# Medicopolitical digest

## Medical academic staffs conference

### Chairman warns of threats to academic medicine

"Unless there is a dramatic change in the way we recruit and retain people there will be no future for academic medicine," Dr Colin Smith warned the BMA's medical academic staffs conference last week.

Dr Smith, a senior lecturer in medicine at the University of Southampton, and chairman of the Medical Academic Staff Committee (MASC), reported that five chairs in general surgery and seven chairs in ear, nose, and throat surgery and in orthopaedics were empty. The number of staff funded by the Higher Education Funding Council for England was down and the number in training posts was at the lowest for a long time. " How are we to recruit to academic practice when the NHS is so much more secure and what is the role for academic surgery if we cannot recruit young people to it?" he asked.

Not surprisingly, the first two motions picked up this theme, demanding that the BMA took urgent action to draw attention to the increasingly apparent threats to academic medicine and calling on the BMA to take a lead in developing careers advice for medical students and new doctors.

#### Research assessment exercise still causes concern

Dr Smith told the meeting that the arrangements for the next research assessment exercise had been published and it had been recognised that many medical disciplines needed a change in the evaluation process. His committee was concerned that the assessment panels seemed to be setting their own criteria and believed that the NHS should be represented on the panels.

Later the conference resolved that the exercise was divisive and discriminatory and called on the BMA to examine its impact on the clinical commitments of medical academics and the distortion of research priorities.

The Quality Assurance Agency was formed in 1997 and brought together the functions formerly carried out by the Higher Education Quality Council and the quality assessment functions of the Higher Education Funding Councils of England and Wales. The chairman of MASC said that it was right that the quality of what academic staff did in research, teaching, and in clinical practice was tested. However, it took time to undertake the quality processes and was costly.

The conference called on the universities to recognise that the European Union's 48 hours working time directive applied to medical academic staff. Dr Smith told representatives that universities had been told that clinical academic staff were not affected; they had to appreciate that it was a health and safety issue. He believed that it might be necessary to take up a test case with the Health and Safety Executive.

### CMO supports academic medicine

"I am a strong supporter of academic medicine," the chief medical officer for England, Professor Liam Donaldson, told the conference. He said that it was important that the major changes in the NHS and the universities which had dominated the 1990s went with the grain of academic medicine and not against it.

He looked to academic medicine to help the NHS in four ways: to find the best ways to address the big health problems; to raise standards of care by introducing more effective treatment; to promote rigour of clinical method and the training necessary to ensure that the practice of medicine does not lag behind the science of medicine; and to educate the students of today to meet the needs of the NHS tomorrow.

When he was involved in workforce planning in the 1980s, Professor Donaldson said that he had referred to the difficulty of reconciling the aims of reducing junior doctors' hours, maintaining a safety net, and adhering to manpower ceilings. The key ingredients remained. But over the past five years there had been unprecedented change. There had been an increase in workload, major changes in service configuration, such as a shift to primary care, a move to a more devolved service, and a growth in self regulation.

DEPARTMENT OF HEALTH

Professor Liam Donaldson

The CMO believes that the specialist registrar grade has been a success, and the Department of Health and the colleges had made efforts to address the academic and research needs of the grade. It was a basic principle that doctors in the grade should develop an understanding of research methodology and be encouraged to undertake research. There were specific provisions for flexibility for people who wanted to pursue a career in research to be admitted to the specialist register without the certificate of completion of specialist training.

The CMO agreed that it was difficult to balance the three demands on medical academic staff of service, research, and teaching with the burgeoning workload and expectations. He welcomed the greater emphasis on teaching. "In the past we haven't given as much prominence to excellence in teaching as we have done in research." He hoped that this would change with the initiatives that were being taken by the Higher Education Funding Councils and the General Medical Council.

The meeting took up the CMO's comments on teaching and resolved that "outstanding teaching performance must be given higher priority as a criterion for academic promotion."

### Solving the problems

The components of the tripartite mission of medical academic staff—research, teaching, and clinical work—all produced problems and these were exacerbated by the professional requirements of reaccreditation and clinical governance and the recruitment problems. But Professor Michael Arthur, professor of medicine at the University of Southamptom, believes that the mission can be maintained and developed.

On the research side he recommended developing a strategy that was owned by the medical school and then empowering that strategy. It was important to build research themes and recruit wisely—rising stars and established talent—and to build an upward spiral.

Teaching could be improved by rewarding teachers with remuneration and promotion and extending teacher training to undergraduates and junior medical staff. At local level there should be fixed sessions for teaching. It was important to share teaching and clinical loads within a team, he said.

