.3	8.5	8.1	1:23.8	1:36.5	-2.0
Rheumatology and rehabilitation	186	27.0	24.7	38.1	36.0	20.4	21.0	7.2	4.8	1:16.7	1:31.0	-2.1
Anaesthetics	1516	25.4	25.9	35.6	35.8	17.5	17.1	7.2	6.9	1:22.8	1:37.9	+0.2
Geriatrics	340	25.1	23.8	35.5	29.1	13.6	9.4	3.7	3.5	1:26.9	1:34.0	-6.4
Community medicine	606	11.5	12.5	19.6	20.4	13.5	13.3	7.2	6.8	1:11.0	1:37.9	+0.8
Postgraduate teaching hospitals (boards of governors)	572	63.2	59.9	119.2	114.7	93.1	91.3	48.9	47.9	No data	No data	-4.5
AHAs (T)	5076	45.6	44.0	79.1	76.4	57.1	54.9	26.5	25.4	1:13.8	1:18.6	-2.7
RHAs excluding AHAs (T)	7115	27.6	27.1	36.2	35.3	15.4	14.6	4.8	4.3	1:19.1	1:33.2	-0.9
Average of three high scoring regions	6377	37.4	36.4	60.4	58.6	39.4	38.2	18.2	17.2	No data	No data	-1.8
Average of three low scoring regions	2738	32.3	31.8	47.9	46.7	27.2	26.4	10.8	10.3	No data	No data	-1.2

*Some consultants have dual contracts or practise in more than one specialty. The total therefore differs from the sum of the parts.

of this work might bring in the shrewdest and least biased judges. We also think that women ought to be better represented and suspect that they are more numerous in the unsuccessful groups.

The quota system

As about half the current awards have been allocated during the past five years and the pattern of distribution has remained much the same, it is obvious just how strong is the unofficial and unequal system of quotas. We hear privately that there are unwritten rules that committee members appear unable to resist. Even the small changes we have noted seem to require enormous efforts to achieve. Thus Sir Stanley Clayton, chairman of the Distinction Awards Committee, has undertaken to "exert some pressure on behalf of anaesthetists and other 'deprived' groups *but it is bound to take time*" (our italics). But the number of new awards distributed at each round means that nearly all anomalies could and should be corrected within one or two years.

It has been pointed out to us that in the peripheral regions and in the low-scoring specialties the awards are already higher than true merit would warrant, and that unofficial quotas favour geriatricians, chest physicians, and others. It is said to be easy for a psychiatrist or an anaesthetist to shine in a dark sky, whereas physicians and surgeons have to compete against a uniform level of greater brilliance. Even so, anaesthetists and psychiatrists, for instance, are familiar with the difficulty of obtaining even a C award for colleagues of advancing years and considerable reputation. A bitter article by an anaesthetist⁷ shows clearly the effects of the system in polarising different groups of consultants into narrow interest groups that are not attractive.

On the other hand, we have already described how costly a luxury it might be if any group trusts, naively, that fairness and merit will be their own advocates, and does not devote some energy to working the system and promoting its own interests.

Many consultants, including most of those without awards,⁸ believe that allocation should not be secret. Secrecy adds to the difficulties of running a fair system, and, though it is not the

main cause of unfairness, it is a source of error and discontent that could easily be corrected. Perhaps local groups of consultants who wish to do so should make a start among themselves.

Conclusion

It is pointless to keep urging that the system should be scrapped. We are ensnared and the

TABLE II—Representation of specialties on distinction award advisory committees, 1976

Specialties in descending order of success	Number of consultants in specialty (total 13 078)	Number of committee seats held by specialty (total 473)*	Representation of specialty as percentage of "fair number" pro rata*
Thoracic surgery†	112	4	99
Neurosurgery†	82	6	202
Cardiology†	103	5	134
Neurology†	139	—	80
Plastic surgery†	80	2	69
General surgery†	1102	75	188
General medicine†	1261	91	200
Infectious diseases†	32	—	—
Dermatology†	191	14	202
Radiotherapy†	185	7	105
Neurological physiology	39	1	71
Obstetrics and gynaecology	682	30	122
Pathology	1416	38	74
Paediatrics†	442	25	156
Dentistry	450	8	49
Average	—	—	100
ENT†	367	14	105
Nuclear medicine	19	—	—
Radiology	757	31	113
Orthopaedic surgery†	694	21	84
Ophthalmology	381	9	65
Chest diseases†	331	3	25
Venereology†	104	—	—
Mental health	1461	29	55
Rheumatology and rehabilitation†	186	4	59
Anaesthetics	1516	38	69
Geriatrics†	340	10	81
Community medicine	606	4	18
Specialties banded under medicine	3129	156	138
Specialties banded under surgery	2437	122	138
Top seven specialties of table	2879	187	180
Bottom seven specialties of table	4544	88	54

*Six seats held by consultants with dual specialties are scored under the larger specialty.

