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Academic medicine

Pay parity and prospects

The government's acceptance of the recommendations of the Doctors' and Dentists' Review Body once again plunges clinical academics into uncertainty about parity of salaries. Acceptance relates only to doctors employed by the NHS; pay rises for clinical academics require agreement and finance from the Department of Education and Science. This results in an annual battle, during which representation to ministers is generally needed to explain the importance of parity between clinical academics and their NHS counterparts.

The arguments are well rehearsed: clinical academics have similar responsibilities to their NHS colleagues; work in the same wards, outpatient departments, and laboratories; play similar parts in health service management; and have a central role in service development. The principle that the same activity in the health service should receive the same financial reward—regardless of which department of state is responsible for the payroll—was recognised more than 20 years ago. Indeed, specific mention of the academics' difficulty in maintaining parity was made by the review body in this year's report: "The anomaly is unfair and gives considerable grievance to an important section of the profession. It is time the matter was finally and permanently resolved."[1]

The annual battle for parity, which resulted in a prolonged dispute last year during which the Committee of Vice Chancellors and Principals informed the BMA that it could not meet the costs of the NHS pay award, is particularly damaging to clinical academics' morale and for recruitment to this vital branch of medicine. The annual dispute also reminds clinical academics that even with parity of salary their NHS peers enjoy advantages over matters such as removal expenses: it is not unusual for a young academic to be out of pocket by £10 000 after moving to a new appointment.

Parity of pay and terms and conditions of service is but one of the issues contributing to the difficulties faced by those choosing a career in academic medicine. That a serious problem exists is clear: commonly senior lecturer/honorary consultant posts and lecturer/honorary senior registrar posts attract substantially fewer applicants than their NHS equivalents. The survey of attitudes of clinical academics conducted by the BMA's Medical Academic Staff Committee and reported in the *BMJ* in January found that more than 40% of respondents reported a fall in morale in the past year, about one third reported a fall in job satisfaction, one fifth regretted having chosen a career in medicine or in academic medicine. Perhaps most worryingly, over half stated they would not advise a medical student or young doctor to take up a career in academic medicine.[2] The reasons offered for poor morale included concern over parity of pay, difficulties in obtaining adequate funding for research, inadequate recognition of workload, and uncertainty over career prospects.

The problems facing young doctors contemplating a career in academic medicine are complex but two important questions need answers. Firstly, how should clinical academics be trained so that they become scientists able to obtain research support in an increasingly competitive environment and at the same time become well trained specialists? Secondly, how may young doctors entering this branch of medicine be assured of sufficient, well structured, and appropriately rewarded career posts? With regard to the first question the importance of research training has been recognised by the Medical Research Council and the medical research charities, and the number and scope of training fellowships has increased substantially over the past decade. However, the restrictions on entry into training grades, which apply particularly severely to posts in institutions capable of attracting support to train doctors in medical research, now threaten these initiatives.

There is no easy solution to the problem of combining rigorous scientific training with specialist training in postgraduate medicine: the problem exists in all advanced countries. But in the United Kingdom the requirements of postgraduate training in certain disciplines may make it virtually impossible for a young doctor to take sufficient time off to become strong enough in research to obtain funding from the research agencies. There are no defensible grounds for the present state of affairs in this country, where it may take up to 15 years of postgraduate training in hospital medicine before a consultant appointment is gained.

Substantial shortening of this period is a good thing in itself and would have considerable advantages for those seeking to combine training in clinical and scientific medicine. The royal colleges could help by investigating overly long postgraduate training and the extent to which training in research could replace clinical work. Other means of enhancing scientific training need to be considered, such as the development of MB/PhD programmes. These should eventually lead to a cadre of young doctors better placed to combine postgraduate training in medicine with research.

So far as the problem of providing properly structured career posts in academic medicine is concerned, it is important to remind those who depend on academic medicine that their

seed corn is at risk if excellence in academic medicine is not sustained in the United Kingdom. These include the universities, research councils, and medical research charities with their responsibilities for teaching and research; the health service with its need for better understanding of disease; and industry, particularly the pharmaceutical industry.

In particular, they need reminding that the clinical, managerial, and teaching demands placed on some clinical academics are such that they have little chance of conducting high quality research and of obtaining research funds in competition with scientists without these responsibilities. The larger medical charities have a creditable record in supporting senior posts in which research time is protected, but many branches of medical research are not directly supported by charities oriented towards a specialty or disease, or the charities are too small to support career posts.

