SUPPLEMENT

Medical academic staff

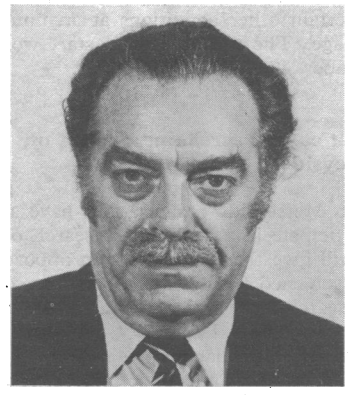
Protest to University Grants Committee

The strong letter of protest to the University Grants Committee about the delay in paying salary increases to medical academic staff was endorsed at a special meeting of the Clinical Subcommittee on 10 September. Chaired by Professor J P Payne, the subcommittee met after the routine meeting of the Medical Academic Staff Committee and were told that the chairman of the UGC had been asked to arrange an urgent meeting to discuss the delay (15 September, p 686). If there is no response within 10 days the subcommittee has decided to seek a meeting with the Secretary of State for Education and Science. Meanwhile, the British Dental Association (BDA), the Federation of Associations of Clinical Professors (FACD), and individual members have been urged to make their own protests to the UGC. [Since the committee met the UGC has acted on pay increases (see box on this page).]

On 9 July representatives of the BMA, the BDA, and the Association of University Teachers (AUT) met representatives of the Committee of Vice-chancellors and Principals (CVCP) and of the UGC to discuss the implementation of the recommendations of the Ninth Report of the Review Body for clinical academic staff. The meeting agreed the method and amount of payment and the UGC promised an implementation circular within a week. A draft arrived three weeks later. This was unsatisfactory and an amended draft has not yet been received. The subcommittee was told that the whole matter had been referred to the Department of Education and Science.

At the subcommittee meeting it was reported that many academic staff thought the delay was a deliberate attempt to withhold payment. Consultants in the NHS have already received the 18% awarded by the Review Body and as a result of joint evidence by the DHSS and the profession the 8% originally awarded for emergency recall fees and now returned to basic pay is expected in October or November. Clinical academic staff, however, were unlikely to see their increases before the beginning of 1980. Their increased awards ranged from £1000 to £2100 backdated to 1 April. In his letter to the UGC Professor Payne had said that he found it difficult to understand why their salary increases should always lag so far behind those in the NHS. There was an increasing demand that statutory interest rates should be paid in the event of a further delay.

One member of the subcommittee thought it would have been better to take what had been offered in the original draft and then argue about the outstanding matters. But the circular had been incomplete. Not only were some of the recommended increases omitted but there was no reference to the fully up-to-date rates. Superannuation had not been dealt with adequately. One of the problems was that the BDA was not prepared to accept the base on which the UGC had awarded an increase to certain dental staff who did not hold honorary consultant contracts. The representative from the BDA, Dr B C Patterson, explained that it was not just a dental problem. The BDA was fighting for all non-consultant contract holders.



Professor J P Payne (above) of the Department of Anaesthetics, London Hospital Medical College, has been elected chairman of MASC for the 1979-80 session. Professor J P Quilliam, Department of Pharmacology, St Bartholomew's Hospital Medical School, is deputy chairman.

If the chairman of the UGC agreed to a meeting, the subcommittee designated Professor Payne, Dr John Dawson (MASC secretary) and Dr Patterson to attend. The subcommittee would also like an immediate meeting of the clinical academic staff salaries negotiating committee to deal with Government ratification and detailed matters of the salary award which the UGC could not deal with.

UGC's response

As a result of the pressure from MASC —see committee report on this page— the UGC has now circulated an implementation letter to vice-chancellors. This authorises payment of the 18% "first stage" to honorary consultants. It may be possible for some finance officers to arrange payment this month, backdated to 1 April. The salary award for junior clinical academic staff has still not been agreed and the UGC wants to refer this to the new clinical academic staff salaries negotiating committee. Probably referral will be accepted by MASC only if there is an agreement that a settlement negotiated would be acceptable to the Government and implemented without further delay.

MASC

At the meeting of MASC earlier in the day the committee was told that the BMA would soon be writing to university finance officers asking for their reaction to adopting DOCAS (deduction of contributions at source) for BMA subscriptions. It would be up to each medical school to decide.

At a conference on medical education in May the Chief Medical Officer had promised a new forum of all the organisations interested in medical education to discuss and exchange information (26 May, p 1440). The University Hospitals Association had suggested a group of two representatives of the FACP, two from MASC, and four from the UHA. The committee decided that the BMA should take no action until the CMO had produced terms of reference, which he would be asked to do. The committee wants the BMA to be represented in its own right on the forum.

General practice teachers

Representatives of the Association of University Teachers of General Practice attended the meeting to seek MASC's help in trying to rationalise the position of GP academics in relation to their clinical and teaching and research commitments. The members of the association who are full-time academic staff are MASC constituents. They

would like to be represented in negotiations by MASC. All medical schools now had some teaching in general practice, Dr J S K Stevenson told the committee; and he explained the matters the AUTGP would like to negotiate:

A relaxation in the NHS regulations relating to unrestricted NHS principals who are also full-time members of academic departments.

Time spent as a full-time medically qualified member of an academic department of general practice should count towards the length of service required to qualify for seniority payments should the doctor return to full-time NHS practice as an unrestricted principal.

The right of full-time academic GPs who are not unrestricted principals to be considered as "honorary principals in NHS general practice."

