TALKING POINT

Remuneration of clinical academic staff

ROBERT LOWE

The salaries of medically and dentally qualified staff in universities and research institutions are determined by different procedures from those in the National Health Service. About 3000 doctors and dentists are concerned and proper provision for them is an important matter for the whole profession.

For 20 years after the creation of the NHS clinical professors were the only university staff who were as well paid as consultants in the Health Service. Other staff received salaries which were higher than those of preclinical university staff, but lower than those of their counterparts in the NHS. Nevertheless, changes in the remuneration of university clinical staff were linked to and followed similar changes in the Health Service. The Medical Research Council followed the universities' example.

In 1967 a pay freeze was introduced soon after a settlement had been reached for NHS doctors and dentists, but before the universities and MRC had made a corresponding settlement. This resulted in a wide disparity between the earnings of NHS staff and their university counterparts and aroused great unrest among university clinical staff. The unrest led them to establish their own professional association, the Association of University Clinical Academic Staff (AUCAS). AUCAS had two advantages over the BMA. It soon won the confidence of the staff it represented and it was unhampered by the need to take into account the views of pre-clinical staff. By contrast, the BMA had never won the confidence of university staff and, despite its size and resources, did not have a committee structure which was appropriate to representing them. The Full-time Medical Teachers and Research Workers Committee (FTMT&RWC) had one representative from each region (not from each medical school), who was often remote from and unknown to members of his electorate and who was answerable to both clinical and preclinical staff.

Influence of AUCAS

The intervention of AUCAS as an independent professional association gave an impetus to improving the remuneration of university clinical staff. It gave persuasive and convincing evidence to the newly-created Prices and Incomes Board, stressing the similarity of work of university clinical staff and their NHS counterparts in teaching hospitals, and stressing also the inseparability of teaching from the clinical aspect and from clinical responsibility. AUCAS requested parity of remuneration between the two groups and the BMA and BDA followed suit. The subsequent judgment of the Prices and Incomes Board (supported also by the Royal Commission on Medical Education) established the principle of parity of remunera-

tion, which was accepted by the Government and implemented for the next six years. Each year, following the Review Body's report recommending changes of NHS salary scales, the UGC approved identical changes in university clinical scales, operative from the same date.

The last three years, however, have brought new stresses and strains to the practical achievement of parity of remuneration between NHS and university clinical staff. Though the basic salaries of NHS consultants and university honorary consultants have remained identical, and those of junior staff broadly comparable, fringe benefits are much more favourable for NHS staff. Generous removal expenses, interest-free home loans, grants towards study leave, payments for domiciliary visits, and several other items all increase the effective financial rewards of NHS posts. The introduction of extra-duty allowances (EDAs) and of payments for units of medical time (UMTs) caused difficulties for universities and the MRC, because they represented a pattern of remuneration which was incompatible with the traditions of university and research appointments. A prolonged period of difficult and frustrating consultations took place in a specially created clinical academic salaries consultative group (CASCg) before the UMT system was introduced in universities. The difficulties of these negotiations convinced those who were party to them that the forum for the discussions was quite inadequate for the future demands which would be placed on it.

The CASCg had an imaginative composition. It was chaired by the UGC and included representatives of the staff side and of the employers. It also included representatives of the Department of Education and Science, which would be responsible for providing the funds to meet any settlement that was reached, and representatives of the DHSS, which had been party to the introduction of EDAs and UMTs. The CASCg, therefore, included representatives of the UGC, Committee of Vice-chancellors and Principals (CVCP), MRC, DHSS, DES, BMA, BDA, AUCAS, and the Association of University Teachers (AUT). Its weaknesses were that the staff side was divided and that it was a consultative rather than a negotiating committee. As a result the DES representatives arrived without plenipotentiary powers and the final decision was made by those who were not party to the discussions and who did not always make clear to the CASCg the constraints within which any settlement must operate.