We may hope that the heightened awareness of health research that has followed Professor Michael Peckham's appointment as director of research and development at the Department of Health will provide a boost for academic medicine. A consensus now calls for the creation of more consultant posts to reflect the growth of specialisation and the needs of an increasingly consultant led service. Such expansion needs to be accompanied by a commensurate increase in career posts in academic medicine, and these posts must offer the same financial rewards as their full time NHS counterparts.

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1 Review Body on Doctors' and Dentists' Remuneration. *Twenty-second report 1992*. London: HMSO, 1992. (Cmnd 1813.)
2 Beecham L. Medical academics' falling morale despite job satisfaction. *BMJ* 1992;**304**:73.

Facilitating prevention in primary care

Not all facilitated activities may be of benefit

The first results of the Oxford facilitation project were published in this journal in 1984.[1] There are now more than 200 primary care facilitators in the United Kingdom employed either by family health services authorities or by district health authorities (Claire Lloyd, personal communication). Most are nurses with a background in community nursing. Their main tasks are to encourage good practice in prevention and the management of chronic disease and to train practice nurses. There is also an increasing band of doctors, usually known as medical advisers rather than facilitators, who are employed by family health services authorities to give personal advice to practices on prescribing policy, medical audit, and other matters.[2] Papers in this issue show that primary care facilitators have reached Australia and the United States. Both suggest the need for caution.

In a randomised trial of different approaches for marketing a smoking intervention kit to general practitioners Cockburn and colleagues (p 691)[3] found that educational facilitators cost 24 times as much as a mail shot and hardly improved the general practitioners' use of the kit.

On p 687 Dietrich and colleagues describe a randomised controlled trial in New Hampshire to assess the effect of facilitation and traditional group education on the performance in primary care of preventive procedures recommended by the National Cancer Institute.[3a] Help from a facilitator was associated with a significant increase in mammography, breast examination by the doctor, faecal occult blood testing, and doctors advising patients to stop smoking, examine their breasts, and eat less fat. Education alone led to an increase in only mammography. The paper confirms Fullard's report from a non-randomised trial that a facilitator providing personal contact and focusing on specific organisational problems may increase preventive activity in primary care.[4]

The American study also confirms that it is as easy to facilitate procedures of unproved effectiveness as those of proved effectiveness. Of the preventive procedures assessed, only cervical cytology, mammography, and advice from doctors to stop smoking are considered to be cost effective in the United Kingdom. In the case of breast cancer Day recently concluded that, apart from mammography, "no other screening modality has been demonstrated to be of benefit."[5] Detecting prostatic cancer by digital rectal examination is feasible but probably does not affect survival.[6] The results of trials of faecal occult blood screening are awaited.[7] And although there is epidemiological evidence linking dietary patterns with various cancers, there is no direct evidence that advice to reduce fat intake or alter other dietary factors reduces their incidence.[8]

Experience of health checks suggests that enthusiasm is more easily facilitated than restraint. Anxieties about the quality, availability, and effectiveness of the interventions and the extent of follow up have been published and widely discussed[9,10] but do not appear to have slowed what seems increasingly like a runaway train. The effectiveness of personal contact in changing behaviour is not in question[11]—the pharmaceutical industry would not spend millions of pounds sending representatives to make personal contact with general practitioners if this was not effective in changing practitioners' prescribing habits. But any change in behaviour achieved by drug representatives is not necessarily beneficial to the patient or the NHS. Although the facilitators employed by the NHS may not have the same conflicts of interest as drug representatives, an adequate scientific basis for the clinical activity they are promoting may be similarly lacking.

Allsop drew attention to the *Guardian*'s description of Mikhail Gorbachev as the "'great facilitator' . . . a necessary but transitional figure in the process of change" and wondered whether primary care facilitators would suffer the same fate.[12] They probably will unless NHS managers recognise the need for formal scientific assessment of the effectiveness of the clinical activities they employ facilitators to promote. Knowledge needs to be disseminated to primary care teams, but an equal need is for clinical research in primary care to establish knowledge of what is good, effective clinical practice. Extrapolation from personal experience, or even from hospital based trials, is seldom adequate. The continuing struggle for resources to complete the two British intervention trials of the effectiveness of facilitated health checks while the runaway train speeds into the distance suggests that

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