the skeleton of William Burke (a popular attraction) to the historic document, dated 24 February 1941, agreeing to the setting up of a Polish School of Medicine in Edinburgh. The exhibition is open until January 1977, and will repay several visits.

The main celebrations of the 250th Anniversary were held in June, when the Chancellor (the Duke of Edinburgh) presided over the graduation ceremony and a commemorative dinner. As well as a scientific programme the many other social events included an anniversary revue organised by the same graduates who had previously put on a very successful Festival Fringe show. Since June there has been a joint meeting of the Medical Research Society, the Surgical Research Society, and the Scottish Society for Experimental Medicine, and also a Pfizer Symposium and a surgical workshop. It was also natural for the Nuffield Foundation and the Macy Foundation of New York to organise a commemorative meeting in this the year of the 200th Anniversary of the founding of the United States: after all, Benjamin Rush, an Edinburgh medical graduate, signed the Declaration of Independence and John Witherspoon, the only cleric to sign the document, was a graduate of the same university.

Hospital practitioner grade

Sadly, the hospital practitioner grade has made an unhappy start. But the sharp disagreements among doctors about it are harming the profession's interests and will do nothing to help their patients. Seven years have passed since the grade was first mooted. Sir George Godber and his colleagues on the working party on the responsibilities of the consultant grade[1] proposed that general practitioners and other doctors such as married women who wanted part-time work in the hospital service should have their own hospital grade with its own career structure and salary scale. But when the DHSS formally announced the new grade in 1975[2] extended negotiations between the BMA's major committees, the JCC, and the Health Departments had trimmed it to fit the requirements of principals in general practice, a metamorphosis that angered the other doctors—many of them experienced women—who saw themselves excluded from permanent, reasonably rewarded, part-time hospital posts.

In fact, since the new grade was introduced appointments have been slow to materialise and in some areas no posts at all have been agreed. This, however, is an occasion when doctors cannot heap all the opprobrium on the DHSS for dragging its feet in negotiations. The long gestation period and hesitant birth are due in part to intraprofessional differences[3] about who should be allowed into the hospital practitioner grade, what its incumbents should be paid, and, recently, HCSA-inspired opposition from some consultants to making any appointments in their areas.

From the start of the NHS there have been vigorous differences of opinion about how general practitioners could best contribute to the hospital service, with GPs themselves divided on the matter. Most doctors believe that GPs should be able to work in hospitals: they can provide valuable skills and hospital posts offer additional professional experience and satisfaction. They have been able to do so as medical or clinical assistants or by looking after their own patients in cottage/community hospital beds. But it has proved hard to recruit sufficient general practitioners into a system in which there has never been a satisfactory balance of training and consultant posts—with unhappy consequences—and in which part-time staff have too often been regarded as pairs of hands.

Professional satisfaction is not the only factor. The pay also has to be comparable with that in general practice, for to independent contractors time away from their surgeries costs money. This fact of life was recognised in 1974 by the Review Body,[4] and since April 1975 the annual salary scale for the hospital practitioner grade has ranged from £610 to £826 per notional half day. (The maximum number of sessions allowable is five a week.[5]) This scale, however, now overlaps that of consultants—whose NHS earnings may in certain instances already be less than that of some of their junior colleagues and who will carry ultimate clinical responsibility for hospital practitioners working in their departments. So it was no surprise that some consultants have protested. Nevertheless, as the BMA's August letter to hospital linkmen[6] pointed out, "the relationship to consultant earnings is an expression not of overpayment to the hospital practitioner but of underpayment of the consultant and will be one of the many gross anomalies which will be pressed upon the Government and the Review Body when freedom to negotiate is restored."

Recent letters in the *BMJ* show that the exclusiveness of the new grade has upset non-general practitioner medical and clinical assistants, who may well find themselves doing the same work as their colleagues from general practice but being paid less for it. On the other hand, were the criteria for entry to the hospital practitioner grade to be widened consultants could find themselves overtaken in financial terms by even more of their supporting staff. A final twist to this unhappy story has been the financial squeeze on health authorities, who, obliged this year to find substantial extra funds out of frozen budgets to pay junior doctors, are probably quite happy to defer appointments to a new grade that will also need more money.

While the profession must accept some blame for the slow emergence of the hospital practitioner grade, the paradoxes it has created are really a consequence of the country's economic crisis. The anti-inflation policy has worsened consultants' already diminishing rewards and, furthermore, they have been demoralised by the decline of the hospital service, the legislation on pay-beds, and the rise of the administrator. Thus, though opposition to the hospital practitioner is understandable, it is wrong and the Central Committee for Hospital Medical Services has acted with commendable responsibility in standing by its agreement with the General Medical Services Committee on the new grade. When consultants' pay can be substantially improved—and this may be some time off—the distorted differentials that have developed in the pay scales of hospital doctors can be corrected. Furthermore, the Representative Body debated all these contentious points in July[7] and the BMA was instructed to review the grade, to negotiate an equivalent part-time grade for doctors who are not principals, and to secure "proper relativity in remuneration for consultants." In the meantime, GPs should be welcomed into the hospitals on the terms that have been so laboriously negotiated. Their time and skills are needed.

1 *The Responsibilities of the Consultant Grade*, DHSS. London, HMSO, 1969.
2 *The Hospital Practitioner Grade*, HSC(IS)179, DHSS. London, 1975.
3 *British Medical Journal*, 1972, **2**, 84.
4 Review Body on Doctors' and Dentists' Remuneration, *Fourth Report*, 1974, p 16. London, HMSO, 1974.
5 Review Body on Doctors' and Dentists' Remuneration, *Fifth Report*, 1975. London, HMSO, 1975.
6 *Linkman letter No 1*, BMA, August 1976.
7 *British Medical Journal*, 1976, **2**, 319.