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Options for change in the NHS consultant contract

Robert W Clarke, Carl Gray

The lead negotiators for the management and consultant sides in an NHS trust in northern England responded to debate in their trust about consultant contracts by offering to research the attitudes of their peers towards a variety of contract options. The options tested included the current contract; models already examined in the trust and elsewhere, such as time sensitive and mild performance related contracts; and some more radical and speculative possibilities, including consultants franchising their services to the trust. Beyond the predictable conclusion that consultants would prefer no change while managers desired it, a time sensitive contract emerged as having potential for successful negotiation. On the other hand, neither consultants nor managers favoured a strict performance related contract or a fee for service contract. There was a strong similarity of opinion between the two groups on the relative salary values of the options, though the consultants consistently priced these higher than the managers.

Since 1948 change to the contractual relationship between consultants and their NHS employers has been slow, gradual, and carefully negotiated nationally. The relative autonomy of NHS trusts raises the real possibility of locally determined change to the established order. Typically trusts wish to forge closer links between consultant activity and business practice. The Review Body on Doctors' and Dentists' Remuneration substantially accepted government proposals to introduce local performance related pay for consultants.¹ Few trusts have so far introduced a new contractual package for their consultants, though new terms and conditions have been introduced for some new appointees.

Published reports on the link between motivation and reward of employees are unhelpful in that the benefits are unproved^{2,3}; while health economists recommend new reward systems based on methods of assessing doctors' work,⁴ others have expressed doubts about the applicability and benefits of such performance related pay systems for doctors.^{5,6} There has been no systematic attitude survey of consultants and managers on this subject.

In our trust there have been several initiatives to introduce variations to the established contract, including a performance related contract, which provoked controversy and resistance. We (the lead negotiators for the management (RWC) and staff sides

(CG)) proposed that we should anticipate negotiation by a research approach.

Our approach was to define 10 different model contracts, and to compare the opinions of consultants, board members, and senior managers by questionnaire. As well as the existing contract, options included some which were based on proposals already made within the trust, some which were based on initiatives elsewhere in the NHS, and others which were more radical and speculative.

Alternative models for the consultant contract

FEE FOR SERVICE

Origin—Piecemeal began in the earliest days of employment in England, before the industrial revolution. Fees for items of service provide some of the remuneration of general practitioners, and many services provided by doctors to other agencies are paid for by single fees. Private practice by consultants in Britain is usually based on fees for service.

Nature—Replacement of the consultant contract by a fee for service system presents no fundamental problems. A contract could be devised whereby the consultant is remunerated on the basis of individual items of service (clinics, operations, procedures, specimens, and other functions). The initial scale would price the current workload at the present basic salary; subsequent years' remuneration would then depend on the type and volume of work undertaken. The administration would resemble that of a private hospital, but increased staff would be needed to monitor and administer the system. Difficulties are inherent in pricing the tariff and controlling workload. Pricing needs to be fair and consistent, but different trusts would be free to set different prices, and the transitional arrangement would need to give doctors similar levels of total remuneration to their existing pay.

A realistic prospect?—Fee for service contracts work well in private practice and have succeeded in North America. Provided a trust had control of the flow of work, and clinical priorities were met, a consultant contract based on fees for service could succeed.

PERFORMANCE RELATED CONTRACTS

Origin—Payment titrated against measures of performance has long been tried in industry, but latterly has become less popular. The review body was persuaded of its merits by the government's

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submission in 1994 and recommended that performance related pay should be introduced as soon as possible, given that an adequate system was developed to meet its criteria.¹

Nature—Some or all of doctor's remuneration would be linked to measures of performance, which could be individual, or relate to teams, or to the whole organisation. Most imaginatively, pay could be linked to actual health outcomes. Meeting or exceeding targets would give the doctor the highest pay for the assessment period; whereas failure to meet targets results in reduced pay. The disadvantages have been well reviewed.⁵ The fundamental difficulties lie in setting realistic targets and measuring performance against them.

A realistic prospect?—This seems to be a likely option as an explicit government policy, despite concerted opposition by doctors' representatives. Strict and mild variants were considered in our questionnaire; the mild variant had been offered to a new appointee in our trust. The strict version provided for a modest basic salary (say £25 000) with a substantial supplement related to exceeding performance criteria agreed between the clinical director and the consultant. The mild version offered a normal basic salary (£45 000) plus a supplement based on achieving or exceeding new business or income generation targets agreed between the clinical director and the consultant.

