SUPPLEMENT

*For Debate***Point of View on Academic Salary Structure**

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British Medical Journal, 1975, 1, 747-748**Pyramidal Structure**

I disagree with the present situation whereby there is close equalization at each stage of academic and N.H.S. salary structure (professor = consultant; lecturer = senior registrar, etc.). This tends to perpetuate a false idea that the work of academics and N.H.S. doctors is more or less identical. I believe that as in non-clinical faculties clinical academic salaries should be based on a stable pyramidal structure. This is what happened before 1968 and the structure could have a series of posts, each with tenure but with no guarantee of promotion, from, say, lecturer, senior lecturer, reader, to professor, with in the last stage a further distinction between ordinary professors and higher grade head of department professors.

I know that many will equate this scheme with the alleged undesirable military and civil service systems. But the system operates throughout industry and in all the non-medical jobs I have worked in. A pyramidal system is less absurd, illogical, and dissatisfying than the extraordinary system in the N.H.S. which depends on a series of temporary posts from junior to quite senior followed too soon, in my view, by a sudden irreversible jump to consultant with its permanent tenure and with a salary scale which at first sight seems to equate a consultant in an unpopular specialty in a peripheral hospital with one in a metropolitan teaching hospital. This latter principle of the equality in pay of all consultants had been partly neutralized by the system of merit awards. But merit awards were not invented to upgrade some consultants who did more valuable work than others but to compensate some of them in the larger centres for what they lost by giving up some of their fees from private practice when they joined the N.H.S.

Aping the N.H.S.

What has worried me in the last few years in the clinical academic world has been the continuing attempts to ape the N.H.S. system. We have done this by having more lecturer jobs of limited tenure from which staff could shuttle from N.H.S. to university at will, and by declaring that senior lecturers, readers, and professors would all be permanent and have salary scales leading to the same maxima as each other and as the N.H.S. consultant. And now the complaint quite naturally is that if the actual work and salary of an academic lecturer has become the same as that

of a registrar then, of course, he must have overtime payment^s and other similar privileges from study leave to house removal expenses.

I feel strongly that academic medicine is not by nature the same as medicine in the N.H.S. I believe that we are suffering from past bad policy decisions of senior academic professors who have sometimes sought to take on more and more clinical duties far beyond the needs of teaching and research and which are better done by the N.H.S. system. I particularly think this is the case with specialties involving much repetitive work such as those dealing with childbirth and abortion and some sections of surgery, but the medical side is also to blame when clinics such as diabetic and hypertension clinics originally begun by academics as research projects continue to be run years later by university staff when they are now properly an N.H.S. responsibility.

"All Generals and No Privates"

Another illogical situation is the equality in pay between professors and all the different kinds of consultant. A professor should be well above the status and pay of a consultant and probably a reader should be too. We have reached the ridiculous situation when weaker brethren of senior lecturer or reader status, at the top of their scales, are put up for personal chairs with the argument "that it will not cost the medical school any more." This debases professorial status and academic departments are staffed with "all generals and no privates."

I believe there should be a close link between salaries of staff in academic and N.H.S. departments, so that a rise in one is always followed by a similar rise in the other. Probably senior lecturer should equate with N.H.S. consultant, the much fewer readers and professors being much better paid. With such a structure N.H.S. merit awards might not need to be paid to academic clinical staff with honorary consultant status (see fig.).

Present N.H.S. salary system and proposed system for clinical academic posts.

The work of academics should be aimed more towards teaching and research than that of our N.H.S. colleagues.

Fighting for Independence

May I issue a last note of caution about not hastily rushing to equate medical school and N.H.S. functions and salary structures. In University College Hospital the medical school's

annual budget is about £1m., the hospital's £10m. I suspect that other medical schools are similarly dwarfed by their sister institutions. I believe we can easily be dominated and even absorbed by the N.H.S. if we do not fight to maintain a distinct and independent role. In the U.S.S.R., where this and so many similar problems have been carried to their logical conclusions, it was decided some years ago that the medical schools should leave the universities and be taken over by the Ministry of Health.

B.M.A. Discusses E.E.C. Medical Directives

The Committee on the E.E.C. had its first sight of the medical directives which had been approved in principle by the Council of Ministers on 11 February (22 February, p. 466) when it met on 12 March under the chairmanship of Dr. A. J. ROWE. Dr. Rowe explained that after the directives had been scrutinized by the Committee of Permanent Representatives they would probably be signed by the end of March.

The Committee noted that several of the changes which the U.K. and the Standing Committee of Doctors of the E.E.C. had wanted had been included. For example, doctors who were British nationals but who had qualified outside the Common Market would be able to work in the U.K.; occupational medicine and community medicine were to be included as specialties; and dermatovenereologists, who were not recognized as specialists in the U.K., would have to decide which of the two specialties they wished to practise. The observers from the Department of Health and Social Security were asked to clarify some of the paragraphs and they agreed to report back to the committee.

