THE ARMED FORCES AS A CAREER FOR DOCTORS

BY
Lieut.-Colonel E. A. SMYTH, M.B., M.Ch.Orth., F.R.C.S.I.
Royal Army Medical Corps

Colonel R. H. Robinson in his article "Future Medical Officers for the Army" in the R.A.M.C. Journal of February 1951 has ably discussed the disadvantages of a Service life. In his later articles, March, April and May, in the same journal, he makes suggestions to counter these factors. His suggestions are roughly:

1) Special conditions for doctors compared with other Army Officers.
2) Propaganda as an aid to recruitment.
3) An Army Medical School.

I will commence this article by discussing these three suggestions.

1) Special Conditions for Doctors Compared with Other Army Officers
   (Apart from the Slightly Higher Rates of Pay Per Rank as at Present).

I feel sure this could never be accepted by the Heads of any of the three Services. If forced eventually, by an acute doctor shortage, to take drastic action, the Admiralty, War Office and Air Ministry would be much more likely to adopt the French system of training doctors at Government expense at existing medical schools. They would then have full control of these doctors, and the conditions of service would be identical with those of combatant officers. This would probably reduce the whole status of Services doctors compared with the rest of the profession, and might result in a comparative lowering of medical standards.

There is another method which could be adopted that would avoid the necessity of special conditions for doctors while working alongside their combatant colleagues. This would be to offer a guarantee, in at least some specialties, of a voluntary transfer to the National Health Service after approximately twenty years' service, and, where not possible, the new terminal gratuity to be increased to £2,000, plus a further increase in pension.

The possibility of transferring to civil medicine was one of the great attractions of the Indian Medical Service.

Special conditions on retirement would be a reasonable means of compensating doctors for (i) their initial expensive medical education and (ii) reduced facilities for increasing professional skill compared with those obtainable in civilian practice.

It should not be forgotten that in the past R.A.M.C. doctors had certain
pension advantages compared with other officers. These advantages have disappeared in all post-war pension schemes to such an extent that today combatant officers can reach the maximum pension of their rank at an earlier age than medical officers. In addition combatant officers are now, on the average, reaching the rank of Brigadier and above younger than doctors. Since the introduction of the National Health Service the chances of retired Service doctors obtaining employment are possibly no better than in the case of other officers.

As regards the purely pension element of retirement, the medical branches should lower the qualifying age for obtaining the maximum pension of a Lieutenant-Colonel from 55 to 50. This would enable an officer wishing to retire to civilian life at 45 (with not less than twenty years' service) to obtain a pension of £527 instead of £437 as under the most recent regulations. In the case of the ranks above Lieutenant-Colonel, two years in the substantive rank should be sufficient to qualify for maximum pension of that rank (irrespective of maximum further tenure in the rank allowed). It is worth remembering that the pre-1939 Indian Medical Service pension amounted to not less than £500 per annum for the doctor who retired on completion of twenty years.

(2) Propaganda

Immediately pre-1939 many accepted short-service Commissions with a view to becoming Regulars. Most of these doctors had very little knowledge of conditions in the Forces. They were attracted by the widely advertised opportunities for specialization and the good gratuities. They knew that if they found the life unsuitable they could resign and purchase a practice. Nowadays, any doctor who accepts a short-service Commission is liable to find difficulty in leaving the Forces and his liability to recall has become a very real thing. Gratuities are now less than half their pre-war value in purchasing power and general practice can now no longer be entered by purchase or any other easy way.

Doctors nowadays, as a result of National Service experience, say they are unwilling to consider the Forces as a career because:

(1) It does not offer a reasonable certainty of continuous and adequate professional work.
(2) They are not prepared to accept a life so full of domestic uncertainties without a prospect of more settled conditions eventually.
(3) They consider that greater financial and professional rewards can be obtained in the National Health Service at home, and the Colonial and other Services abroad.