Birth of MASC

The staff side have now moved a long way towards presenting a united view point. The BMA has agreed to disband the FTMT&RWC

and replace it by a new Medical Academic Staff Committee (MASC), which is modelled closely on the AUCAS pattern of organisation and which gives negotiating rights to separate preclinical and clinical subcommittees. AUCAS has agreed to disband and its members will now be represented by MASC and its clinical subcommittee. The traditional close liaison between the BMA and BDA should ensure a common policy. The only remaining bar to unity is the AUT with its claim to represent all university staff, including those on clinical scales. It is, in fact, doubtful whether those few clinical staff who are members of the AUT would wish the AUT to represent their interests in salary negotiations. Their membership of the AUT probably reflects their desire to contribute to the only association which represents all university teachers and whose expertise on superannuation has benefited all university staff.

Urgent need

The introduction of formal negotiating machinery for university clinical salaries is now urgent, and should be settled within the next few weeks. As its immediate task, the new negotiating committee must consider the form of a new contract for university clinical staff in the light of the profession's decision on the form of a new consultant contract in the Health Service. If university and MRC clinical staff are to maintain genuine parity of remuneration with their NHS colleagues, some cherished traditions of university remuneration must be challenged and there must be some adjustment in the boundaries of costs which are borne by the DHSS and those which are borne by the DES. Any proposed readjustments of boundaries, however, must be acceptable to the UGC and the CVCP, which will need to be satisfied that they do not impair a university's autonomy in selection and appointment of the staff it needs to fulfil its teaching and research commitments.

Some of the more radical proposals for a new pattern of remuneration would not be acceptable to the UGC and the CVCP—for example, the proposal that the NHS should pay for the clinical sessions of university staff while universities pay for their teaching and research work. Implementation of such a proposal would also jeopardise the principle of parity of remuneration, because the probable outcome would be that clinical sessions would be remunerated at NHS rates, while teaching and research sessions would be remunerated at university non-clinical rates. Similar objections cannot be raised for fringe benefits such as removal expenses, travel expenses, and grants towards the expenses of study leave, and there seems no good reason why DHSS funds should not be made available for some or all of these.

The very factors which have helped univer-

Committee on the EEC

At the Committee on the EEC on 28 September Dr Alan Rowe was reappointed chairman and Mr Roger Brearley deputy chairman. As well as standing committee representatives the DHSS, GMC, RCN, and Councils for Postgraduate Medical Education have observers on the committee. There is a smaller EEC Working Group which considers "the medicopolitical implications of EEC membership with a view to the formulation and correlation of BMA policy and to report to the Council."

Some time ago the committee had agreed to invite the Overseas Doctors Association to send an observer when matters affecting doctors with third country qualifications were to be considered. In fact, an invitation had been extended at every meeting, though an ODA representative had not always been able to attend.

Doctors with third country qualifications are excluded from the provisions of the Medical Directives and, though this problem affects other EEC countries, the BMA and the DHSS had been trying to see if in the long term this could be overcome. The ODA had now complained that "the expressions of sympathy uttered by the BMA have not been supported by practical efforts to rectify the anomaly" and had asked for full membership of the committee. Dr Rowe denied that the BMA had done nothing. The two associations had produced a joint memorandum. He had always said that progress was likely to be slow because of the interests of the other eight Member States. If the ODA wanted formal representation on the committee he recommended that they submit a request to the BMA.

NHS treatment of EEC nationals

The working group had considered a DHSS draft circular on NHS treatment for people from the EEC and countries with reciprocal health agreements with the UK. The General Purposes Subcommittee of the GMS Committee had seen the draft and had decided that unless and until there was reciprocity with

these countries for the provision of free health treatment for the self-employed general practitioners would not be prepared to co-operate in these arrangements. The sub-committee had asked that the question of free treatment for the self-employed should be taken up again with the DHSS.

Workshop on occupational health

Dr R Mc L Archibald referred to the workshop on occupational health which the Standing Committee of Doctors of the EEC and the European Commission were organising in November. It was, he said, an ideal opportunity to exchange views and he hoped that an adequate deputation would go from the UK. The committee agreed to ask the DHSS formally to support the workshop.