BUSINESS DRIVEN CONTRACTS

Origin—We devised this type of contract as a model for consideration. The senior managers of trusts are anxious to match the expenditure on clinical activity with the contractual income available from purchasers to pay for it.

Nature—A business related contract would explicitly link doctors' pay to the trust's contractual income. A basic salary would be paid for achieving basic contractual targets and additional financial incentives would be paid for accepting income generating work, for example, extracontractual referrals, and achieving improvements in the costs of providing treatment, through "efficiency," new working practices, or rationalisation. The contract would facilitate increased contract awareness, with the highest reward achieved by meeting targets and encouraging efficiency and adaptation to new ways of working. Professional judgment would be shared with clinical directors and the business director on type and volume of work issues.

A realistic prospect?—This option is entirely speculative.

CALMAN TYPE NEW CONTRACTS

Origin—The Calman report set out the conclusions of the government's Chief Medical Officer and his committee on reform of the training and accreditation of specialists in the National Health Service.⁷ The new specialist would have a shorter defined training period of five years, after which specialist accreditation would be granted. The nature of the training would be improved. Many royal colleges are currently adapting their training programmes, examinations, and qualifications to the new policy.

Nature—The new "specialists" are intended to be available for unsupervised independent practice at a younger age than present consultants and are expected to undertake more direct patient care and a continuing role in out of hours and emergency patient care, for which fewer junior doctors will be available. Contracts for such "new style" consultants (or Calman specialists) are likely to change from the present, as the doctors will be appointed younger and will work longer hours. The number of such doctors is likely to increase progressively. As the government has stated that no

new money will be provided, individual remuneration is likely to be less than present.

A realistic prospect?—This policy is already being implemented, and a generation of trainees has embarked upon Calman type training in various specialties. The emergence of Calman specialists is inexorable. Their contractual arrangements are the subject of much speculation.

ENHANCED PROFESSIONAL CONTRACTS

Origin—We devised this type of contract as a counterbalance to the business driven contract model.

Nature—This model emphasises the professional autonomy of the present consultant contract by exaggerating the professional and beneficial aspects and excluding managerial linkage. Doctors are not evaluated in relation to contractual targets or performance in business terms but retain a professional contract without time limits. A professional appraisal system is developed focused on clinical audit and continuing medical education. Doctors are reinforced as the guardians of clinical quality. Additional pay and bonuses would reward activity that increased the income of the trust by various means. Early retirement is encouraged. The 10% rule for private practice in whole time contracts is abolished; 7 days' longer holiday is awarded; there are additional increments on starting; and all other terms and conditions are retained.

FIXED TERM CONTRACTS

Origin—Fixed term or rolling contracts are common in industry and science. These have been introduced by some trusts already.

Nature—Doctors would be employed on fixed term contracts, expiring after a defined period such as three or five years. The rolling variant includes an annual review of performance with renewal for the defined period. For the doctor there is insecurity; for the employer there is the ability to remove unwanted staff without the expense of redundancy and increased flexibility in employing senior doctors.

A realistic prospect?—Such contracts already exist in the NHS for senior managers, and some consultants.

TIME SENSITIVE CONTRACTS

Origin—The present consultant contract is notionally time based, with assessment in sessions but flexibly worked. West Dorset Trust has negotiated but not yet implemented a more explicitly time based contract. Furthermore, the European Commission wishes to place upper limits on employees' working hours generally.

Nature—The contract specifies 10 core sessions (35 hours) that include seven fixed clinical sessions and three flexible professional sessions. There is a fixed upper limit on contracted hours of 45 hours, 30 minutes (13 sessions). Other benefits include unlimited private practice for all without financial penalty; a single point salary scale; periodic additional attainment awards integrated with national distinction awards; and the involvement of each consultant in an annual performance review with his or her clinical director, ratified by the medical director and chief executive.

A realistic prospect?—Such a contract was negotiated in one NHS trust.

FRANCHISES

Origin—Franchises are common in commerce, such as restaurant chains, and in medical practice in the United States. Similar group practice is usual in general practice for doctors and dentists and in solicitors' and accountants' firms in Britain.