Service life is of such a nature that it will never be popular with doctors unless it can provide the possibility of transfer to a more fixed abode for those who may find it inconsistent with professional or family life.

If propaganda is to be of any value it must be aimed at this factor by offering guaranteed transfers to the National Health Service, or very large
pensions and gratuities in lieu. The doctor who may wish to return to civilian life in his forties must be catered for adequately. It is neither good for recruitment nor for efficiency to force some unwilling Regulars to continue to the age limit for purely financial reasons.

(3) An Army Medical School

This suggestion of Colonel Robinson's is most interesting. There is the danger that such a school might become a State institution for the production of "cheap doctors" at Government expense, and consequently its graduates completely divorced from those of other medical schools. On the other hand it could produce doctors with a good background of military training and professionally more interested in Preventive than Curative medicine. They would therefore adapt themselves more happily to a Service career.

The most valuable type of doctor to the Forces would be one who has been trained roughly as follows:

1. About a year in a purely military capacity.
2. A few years of a "roving commission" in as many junior posts as possible, such as Regimental Medical Officer, Ships Surgeon, R.A.F. Station M.O., Field Hygiene Section, Field Ambulance, D.A.D.M.S., etc.
3. A total of about two or three years in large Service hospitals, allowing sufficient time for an apprenticeship of some months in all the specialist and administrative departments.
4. Some experience under the direction of a specialist in Preventive medicine.

He would now have an ideal background for administrative work in peace and war. Some would still prove unsuitable for high administrative posts, but no more so than at present, and at least they would have the advantage of a much wider experience than is usual.

Specialization in curative medicine nowadays (and more so in the future) does not "fit in" with what is required of the Regular, because curative work requires full-time devotion for life to a particular branch of medicine. The curative specialist of the future will have little or no experience of conditions outside his own speciality. The time is at hand therefore when the Forces must make the choice between:

1. Maintaining the present system under which they attempt to train and maintain specialists without
   a) providing adequate clinical work of a specialist nature,
   b) any reasonable assurance to specialists of being able to devote themselves whole-heartedly to their work. At present specialists are constantly aware that in time of war they will be forced into administrative work and that even in peacetime they can be transferred without warning to other work. As they become more senior the advisability of a voluntary change to administrative work must be constantly in their minds. Therefore the present system is unsuitable from both the Professional and the
Administrative sides. Personally, I have reached the stage when I am uncertain whether my periodic nightly studies should be concentrated on my speciality or training manuals and recent A.C.I.s. Yet a high standard of work is expected by the combatant branches and, in fact, the prestige of the Medical Services largely depends on the work of its specialists.

(2) Stopping all specialization in curative branches and gradually replacing Regular specialists by civilians—possibly seconded in some way from the National Health Service:

(3) The third alternative is vastly to increase the scope of hospital work by admitting a percentage of civilian patients in peacetime, and perhaps, in addition, founding a medical school on the lines suggested by Colonel Robinson. A number of highly experienced Regular specialists could then be created and given a full career in their particular specialities. In time of war they would be most useful as administrators in their own branches. They would have facilities to bring perhaps fame to Service medicine.

The reputation of professional work greatly influences both the quantity and quality of prospective candidates for Regular commissions in all branches.

I suggested in a previous article, published in the British Medical Journal October 1, 1949, that all Service Medical Officers should commence their careers as General Duties Officers. Following an apprenticeship to as many different departments of the Forces as possible, they should commence a schedule of training leading eventually to a division of all Regulars into one of the following three classes:

(1) Future General Administrators.
(2) Future Specialists in Preventive Medicine and Administration.
(3) Future Specialists in Curative Branches only.

The rapidly changing picture of Modern Medicine makes it impossible to continue the old rule that "ALL Medical Officers will be available for ALL duties in their Medical Service."