Medical directives

The chairman reported that some EEC countries had still not fully implemented the medical directives. The necessary amending legislation in Italy, for instance, was only in draft. The nurses' directives, he said, almost mirrored the medical directives. Member States had been given two years to make the appropriate amendments to their legislation. The Committee of Senior Officials had been enlarged and there was now an advisory committee on training for nurses. The directives for pharmacists and midwives were also proceeding.

Registration of EEC doctors

The DHSS had produced a draft circular on the registration of doctors from other EEC countries. It included the following paragraph: "All doctors from other EEC countries will be required to join a medical defence organisation recognised by the Secretary of State (or take out a suitable insurance policy)." The BMA had commented that this requirement did not apply to UK doctors who were UK nationals and the DHSS had agreed to rephrase the paragraph: "All doctors from other EEC countries who wish to work in the NHS hospital service will be required to join a medical defence organisation recognised by the Secretary of State (or take out a suitable insurance policy). Doctors working in general practice in the NHS are not obliged to belong to a medical defence organisation though they might well be advised to do so."

The French Government had said that a doctor could not be on more than one medical register. He could not guarantee continuity of care in two places. The French had overcome the question of "prestation de service" (providing a specific service at a specific time) by saying that continuity would be provided by appointing a locum in one place. The observer from the GMC told the committee that the Council had no objection to a doctor's having his name on several registers. However, it was a simple procedure to take a doctor's name off a register if he wanted to work in another EEC country and then reinstate him when he returned.

Linguistic competence

The 1977 ARM had resolved: "That no doctor should be registered to practise within the United Kingdom without satisfactory evidence of a sufficient command of English." The Standing Committee of Doctors, however, had taken the view that "on the basis of the Treaty of Rome and the medical directives, a migrant doctor should not be subjected to a language examination in any form whatsoever." The UK delegation had abstained in the vote on the statement though the delegation did support, Dr Rowe explained, another part of the statement that "the Standing Committee considered that knowledge of the language of the host member state constitutes an ethical duty for the migrant doctor to guarantee the proper exercise of his medical duties." This viewpoint was very strong—if a doctor did something which could be attributed to lack of knowledge of the language this would be considered a grave ethical fault. The UK was not the only country which took a firm line on linguistic competence. Luxemburg legislation stated that a doctor must provide proof of adequate knowledge of the language of the host country.

In brief . . .

Scottish GMSC

At its meeting on 21 September the Scottish General Medical Services Committee reappointed Dr Joan Sutherland and Dr A G R Law chairman and vice-chairman. After a debate on the incomes policy and the Review Body the committee decided to set up a working party, to be convened by Dr D C Marshall, to explore how the committee could "demonstrate leadership to general practitioners in Scotland; supply them with information on the gravity of their present situation in relation to remuneration and the effect of the Government's pay policy; and seek the views of Scottish GPs and assess their reaction to the situation." Proposals for a limited scheme for direct payment for related ancillary staff were accepted and the Scottish Home and Health Department has agreed to provide GPs with their prescribing statistics five months in arrears rather than a year as at present. The trainee car allowance has been increased to £1125 per year with effect from 1 April 1977. The committee and the SHHD have agreed a definition of a deputising service—"Deputising service means any person or body carrying on a business which consists of or includes the provision of deputies for periods which normally do not exceed 72 consecutive hours." It is hoped that the draft instrument which will form the regulations will be available shortly. Discussions will start soon with the Department on possible improvements in inducement practice payments.

Talking Point—continued

sity clinical staff to improve their own remuneration have unfortunately operated to the disadvantage of preclinical staff. In safeguarding their own interests, clinical staff have not been able to protect those of preclinical staff, who are now paid on the same scales as other university teachers. Preclinical departments are failing to attract sufficient numbers of medically qualified staff, who can earn better salaries as members of the clinical departments, where they can also obtain equally good research facilities. This is a matter of concern for the whole profession because it threatens our future standards.

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