Linguistic Knowledge

The CHAIRMAN said that two major changes had now been incorporated into the directives. The power to assess language ability had been strengthened—"member States will see to it that, where appropriate, the persons concerned acquire in their own interests and in that of their patients, linguistic knowledge necessary for the exercise of their profession in the host country." Mr. A. PARROTT (D.H.S.S.) said that it was now up to the profession to say what was required in this respect for the protection of the public health and the chairman urged that the views of the bodies represented by the committee should be obtained as soon as possible.

The other major innovation, continued Dr. Rowe, was the Council of Ministers' decision to set up a committee of senior officials in public health to analyse any difficulties which might arise from the implementation of the directives; to collect all relevant information on the conditions under which general and specialist medical care is given in the member States; and to deliver opinion enabling the Commission to direct its work with a view to possible amendments to the directives. As Mr. Parrott had explained, this was really a precedent as no other directives affecting the professions had yet been approved. But he did not think that it would interfere in any way with the

work of the advisory committee whose task was to ensure a "comparably demanding standard of medical training in the Community." He saw it as a management committee with the task of making the directives work and of maintaining close liaison between the member States.

Mr. R. BREARLEY reported that Dr. P. Pouyau of the Union Européenne des Médecins Spécialistes (U.E.M.S.) proposed to write to the Standing Committee's president protesting at the setting up of a committee to supervise the application of the directives without prior consultation with the profession and urging the Standing Committee to ask for a place for the profession on the new committee. While agreeing in principle about the lack of consultation the Committee thought that there should be full co-operation with the profession and asked for clarification of the role of the new body.

Dossier of Behaviour

As well as a report before migration for the provision of evidence of good character or good repute the State of origin is required to forward "all necessary information regarding measures or disciplinary action of a professional or administrative nature taken in respect of the person concerned or criminal penalties imposed on him when pursuing his profession." In some E.E.C. countries large dossiers of such information were collected so that a doctor who had committed an offence could never be restored completely to good standing. Dr. G. E. W. WOLSTENHOLME told the Committee, and Germany and the U.K. had been opposed to such measures. But the General Medical Council did consider, he said, that there should be some kind of record. The Committee agreed that when legislative changes were made arising from the recommendations of the Merrison Committee of Inquiry into the Regulation of the Medical Profession there should be provision to bring the U.K. into line with other members of the E.E.C. in this matter.

A certificate of physical or mental health could also be demanded by the host State and at present this was not required from U.K. graduates. Dr. ROWE said that the Merrison Committee might make a recommendation on these lines and a policy decision could be taken by the Representative Body on behalf of the profession.

General Practice

The Committee discussed the position of

general practice, which had not been included among the recognized specialties in the directives because there were not two member States who recognized it as such. The Council of Ministers had noted the increasing tendency to lay stress on the importance of the training for general practice and had requested the E.E.C. Commission to study the problems arising from the trend and to set out appropriate proposals. Dr. J. S. NOBLE, Chairman, Representative Body, pointed out that the profession could work either for the establishment of a specialty or towards the improvement of standards of employment, though the two were not, of course, mutually exclusive. The existing directives were to come into force in 18 months' time and it would be impossible, Dr. J. HAPPEL thought, to bring forward the date—recommended by the Conference of Representatives of Local Medical Committees as 1977—by which all N.H.S. principals should be required to undertake an adequate course in vocational training. Would general practice be in the hands of immigrant doctors while U.K. graduates were doing the training which could not be imposed on foreigners, he asked. He hoped a solution could be found, and Dr. J. KILGOUR (D.H.S.S.) suggested that the Standing Committee might play a role in persuading other member States to agree with the U.K.'s view on general practice.

Mr. P. McNALLY asked about the position of Commonwealth graduates with U.K. reciprocal qualifications vis-à-vis the E.E.C. Dr. Kilgour replied that only nationals of a member State with a qualification from a member State came within the scope of the directives.

Advisory Committee

Finally, the Committee looked at the composition for the advisory committee on medical training. The Standing Committee had had to concede that this advisory committee to the Commission would have responsibility for basic and further training, which would include continuing education as well as the specialties. The Standing Committee had wanted to nominate experts to this body; this had not been granted but the CHAIRMAN said that the national delegations had been asked as a matter of urgency to signify to their governments how the nominations of experts from the practising professions in the member States should be arranged. When the Standing Committee met in May, Dr. Rowe concluded, the delegates would discuss the work to be done in the transitional period before the directives came into force.