†Specialties banded under surgery.

‡Specialties banded under medicine.

Hospital waiting lists

BMA's critical response

The BMA was quick to respond to the latest figures for hospital waiting lists announced by the Secretary of State on 7 February.

In a written answer in the House of Commons, Mr Ennals reported: "At 30 September 1977 the provisional figure for all specialties in England was 591 000, of which 40 000 were classified as urgent cases and 551 000 as non-urgent cases."

"Total numbers of people awaiting admission to hospitals have fluctuated around half a million practically since the inception of the NHS. During 1975 there was a marked increase, and in 1976 the total, although growing much more slowly, increased to a new peak of about 607 000 in December 1976. Early in 1977 they fell back again, and have remained at or below 595 000 for the three successive quarters of that year for which figures are available. The number of urgent cases has fluctuated between 37 000 and 40 000 since they were first recorded in September 1975, and the latest provisional figure is 40 000. This is disappointing; the number of urgent cases dropped in mid-1976 but unfortunately the improvement was not sustained."

"I am very concerned about these figures."

Although there has been a steady, if modest, increase in resources available to the NHS, much of this has had to be devoted to other aspects of the Service to which the Government attaches high priority, such as the services for the mentally ill, the elderly, and the handicapped, including care in the community. In response to a circular from my Department in 1975 commending good practices and asking health authorities to review the management of their waiting lists, a number of useful steps are being taken or considered locally. These included centralising and streamlining of admissions procedures, greater flexibility in use of hospital beds, use of day surgery and five-day wards for minor operations, and day facilities for investigations, regular dissemination of waiting list information to general practitioners. In addition, health authorities have included in their capital programmes for the current year projects designed to assist in reducing waiting lists to a total value of some £9½m, to be financed from within their cash limits. Reports from authorities and discussions I have had with RHA chairmen show that health authorities are doing a great deal to tackle what has proved for successive administrations an intractable

problem. I intend to pursue vigorously our joint efforts to improve the situation."

Chairman of Council's comment

Commenting on the figures Dr J C Cameron, BMA Council Chairman, said: "The sum total of human misery represented by these record figures for waiting lists over the past year is a scandal without parallel in any technically developed country. The Government's policy of robbing the acute services to improve the service for the mentally ill and geriatric (many of whom themselves need the acute services) must at least in part be to blame for the Government's inability significantly to reduce the length of waiting lists. Meanwhile there remain empty new hospitals and understaffed surgical departments."

"Mr Ennals has already admitted in a letter to the Secretary of the BMA (21 January, p 189) that health service resources 'do not meet all needs.' This latest statement is a further admission of the fact that the Health Service is hopelessly underfinanced. Doctors have been doing their best in impossible circumstances to keep the waiting lists down."

trap was too well baited with its seductive mixture of money and "merit." Realistically, we should like to call for the immediate reconstitution of the committees on a fair and worthy basis, instead of the present lopsided arrangements. Secrecy only aids a biased system that eventually damages all doctors. It is germane to consider whether some of the gravest deficiencies in medical education, the disastrous prescribing habits of British doctors, and the epidemic scale of admission for overdoses^{9,10} may all be linked with imbalance in the status and power attached to the fashionable specialties. This may be more important than the relatively trivial issue of greed in a tenacious priesthood. Meanwhile the system becomes a two-tier pension scheme (Cs for the average, Bs and As for their betters) for a profession whose members mostly seem to die young.

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Gold medallists

One criterion for the award of the Association's medal for distinguished merit is that the recipient "shall have conspicuously raised the character of the medical profession by scientific work." At its last meeting the BMA Council awarded the gold medal to Mr Denis Burkitt, CMG, DSC, MD, FRCSED, FRM (left), and to Sir John Charnley, CBE, DSC, FRCS, FRS.

In brief . . .

Medical students and the BMA

The BMA Council has approved in principle the extension of associate membership to all medical students. At present it is limited to those within three years of qualification. The benefits include free advice from the MIA, participation in various insurance schemes, the right to attend BMA division meetings, and—in the final year—receipt of the *BMJ* and *BMA News Review*. There are over 1000 associate members and 85% of them become full BMA members on qualification.

Workplace membership of BMA divisions

The BMA Council will recommend to the ARM that the place of work should normally be the deciding factor in determining which division a member belongs to. The Council decided that with the growing trade union activities of the Association, this was a logical arrangement. Any member who wishes to be reallocated should contact the secretary of the BMA's Organisation Committee.