Negotiations on behalf of those who do not hold contracts as unrestricted principals to allow them to be paid a sum in addition to salary that would be equivalent to any seniority or vocational training payment that they would have attracted if they were in NHS practice.

The representative from the GMSC, Dr S E Josse, pointed out that a relaxation of the regulations would be against the jealously guarded principle of an independent contractor status. He also said that seniority payments were supposed to reflect the responsibilities of general practice, with which he did not think academic medicine could be equated. He thought that there should be a representative of the AUTGP on MASC but Dr R Blamey said that the association should be represented through the normal election procedure. The committee adopted Professor R N M MacSween's proposal that the Clinical Subcommittee should consider setting up a working party with representatives of the AUTGP and the GMSC.

Recruitment

The BMA's recruitment secretary, Dr Ian McKim Thompson, reported that in 18 months the associate membership among medical students had increased from 600 to 4000 and he hoped that the figure would reach 7000 by the end of the year. Dr A D Hally had suggested that MASC should play a part in the recruitment programme and Dr Thompson said that he would appreciate help in the distribution of posters and membership forms. He asked members to write to him. Local BMA offices and officials were better placed to organise events in their own medical schools than he was and the BMA helped medical student societies with speakers and occasional grants.

Several successful courses had been held for students and he would be manning a BMA stand at the forthcoming conference for new students at Birmingham University. Dr Thompson hoped that the BMA's new computer would give individual members' medical school, and also, if given the proper information, indicate where recruitment was successful or falling off.

Preclinical staff

The committee considered two papers prepared by Dr D Bowsher. One compared qualifications of medically qualified staff in clinical and preclinical departments and their academic relationships; the other compared salaries of full-time NHS consultants and medically qualified preclinical staff. Dr Bowsher pointed out that in continuous objections—that they would be "invidious" —to differential salaries for medically qualified staff in preclinical departments no attention had been paid to the increasing number of non-medically qualified members of the full-time academic staff in clinical departments where differential salaries were acceptable.

In his other paper Dr Bowsher gave the following example. In the 20 years between 45 and retirement at 65 the medically qualified preclinical senior lecturer will earn £215 000 (at the rate of £10 775). In the same time the full-time NHS consultant with a C distinction award will earn £311 820 (£14 259 for the first 10 years and £16 923 for the second.) Dr A Glass said that he and Dr N A H Dawnay were making progress on the report they were preparing on current preclinical staffing and recruitment and they would produce the results as soon as possible.

Medical Research Council

The Secretariat had proposed that MASC's Medical Research Council Subcommittee should be reconstituted to enable the BMA to represent the MRC's 150 doctors more effectively. Half the doctors were members. Dr Dawson explained that they had a completely different code, based on the Civil Service. The BMA dealt directly with the MRC on matters which affected clinical scientific officers—for example, salary levels. Matters which affected more than one group went through the national joint staff side committee. Attendance at this committee and its subcommittees, Dr Dawson estimated, took between 10 and 13 full days a year. He thought that it was dishonest to claim to represent these people if the job could not be done satisfactorily. It was undemocratic for them to be represented by permanent staff; at present their interests were not being properly looked after. The committee asked Dr D C Roberts to continue to represent the BMA at MRC meetings for the current session and Dr Dawson to explore ways of improving liaison.

Product liability

Danger of legislation

If a draft EEC directive, at present being considered by the European Commission, is approved doctors could be held liable for their acts or for damage caused by drugs they supply or equipment they use. The directive, on liability for defective products, was fully debated at the meeting of the Committee on the EEC on 13 September.

First published in 1976, the directive gives clear instructions on the conditions under which liability will be incurred and defines the limits of financial responsibility and time limits within which responsibility can be placed with the "producer." Where the "producer" cannot be identified each supplier —that is, dispensing doctor or pharmacist in the case of medicines—would be treated as the producer unless he tells the injured person within a reasonable time of the producer's identity.

Article 6 of the directive makes it clear that side effects for medicinal products are covered for it says that "damage" will include "death or personal injuries." The Royal Commission on Civil Liability (the Pearson Commission) also recommended that producers should be strictly liable for damage or personal injury caused by defective products and that drugs should not be excluded. The Government has not yet commented on the commission's recommendations. A consultation paper has been circulated by the DHSS to try to identify the main problems and to seek views on how they might be resolved.

The DHSS representative told the committee that a revised draft directive would shortly be examined by a group of government experts and then passed to the Council of Ministers, which would have the final decision.

The Medicines Commission has recommended that medicine should be excluded from liability legislation.

Against the profession and public interest

In the committee's view medicine and medicines should be removed from any general legislation and, if necessary, special legislation introduced. The proposals, it believes, would lead to defensive medicine and the insurance costs would be astronomical. The chairman pointed out that because of the strength of consumer organisations, particularly on the continent, and the fear of another thalidomide incident, it was likely that some kind of product liability legislation would be introduced. But it would not be in the public's interest either. One of the articles specifies that "the producer shall not be liable where, as soon as he has become or ought to have become cognisant of the defect, he has taken adequate and timely steps to inform the public and adopted furthermore all measures which . . . might reasonably help to eliminate the injurious effects of the defect." This would mean that warnings would have to be issued with each product. Furthermore, such an instruction would be difficult to apply to medical services.

It was obvious to the committee that the profession would have to act quickly if its views were to be made to the UK government. The nurses, midwives, dentists, and pharmacists will be asked for their support in an approach to Ministers. The committee was anxious also that all branches of the profession should be made aware of the dangers inherent in the proposals.