A new academic career structure in general practice in Northern Ireland

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SUMMARY. A new academic career structure in the Department of General Practice, the Queen's University, Belfast is described. This represents an interesting innovation to try and solve the recruitment problems and imbalance of junior and senior posts since the establishment of the Chair of General Practice in October 1971.

Historical development

UNTIL the summer of 1976 members of my staff were appointed under the same hospital-orientated joint appointment system as all other clinical academic staff in the Medical School. This system, the brain child of the late Sir John Henry Biggart, Dean of the Medical Faculty for 34 years, is peculiar to Northern Ireland. A joint contract is made between the doctor, the Queen's University, and the local service authority, Eastern Health and Social Services Board. The salary is split in agreed proportions between the two bodies. In the beginning there were three established academic posts: two senior registrar/senior tutor posts (five-year contracts), equivalent in Britain to lectureships although not tenured, and a senior lectureship post graded consultant with eligibility for distinction award. The latter post became vacant owing to death, and a crisis of recruitment occurred in the spring of 1976.

Financial problems

A decision to treat the vacant lectureship post as a non-consultant post was conveyed to me in August 1976 by the Department of Health and Social Service (N. Ireland), following consultation with London. The new lecturer was to be paid on the lower non-consultant pay scale, which is roughly equivalent in Britain to the clinical lecturer scale without honorary consultant contract (now £8,835-£11,855). The conditions of contract entitled the successful applicant to no additional financial benefits, yet he was required to perform clinical duties in general practice for 21 or more hours per week. He was, unlike his predecessor in the senior lectureship post (consultant status), to be ineligible for a distinction award "which forms part of the remuneration of NHS consultants and community physicians only" (DHSS, 1977; personal communication).

Academic criteria for promotion

At that time, as now, other factors adversely affected recruitment to senior posts. Applicants from general practice had to meet the same stringent criteria for promotion to senior lecturer and/or reader in general practice as applied to other clinical and pre-clinical disciplines. This meant the possession of higher academic qualifications and/or a curriculum vitae showing considerable teaching experience and research publications. Such persons are hard to find in general practice, because of the nature of its development in the past. Also, recruitment is in competition with the financial support offered to postgraduate trainers in general practice and to those giving up much more time in a part-time capacity as course organizers or general practice advisers within the local postgraduate organization. These difficulties led to early efforts to find a compromise and to define an academic career structure in the context of arrangements relating to general practice as a whole. As a result, a temporary solution was agreed in 1977 and a sound applicant, vocationally trained in general practice with appropriate academic and professional experience, was appointed on the NHS consultant salary scale, but was given non-consultant status. He was entitled to no additional financial benefits.

The new career structure

Conscious of these many difficulties, similar to those already defined by Acheson (1976) in Britain, I initiated discussions with senior officials of the Eastern Area Health and Social Services Board (greater Belfast area), the Queen's University, Belfast, and the Regional Adviser in General Practice. Proposals were formulated as shown below, for a new academic career structure in my department. These were eventually ratified by the

Department of Health and Social Services, Northern Ireland (1978), approved by the Senate of the University in March 1979, and implemented from 1 April 1979. Under the agreement:

1. Non-consultant status applies to both lecturer and senior lecturer appointments in the Department.

2. Lecturer and senior lecturer posts are tenured.

3. Lecturer and senior lecturer posts are paid on the NHS consultant scale (presently £11,859-£15,279)

4. It follows from (3) that promotion from lecturer to senior lecturer is an academic honour, but brings no financial gain.

5. The non-consultant senior lecturer scale in Britain (£8,835-£11,855) approximates to the Northern Ireland non-consultant scale (£8,106 in five increments to £10,182) which was chosen for the tutor/principal post (new grade). The latter is higher than the lecturer non-consultant scale in Britain (£5,480-£9,554).

6. All grades—tutor, lecturer, and senior lecturer—are entitled to additional financial benefits defined below.

Summary of proposals

1. That there should be a three-tier structure of professor, lecturer/principal or senior lecturer/principal, and tutor/principal in the department.

2. That the senior lecturer/or lecturer/principal be paid on the salary scale pertaining to that of the NHS consultant scale.

3. That the tutor/principal be paid on the salary scale (five increments £8,106-£10,182) pertaining to that for the lecturer/non-consultant grade (see later).

4. That the Queen's University, Belfast should pay the full basic salary direct to the lecturers or tutors referred to in (2) and (3) above.

5. That the salary of these lecturers be shared equally between the Eastern Health and Social Services Board and the University, with the Board reimbursing its share to the University at agreed intervals.

6. That these lecturers or tutors should receive an allowance in recognition of the fact that their general practice duties require them to provide a car and telephone (in January 1979 this was £1,328 a year).

7. That the Eastern Board should explore how (6) might be achieved and should be responsible for paying such allowances direct to the lecturers.

8. That the lecturers should also receive an allowance equivalent to the vocational training or seniority allowance, provided that they have the requisite training or service, and that this allowance should be payable by the Board.

9. That the Board, in association with the Central Services Agency and with advice from the Professor of General Practice, should secure the best possible financial contribution from the practices concerned for the services rendered to those practices by the lecturers.

These proposals were designed to overcome the various problems which have been discussed.

