TALKING POINT

Plight of medical assistants

SANJOY ROY-CHOWDHURY

The suspension in May of a consultant because of industrial action by trade union members (16 October, p 958) has highlighted the need for hospital doctors, particularly the permanent staff, to unite against an erosion of their dignity and professional standing. But medical assistants—the Cinderellas of the career grade—have been seething with discontent for a long time. Created as a result of the Platt Report,¹ they are a hybrid, with some of the responsibilities of consultants combined with the ill-defined status previously accorded to junior medical staff. Medical assistants received the final derisory seal of approval of their brotherhood of consultants when in 1970 their Review Body award was halved as senior medical staff in poor comparison to that granted to junior doctors. But few people objected to medical assistants being treated in this way.

Contradictions

To be fair to the DHSS it does not make bureaucratic distinction between consultants and medical assistants anyway. In the latest return of provisional statistics of all hospital medical staff² the category “consultants” is swollen by the inclusion of more than 1100 medical assistants. This casual lumping together of the two career grades is odd because of the contradictions in the professional life of medical assistants. This sub-consultant grade was created as an adjuvant to the consultants, with its incumbents supposed to work under the general direction of a consultant, though with no less independence—like an editor and his deputy. Yet it has not worked out that way. Most medical assistants work happily with independent responsibility and little supervision. Nevertheless, it is the few unhappy stories which have now made even the contented ones aware of the fragility of their professional tranquillity. Witness some of the comments I have received.

“I have 12 years’ experience in the specialty with an English postgraduate qualification. Still I am on first on-call on two nights a week.”

“We do not have a fixed rota, but nights on-call are fixed. I am asked to take over (in addition to my work) within minutes as soon as the doctor in charge thinks he has done enough for the day.”

“I do not have anybody to relieve me. During the absence of any of the consultants I am given his work but I am not excused from being first on-call at night.”

“I feel I am working as a SHO with much less money since the junior doctors’ pay agreement.”

Another says medical assistants “are not consulted in matters of policy and have no opportunity to exchange views and ideas with

their colleagues. On the contrary, this seems to be deliberately discouraged.”

Inadequate representation

And so they continue, the unhappy stories of qualified, experienced medical practitioners, who probably have already given the best years of their lives to the hospital service. Medical assistants are not primarily discontented about their pay—though it does compare unfavourably with that of the newly introduced hospital practitioner grade—but about the threat to their professional status. Consultants have always known their rights; junior doctors have recently asserted themselves and obtained what was always their due. Nevertheless, the DHSS circular on local advisory committees,³ which states that every doctor in the Health Service should participate in the medical advisory structure, seems to ignore most medical assistants. Those who have obtained representation have only done so after a struggle. The same weakness applies to the staff consultative machinery of the Whitley Council.⁴ Yet Whitley clearly spells out that staff should have greater participation and responsibility to improve their working conditions. When medical assistants complain about lack of representation some are labelled as “politically motivated,” or “trouble makers.” Administrators should take corrective action straight away.

Personal rank of consultant?

The ultimate fate of medical assistants—whose existence in the twilight area cannot be wished away—is directly related to the future smooth running of hospital medical care. But the relatively few doctors in this grade, whose contribution to the community has never been in doubt, will continue to present a perennial threat to the prosperity of the NHS so long as they are taken for granted as pairs of hands. A new, and long overdue, contract, now being discussed (p 183), will sort out many of the functional problems. Nevertheless, a real act of medical statesmanship will be needed to prevent a recurrence of the injustice inflicted on that previous subconsultant grade, the SHMOs, and the turmoil it caused to the career grades. It may require a radical revision of attitudes among those at the top of the professional hierarchy (the DHSS and the royal colleges among others) but ways and means should be found for long-serving medical assistants, after a suitable period of intensive training, to be granted the personal rank of a consultant in their own specialty.

Before the establishment throws up its arms in horror, fearing pollution by “ill-qualified, ill-trained, ill-experienced” medical untouchables, let me suggest a formula. There should

be a complete ban on new medical assistant appointments. Since there is no such thing as first- or second-class doctors, these long-serving doctors will have to be levelled up by adequate refresher courses before promotion is considered. That is one way of recognising their contribution to the NHS.

If a postgraduate qualification is necessary—and some medical assistants already have one—prolonged study leave ought to be allowed. Several consultant appointments, however, have been made recently in less popular specialties where the candidate did not have any postgraduate qualification.

An occasional ungracious comment is heard that medical assistants are free to apply in open competition with senior registrars for a consultant job. What is pointedly ignored is that the wretched medical assistant is already in the specialty with vast experience and seniority, and he has often been propping up an unattractive part of the NHS light years away from a teaching hospital ladder. The blue-eyed versatility and farm-fresh academic flavour of the university applicant is no longer available to him—it has faded while he has been keeping alive a section of the hospital service that would otherwise have collapsed.

Lastly, some medical assistants may not want such a change or are not keen to embark on a period of refresher training. A revised “no detriment” contract will remain for them as of right.

References

- ¹ Ministry of Health, *Medical Staffing Structure in the Hospital Service* (Platt Report). London, HMSO, 1961.
- ² DHSS, *Hospital Medical Staff in England and Wales*, national tables at September 1975. London, 1976.
- ³ DHSS, *NHS Reorganisation Circular HRC(74)9*. London, 1974.
- ⁴ Whitley Council, *General Council's Conditions of Service*, June 1975.

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New contract for medical assistants *contd.*

reimbursement of telephone rental and an appropriate percentage of the cost of calls.

Appeals machinery and no detriment

It will be up to each practitioner to negotiate his contract with the employing authority, but to deal with disputes, an appeals machinery will be established. At least one member of any appeals committee must be a practitioner (medical assistant).

The right to every practitioner who so desires to retain his existing contract must be preserved.