I will complete this article by describing the advice I would give to a young doctor who might happen to consult me regarding the pros and cons of a career in the R.A.M.C. I will discuss the question under the following headings:

FINANCIAL

I agree with Colonel Robinson that civilian practice will, in the long run, pay him better; although the most recent increases in pay and pension, and the introduction of a terminal gratuity, have considerably reduced the gap. Nevertheless I believe that some private capital is still necessary in the Army, otherwise the married officer will find difficulty in ever owning such material things as a new motor car and a properly furnished house.
Frequent changes of station and accommodation must be accepted. These are usually much enjoyed by the young single officer, but naturally lead to separations of varying periods and frequency when married. For the married officer these changes entail expenses in clothes, furniture, hotels, taxis, tips, etc., which are inadequately covered by allowances. The lack of a fixed home, where one can accumulate and maintain personal possessions, is always a great nuisance. Speaking personally, the high cost of holidays has always been one of my difficulties while on foreign service. In the United Kingdom distances are short and much time is often spent with parents and relatives.

The loss of India has changed the whole feature of overseas service. India offered a large selection of excellent stations, high Indian Army rates of pay, subject only to local income tax, and locally-qualified Assistant Surgeons relieved R.A.M.C. officers of much of the drudgery of inoculations, form-filling, and the disposal of minor medical conditions. In a few stations there was time and scope for some private practice.

Nevertheless, although foreign service is "not what it was," it still offers the warm friendliness that always exists between Servicemen and their families, and more time and opportunity for sport and leisure than in civilian practice at home.

**Education of a Family**

The difficulties are enormous, as described by Colonel Robinson in his article on page 133 of the *Journal of the Royal Army Medical Corps*, February 1951.

**Discipline**

I would again refer to Colonel Robinson’s excellent presentation of this feature (same page of the Journal).

**Professional**

Preventive Medicine in the Army offers a stimulating and fruitful career. I would advise a young doctor, keen on this branch, to choose the Army. Not only are there excellent chances for practical experience, but the work is so closely linked with the Administrative Departments that the chances of reaching the highest ranks are excellent.

**Specialization in the Curative Branches**

I would advise against specialization in Surgery, especially General Surgery. It is not a good career in the R.A.M.C., in spite of the fact that in overseas stations General Surgeons are perhaps the most essential of all the specialists, or at least the effects of their absence are the most dramatic.

Specialization in any branch of Surgery—particularly General Surgery—has the following disadvantages:

1. The qualifications and training take longer, and are perhaps the most difficult.
(2) The chances of promotion to the highest ranks are comparatively poor—even the War Office Director of all Surgery in the Army nearly always holds a lower rank than a Deputy Director of Medical Services of a Home Command. The surgeon is naturally at a disadvantage on the administrative ladder compared with those who have spent most of their service in this branch, or even compared with those who have been in less exacting curative specialities.

(3) The chances of employment of ex-Surgical Specialists in civilian practice appear poorer than in the case of Specialists in Medicine, Pathology, Anaesthetics, Dermatology, or Army Health.

(4) Leisure is more interrupted than in any other branch of the R.A.M.C.

(5) Unlike the Medical Specialist, experience in tropical countries is of little or no professional value.

(6) Army Consultant Surgeons—owing to insufficient operative work—lose professional skill much more rapidly than in the case of Consultants in other lines.

Medicine, unlike Surgery, is a reasonably good speciality to select in the Army. The lack of clinical experience compared with civilian life is partially compensated by experience gained in tropical medicine. Also a physician lives a calmer and less worrying life than a surgeon.

Pathology is a much privileged speciality in the Army and offers good experience in Bacteriology and Tropical Pathology. Pathologists have been on the whole remarkably successful in reaching the highest administrative ranks.

Psychiatry is at present generously treated as regards the rank element, and allows opportunity for gaining a wide general knowledge of Army life.

The chances of a successful career for those who do not wish to specialize are excellent, but personally I believe the combination of Administrative experience, plus a speciality in Army Health, is likely to give the most satisfying and successful career obtainable in the R.A.M.C.
The Armed Forces as a Career for Doctors

E. A. Smyth

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