Junior staff—the lowest tier

An ad hoc committee or panel of the Central Services Agency (equivalent to the family practitioner committee in Britain), consisting of university, consultant, and general practitioner representatives (including the Professor of General Practice), appointed two young doctors to be tutor/principals from 1 August 1979 on three-year joint contracts (Queen's University and Eastern Health Board). Both are vocationally trained and have the MRCGP qualification. These posts, analogous to our previous senior registrar/tutor posts, are clearly defined as academic training posts and carry a sufficiently high salary to be attractive compared with similar posts in other disciplines. The starting salary was £9,669 per year (one increment from the top), rising next year to £10,182, plus vocational training allowance and £1,328 car allowance per year. They do not receive Units of Medical Time (UMTs). The overall income narrows the gap with earnings of general practitioner colleagues of similar age in the NHS. The origins of their particular university 'non-consultant' salary scale are obscure. It was devised 15 years ago by the then Dean of the Medical Faculty, Sir John Henry Biggart. It may have originated in the NHS medical assistant scale. Their contracts require them to spend not less than 20 hours per week in general practice and to perform regular out-of-hours duties in the evenings and at weekends. By financial agreement with two general practitioners whose senior partner has recently retired, they work as 'clinical assistants' in a practice of 9,000 patients in the Dunluce Health Centre—the top floor of which houses the new Department of General Practice. They do not attract basic practice allowances nor have they list responsibilities. The tutors have no guarantee of a tenured university post at the end of their contracts. This will depend upon the quality of their work and aptitude displayed for academic life.

Lecturer/senior lecturer—the middle tier

Our staff structure presently has no lecturer in post. Two senior academic medical members were promoted to senior lectureships on academic merit. They have now accepted contracts under the new agreement and are happy to do so, because of the additional financial benefits already defined in the agreement. Their clinical commitments of not less than 20 hours per week in general practice are similar to the tutors. One, however, is a substantive principal with an NHS contract, and is one of my legal partners in a practice of 11,000 patients. The other serves, like the tutors, as a clinical assistant, in the same practice as they do. In the process of time he

too may achieve an NHS contract as a principal. This obviously depends upon the agreement and goodwill of the general practitioners in the partnership to which he is attached.

The lectureship, or senior lectureship, posts are tenured, and appointment to vacancies or new posts would be by the University Board of Curators. Upgrading to senior lecturer, on criteria applicable to all disciplines, raises academic status but confers no additional financial benefits. The reason for this decision is obvious—the University Grants Committee impose a 60/40 ratio of lecturers to senior lecturers outside the Medical Faculty, and financial resources are likely to shrink even more, so that promotion to higher academic posts may become more difficult to achieve.

Following implementation of the new agreement (1 April 1979) my share of practice profits, and that of my senior lecturer, are now being returned to the service authority (Eastern Health Board) and not, as was formerly the case, to Queen's.

The top tier

The top post is the Head of the Department of General Practice. I have the Chair of General Practice and hold a consultant contract and an NHS contract as a principal. This anomaly has proved to be extremely valuable for the development of the academic discipline of general practice in Belfast. It has helped to bridge the 'psychological and credibility gap' between hospital medicine and general practice. Confidence in the Department has been developed on both sides. I am on the medical staff of both teaching hospitals—the Royal Victoria Hospital and Belfast City Hospital—and my Department, with the associated Dunluce Health Centre, is immediately adjacent to the latter hospital. Liaison with consultants in both hospitals is excellent. My continued attempts to stay involved to a reasonable extent on a weekly basis in NHS general practice have, I hope, 'kept my feet on the ground' and retained the respect of my general practitioner colleagues. However, I share the concern often expressed by many of my senior colleagues in academic medicine about the danger of over-commitment of staff to service. A careful balance must be maintained to ensure that enough time is available for teaching and research. Some believe that even the clinical content per week defined in this paper is too much, certainly for a head of department, who also has an enormous administrative load. A colleague wrote to me recently and summed up his fears by saying: "It isn't really possible to have two major open-ended jobs at the same time." My bias in practice is to develop a 'mixed' rather than 'pure' type of university practice. In the former, some of my staff work side by side with NHS principals in the same practice. They make a substantial contribution to relieving workload, whilst contributing somewhat less to providing continuing cover. Each of my tutors or lecturers does three or four consulting sessions per week, is on call one evening per week, and does a weekend day and evening session about one weekend in four.

Conclusion

I feel that the new agreement is working well to everyone's satisfaction. My junior staff realize that in most instances they are financially better provided for than colleagues of similar age and experience in the hospital disciplines. The latter, however, have different prospects, because they are striving competitively to reach consultant status and the 'pot of gold over the hill'. Consequently they accept lower paid training posts to acquire necessary experience and higher qualifications. In conclusion, I am extremely grateful to the senior DHSS and University officials, who by their friendly and co-operative attitudes have done their best to further the development of my department and raise academic standards of general practice in Northern Ireland.

References

Acheson, H. W. K. (1976). The university department of general practice: its function and role. *Journal of the Royal College of General Practitioners,* **26**, 691-694.

Addendum

The salary scales quoted refer to when the new academic career structure in general practice in Northern Ireland was implemented on 1 April 1979. There have been substantial increases since then in accord with the most recent recommendation of the Review Body on Doctors' and Dentists' Remuneration in the NHS.

Effects of aspirin on the stomach

In a survey of the published evidence linking aspirin ingestion to gastric mucosal damage an attempt has been made to assess the role of aspirin in the pathogenesis of acute and chronic gastric haemorrhage and peptic ulceration. It seems that aspirin ingestion rarely causes clinically significant gastric damage in normal subjects, and then usually only with large or frequent doses. Even in these rare instances the specific role of aspirin remains uncertain.

Reference

Wynne, D. W. R. & Turnberg, L. A. (1980). Reappraisal of the effects of aspirin on the stomach. *Lancet,* **2**, 410-416.