Nature—A group of doctors agree a franchising

Contract	Ranking		Salary expectations (£)	
	Consultants	Managers	Consultants	Managers
Present contract	1	5	61 300 (22 220)	52 310 (4 210)
Time sensitive	2	2	70 870 (18 200)	65 420 (8 530)
Enhanced professional	3	10	72 200 (19 080)	57 000 (4 580)
Calman inspired	4	4	86 320 (30 390)	74 620 (26 420)
Performance related (mild)	5	1	74 030 (21 720)	70 000 (26 200)
Business driven	=6	3	85 680 (24 590)	69 090 (12 030)
Rolling fixed term	=6	9	157 690 (74 930)	92 730 (30 330)
Franchising	=6	8	150 000 (66 570)	85 560 (29 010)
Fee for service	9	6	102 500 (32 500)	72 500 (15 210)
Performance related (strict)	10	7	96 360 (30 460)	75 000 (15 810)

contract to provide a defined service. A single annual sum pays for all their costs. The partners have discretion to allocate funds as they wish and to decide numbers and pay of medical staff. The contract is periodically renegotiated.

A realistic prospect?—This is a realistic prospect which works well for doctors in the United States and other professions in Britain. It has been advocated by some doctors' representatives.

Methods and results of the survey

The questionnaire was sent to all 50 consultants working in Harrogate NHS Trust and to 19 senior managers (including all members of the trust board) in July-October 1993. Thirty three consultants (66%) and 15 managers (79%) returned the questionnaire. The strongest response was that consultants generally were resistant to any change. Both groups clearly rejected four options as less desirable than the present contract: fee for service, strict performance related, rolling fixed term, and franchising (see table). Within the top five for both groups were the present contract and the mild performance related, the Calman inspired, and the time sensitive models. The models that showed the most divergence were the enhanced professional model (ranked highly by consultants) and the business driven model (ranked highly by the managers). Our overall conclusion was that of the options for change the time sensitive model showed the greatest likelihood of successful negotiation.

Another part of the questionnaire sought to gain an impression of what the consultants would expect to be paid for each option and what the managers would

expect to have to pay. There was close correlation between the two groups' perceptions of the relative values of each option with the present contract costing the least and the franchising contract the most. The consultants' aspirations consistently outstripped the expectations of their paymasters (see table).

Discussion

As a research study confined to one NHS trust the general applicability of our findings is limited. Our overall result was predictable, portraying consultants as conservative and resistant to change and managers as adventurous and seeking to control doctors.

Nevertheless, as well as providing an invaluable basis for local negotiation in one trust, the results may be of wider general interest in stimulating debate. The options which were generated ranged across the possible forms which future change might take, and the survey gave broad indications of the initial stances of the two parties to local negotiation. There does seem to be scope for successful negotiation. This is best summarised as a compromise between greater time sensitivity and preserved clinical autonomy on the one hand and enhanced performance review and some linkage of pay to performance on the other. The numerous NHS trusts and their doctors will soon be confronting these issues in local negotiation.

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A MEMORABLE PATIENT

Telling the truth

When I started my medical training in internal medicine in the late 'sixties I was taught that a doctor should never tell his patients that they were suffering from a fatal disease. When a malignant disease was diagnosed we used terms such as chronic infection and said that the particular condition was difficult to treat.

Now, 30 years later, it is hard to imagine that doctors did not tell their patients the truth as best they could. We were all convinced that a patient could not tolerate the idea of imminent death and that it was our duty to protect them. In my early training days I still vividly remember a woman in her mid 50s who was suffering from metastases of breast carcinoma. I told her that she had a chronic infectious condition and that we would try to treat her. When she asked me if the condition was related to her previous breast cancer I denied the possibility. At the time I had had about half a year of training in internal medicine and I felt increasingly uncomfortable in these situations. I thought that we were wrong, and with this particular woman I found it more and more difficult to talk to her

and to look her in the eye. I noticed that my visits to her became shorter. This was a desperate situation because she was deteriorating and I felt more and more guilty.

One morning, at my regular visit, when I hardly dared to look at her, she said: "Doctor, why don't you sit for a few minutes at my bedside." I hesitatingly did so. Although she was very ill, she had vivid bright eyes that looked straight at me. She said: "You need not feel guilty that you did not talk to me about my disease. I know that I am dying of breast cancer and I have accepted this, so please don't be sad." I realised in a flash that by denying the true position to this patient I had isolated her more and more instead of standing close to her.

Since then my attitude has changed. I realised that it was not only the right of patients to know their condition, but that by denying the situation you could not help or comfort them in their last and often difficult period of life.—GEORGE HENNEMANN is a professor of medicine in Rotterdam