Interest in stress has broadened as organisations have finally accepted that stress costs them vast amounts of money—through absence, litigation, and the fact that unhappy, tense, tired, or anxious doctors do not produce quality care.[3] Indeed, stressed doctors may make considerably more errors than those whose sense of well being is high.[4] This is particularly true if they have insufficient hours of sleep;[5] however, we now know that working long hours in itself is not the cause of problems provided a doctor feels well supported. Stress and all its related problems come both from the workplace and from the individual. Individual causes may be to do with personality or with ways of thinking, such as being particularly self critical, or having certain types of unsupportive early family relationships; or they may come from job related factors such as lack of sleep, poor communication, and poor teamwork.[3] Better teams have less stressed staff,[6] probably because they support each other, notice when one person is performing below par, and step in to help.

Making mistakes is a major stressor—not a new one, but one which is escalating alongside the price of error and the raucous publicity that surrounds it. The misery that can follow, unless such errors are turned into genuine learning opportunities, can stay with doctors throughout their lives.[7] Handling error sensibly and sensitively for patients and doctors alike has become a critical requirement of management.

So what is being done to lower the stress levels of our medical staff and thus raise the well being of their colleagues and their patients? What is now being done that was not done 20 years ago when stress was a forbidden word? Well, soon after the first reports of high levels of stress and depression in doctors became apparent, the National Sick Doctors scheme began, the BMA set up a telephone helpline, and most regions began to provide a free counselling or psychotherapy service for doctors. Initiatives from the Department of Health come and go. Hours have reduced and sleep patterns improved, largely due to pressure from Europe. However, I am not aware that a truly proactive means of attending to the health of NHS staff, including doctors, has been planned.

What we need is a systematic approach to the problem.[3] We need to accept (rather than constantly rediscovering) that we know enough about the main causes of high stress levels in doctors to address the principal organisational stressors using primary preventive interventions. Providing teamwork and leadership training to clinicians would be an excellent beginning, and making quite simple changes to the way work is organised—such as having a 12 month house officer rotation in one hospital rather than two—appears to affect stress levels dramatically.[8]

There can be primary prevention for individuals too through training, career counselling, and educating about error. When these strategies are not enough, there need to be secondary services providing coaching, counselling and psychotherapy, or alcohol and drug treatment that are available rapidly for staff, showing the acceptance that things do go wrong for most people at some time or other.

Stress is here to stay and the sooner we accept that tackling it is a normal part of management, and an essential part of patient safety, the sooner the lives of doctors and their patients will improve.

Jenny Firth-Cozens *special adviser on modernisation of postgraduate education*

London Deanery, London WC1E 7HX
(jfirth-cozens@londondeanery.ac.uk)

Competing interests: JFC provided expert opinion in some legal cases where the plaintiff sued for damages caused by work stress.

1 Firth-Cozens J. The psychological problems of doctors. In: Firth-Cozens J, Payne R. *Stress in health professionals: psychological and organizational causes and interventions*. London: Wiley, 1999.
2 Wall TD, Bolden RI, Borrill CS, Carter AJ, Golya DA, Hardy GE, et al. Minor psychiatric disorders in NHS trust staff: occupational and gender differences. *Br J Psychiatry* 1997;171:519-23.
3 Firth-Cozens J. Interventions to improve physicians' wellbeing and patient care. *Soc Sci Med* 2001;52:215-22.
4 Jones JW, Barge, BN, Steffy BD, Fay LM, Kunz LK, et al. Stress and medical malpractice: Organizational risk assessment and intervention. *J Applied Psychol* 1988;4:727-35.
5 Weinger MB, Ebden P. Sleep deprivation and clinical performance. *JAMA* 2002;287: 955-8.
6 Carter AJ, West MA. Sharing the burden: team work in health care settings. In: Firth-Cozens J, Payne R. *Stress in health professionals: psychological and organizational causes and interventions*. London: Wiley, 1999.
7 Mizrahi, T. Managing medical mistakes: ideology, insularity and accountability among internists in training. *Soc Sci Med* 1984:19;135-46.
8 Firth-Cozens J, Moss F, Rayner C, Paice E. The effect of one-year rotations on stress in preregistration house officers. *Hosp Med* 2000;61:859-60.

Ethnic and sex bias in discretionary awards

Eliminating bias is part of modernising any new consultants' contract

See Papers p 687

George Bernard Shaw, in his preface to *The Doctor's Dilemma*, summarised his conclusions as follows: "Nothing is more dangerous than a poor doctor." His solutions included making doctors into "civil servants with a dignified wage paid out of public funds" and "municipalise Harley St."[1] Shaw's reaction to the NHS, which arguably made hospital doctors into civil servants, is not recorded. Although he was aged 92 in 1948, he would probably have pointed to the implications of failing to municipalise Harley St.

The United Kingdom is unusual in the extent to which the state employs hospital consultants in state owned hospitals. International trends towards greater autonomy for local organisations have been partly reflected in the United Kingdom with the development of NHS hospital trusts from 1991 and, more recently, the plans for foundation hospitals.

Any economist reviewing how hospital doctors in the United Kingdom are paid would be struck by the following. Firstly, NHS national pay scales, which have survived the shift of consultants' contracts from regions to hospital trusts, make up 71% of consultants' income (table). These pay scales take no account of performance, let alone regional differences in the

BMJ 2003;326:671–2

costof living, nor of the costs of qualifying and remaining up to date, which plausibly vary by specialty. Secondly, around half of all consultants hold NHS discretionary awards, which vary by specialty, sex, and ethnicity and account for some 6% of consultants' total income. Thirdly, private practice, which varies by specialty, sex and ethnicity, accounts for 23% of consultants' income. Fourthly, NHS salaries qualify for generous pensions based on final salaries—which are boosted by the additional NHS awards.