### The conference …

- Believed that there should be nationally agreed resources to meet the increasing teaching demands by universities for students to spend time in primary care
- Called on the chairman of the Institute of Learning and Teaching to review the application of its scheme to medical education
- Supported efforts to determine the practical impact of medical research on evidence based clinical guidelines
- Called on the government to fund universities sufficiently to allow a 10% increase in salaries for non-clinical academic staff
- Believed that clinical governance would work only if adequate resources were provided
- Called on universities and the BMA to establish forums for local negotiation of non-salary aspects of terms and conditions of clinical academic staff.

CHARLES MILLIGAN

**Dr Peter Dangerfield, a lecturer at the University of Liverpool, chaired the conference**

## Consultant contract talks move forward

Representatives of the BMA's Central Consultants and Specialists Committee and the Department of Health hope to make enough progress in negotiations to give joint evidence to the doctors' review body.

The consultant contract working party has agreed that the main issues for discussion will include workload, including on-call responsibilities; the development of an appraisal system to review consultants' work and responsibilities and to identify the most effective use of their skills and time; consideration of the contractual aspects of poor performance; consideration of the relationship between NHS work and private practice, including the operation of the 10% rule; and better ways of rewarding consultants. This will include further development of the discretionary points system, which rewards service provision and achievement at local level, and a review of the distinction awards scheme to see how it can be made more equitable and responsive to consultants' service provision and achievements.

## BMA criticises report on prescribing

The BMA has criticised some of the main recommendations in the Crown report on the prescribing, supply, and administration of medicines. The BMA believes that the report "fails to establish a case for a change to pharmacy prescribing." On the proposal that two types of prescribers—independent and dependent—should be recognised, the BMA says that an extended role for pharmacists would best be facilitated by health professionals working as part of a closely integrated team. It supports appropriately trained pharmacists and practice nurses assuming the role of dependent prescriber but would have reservations about high street pharmacists doing likewise. The BMA rejects the idea that dependent prescribers would be able to alter prescriptions issued by GPs. It also says that problems of patient confidentiality could arise if, as the report recommends, local pharmacists had access to practice records. Several resource issues are raised in the report, the association says, "not least that there will be an overall increase in prescribing and a consequent increase in costs. This would have implications for primary care group budgets."

## Health bodies could improve financial management

Management of the NHS's financial resources is a key element in providing effective healthcare resources and could be improved, according to a report from the Audit Commission.

*A Healthy Balance* sets out the financial position of health authorities and trusts and identifies what they need to do to make the best use of available resources. Authorities and trusts spend about £34bn a year. The financial performance of trusts in England has improved from a net deficit of £221m in 1996-7 to a net deficit of £104m in 1997-8, and for health authorities from £238m to £8m.

In Wales, the annual deficit for trusts was £9m in 1997-8 compared with £0.7m in 1996-7, and Welsh health authorities have reduced their annual deficit from £14m to £11m. However, the cumulative net deficit of health authorities and trusts in England and Wales at 31 March 1998 was £541m compared with £409m the previous year, and the percentage of health bodies with a cumulative deficit at the end of the year has increased.

The management paper says that there is no one answer to success, but it suggests that better financial management is likely to result when members of trust boards and authorities are able to identify and manage the different and often competing pressures on resources; can instil a culture of strong financial awareness at all levels of the organisation; accept that financial management is a key responsibility for staff at all levels and that staff need to be trained properly; ensure themselves that robust budget setting and monitoring processes are in place; and are willing to take harsh decisions at times about staffing and service provision.

The paper includes a pull out checklist for members of boards and authorities to help them to identify priorities and decide who should take the lead in addressing them.

*A Healthy Balance: financial management in the NHS* is available from the Audit Commission publications (freephone 0800 502030), price £15.

## Action needed to help demoralised consultants

Without urgent remedial action there is a danger that the NHS will find itself with a deeply demoralised consultant workforce, with an increasing number seeking early retirement or alternative employment.

This is the conclusion of a report from the Policy Studies Institute and the North Thames Department of Postgraduate Medical and Dental Education. The main theme identified in the research was the extent to which consultants felt disempowered and disenfranchised in the trusts. Participants felt that increasing responsibilities had been imposed on them in an ad hoc manner.

The report says that there is a need for more consultants and a need to reassess the consultant role. It believes that consultants in the future will not be willing or able to cope with the overload and stress identified. The report makes recommendations for employing authorities, royal colleges, postgraduate deans, and consultants themselves. Consultants should make clear if the volume or intensity of work is compromising quality of patient care, training of junior staff, or the reasonable balance between work and private life. They should work together to ensure that the voice of the consultants is heard and recognise that they can no longer all carry out every aspect of the consultant role all the time.

*Stress among Consultants in North Thames* is available from the dean director, North Thames Department of Postgraduate Medical and Dental Education, 33 Millman Street, London WC1N 3EJ.

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