To get the NHS to deliver services more predictably, changing the way in which consultants are paid has become a priority. According to the *NHS Plan*, "the current consultants' contract is far from satisfactory. Too few have proper job plans setting out their key objectives, tasks, and responsibilities and when they are expected to carry out their duties."[2]

Or, taking a much cited analogy: "No normal company would contemplate it. Take your most highly skilled and talented staff … Give them a job for life, an index linked pension, and six weeks' paid holiday. Then let them go and work for the opposition—not just out of hours but during the normal working week. It sounds crazy. Yet that is more or less exactly how the NHS consultants' contract works."[3]

What of discrimination in NHS discretionary awards? For the first half century of the NHS, consultants controlled the distribution of distinction and merit awards. This provided incentives to performance as judged by peers, at a time when few other criteria existed. It also encouraged doctors to commit to the NHS and academic medicine. But as doctors became more heterogeneous in terms of ethnicity and sex and as their performance became more measurable, the entire system has come to seem archaic. The awards have been renamed (currently distinction awards and discretionary points) and reformed to take the views of hospital managers into account.

The process of unmasking how these awards are allocated has been causing some amusement to outsiders. Attention has long ago been drawn to differences by specialty.[4] From being top secret, the names of award holders are now available on the internet. Over the past decade, disparities by ethnicity have been highlighted, mainly by Esmail, who as a general practitioner does not qualify for one of these awards, and his coauthors. They have highlighted disparities by ethnicity in admissions to medical school,[5] then distinction awards,[6] and now discretionary points.[7]

What of their recent findings? More white consultants get discretionary points than those from other ethnic groups (56% *v* 41%) and more male ones than female ones (55% *v* 44%). The authors claim that discrimination cannot be excluded as a factor accounting for these differences, and that continuation of the scheme is difficult to justify. Both being non-white and being female are associated with lower chances of getting an award. Where possible, the authors have allowed for age, type of hospital, and specialty, showing that these make little difference.

Two caveats apply. Firstly, any discrimination by ethnicity applies less to entry than to progress in the medical profession. The NHS employs a disproportionate share of non-white (if not female) consultants. Secondly, the degree to which consultants' choice affects their career progress is unknown. Choices of specialty, between NHS and private work, and between work and leisure, all reflect preferences and constraints. Constraints may be fair or otherwise, but career paths reflect individual choices to some extent. Attempts by the advisory committee on distinction awards to identify potential candidates from female and non-white consultants have had little success.[8]

This time the government has been listening. Having accepted that "institutional racism" exists in many public sector bodies including the police and the NHS it sees disparities in distinction awards as inbuilt biases against particular groups and specialties.[9] The government has committed itself to sweeping away bias and outmoded working practices as part of modernising the NHS. In return for record increases in NHS funding, national performance targets to do with waiting times and standards will have to be met.

A new employment contract for hospital consultants is part of the modernisation programme. A recently proposed contract would have required NHS consultants to commit to the NHS, restrict private work, and be paid according to their performance, via a unified discretionary awards scheme. After its overwhelming rejection by consultants in England and Wales its future is unclear. What is clear is that if other elements of the modernisation strategy are to succeed, particularly greater autonomy for the best performing hospitals in the form of foundation status, then contracts that reflect the commitment of consultants to the hospital that employs them seem essential.

Failure to modernise the NHS, claim its advocates, could lead to much more radical reforms, including a greater role for private hospitals. Either way, distinction awards and discretionary points, along with national pay scales, all of which can be seen as part of the civil service, seem unlikely to survive much longer.

Estimated total income of consultants, 1999

	£ million (%)
NHS gross pay	1877 (71)
NHS awards	169 (6)
Private earnings	601 (23)
Total	2647 (100)

Author's estimates, based on references 3 and 9.

James Raftery *director*

Health Economics Facility, Health Services Management Centre, Birmingham B15 2RT (j.p.raftery@bham.ac.uk)

Competing interests: None declared.

1 Shaw B. *The doctor's dilemma*. London: Penguin, 1946. (Preface.)
2 Department of Health. *The NHS Plan*. London: Department of Health, 2000. www.nhs.uk/nationalplan/ (accessed 19 Nov 2002).
3 Examination of witnesses (questions 156-179). *House of Commons Official Report (Hansard)* 2000 Jun 22. www.parliament.the-stationery-office.co.uk/pa/cm199900/cmselect/cmhealth/586/0062205.htm (accessed 2 Nov 2002).
4 Bruggen P, Bourne S. The distinction awards system in England and Wales 1980. *BMJ* 1982;284:1577-80.
5 Esmail A, Nelson P Primarolo D, Toma T. Acceptance into medical school and racial discrimination. *BMJ* 1995;310:501-2.
6 Esmail A, 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.
7 Esmail A, Abel P, Everington S. Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women. *BMJ* 2003;326:687-8.
8 Department of Health. Advisory Committee on Distinction Awards. *Annual report 2002*. London: DoH, 2002:3.
9 Department of Health. *New award scheme—rewarding commitment and excellence in the NHS*. London: DoH, 2002.