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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Wasted journeys in the NHS

SIR,—The time consuming and expensive experiences of junior staff seeking promotion within the hospital services[1] have prompted the Association of Surgeons in Training to suggest three possible ways of alleviating the problems (I quote with their permission).

(1) If it is decided that all candidates should make a preliminary visit this should be stated clearly and a number of fixed days set aside when consultants are available to meet potential candidates. A proper appointment can then be operated.

(2) No preliminary visits, the shortlist being decided on the curriculum vitae alone and the shortlisted candidates being invited to visit before the interview.

(3) Two shortlists, the first being large with about 15 candidates selected from the curriculum vitae alone. This group could then be invited to visit and as a result the definitive shortlist made.

The Oxford surgeons felt that the third option might be beneficially applied to selecting a shortlist for a recent senior registrar post. There were 48 applicants for the post, of whom 12 had obtained a higher degree in surgery (MS or MD), five had submitted their thesis, and six had completed the work but had not yet submitted it. The average age of applicants was 33·5 years, meaning that these trainees might eventually achieve a consultant post when aged 37 to 38. Such is the situation in general surgery today.

Shortlisting from curricula vitae alone is not easy and may indeed be worrying because the difference between individuals appears so slight. We thought that it would be more just and more economical of candidates' and surgeons' time to make an unofficial "long" shortlist and invite only those individuals to visit the hospital. A tour of the hospital with one of the present senior registrars and meetings with the consultants would be arranged. After this the official shortlist was to be decided.

Seventeen applicants selected on the basis of their curricula vitae were therefore invited to the hospital on a specific day to meet some of the consultants. The letter explained that they had been initially selected to attend this informal visit and that a formal shortlist would be drawn up afterwards. It also said that as the arrangement was informal the region would not allow a claim for expenses.

A brisk response from the regional medical officer followed, stating that this method of selection contravened agreements negotiated between the Hospital Junior Staff Committee of the BMA and the DHSS (HN(PC)(76)5). It apparently also made the regional health authority liable for claims for travel expenses from these 17, as well as a later further claim from those officially shortlisted, and this was unacceptable to the region as the employing authority.

The proposed initial visit of the 17 candidates had therefore to be cancelled. For the surgeons an opportunity to assess personality and enthusiasm before the formal shortlist was made was sadly lost. In the future, to save large numbers of applicants from travelling, visits will probably be limited to the shortlisted candidates only. Should junior staff feel that the present rules are too rigid, perhaps they should reopen negotiations through the HJSC.

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1 Kelly MJ. Wasted journeys in the NHS. *Br Med J* 1984;**288**:1311.

Stagnation and despair in medical research

SIR,—The leading article by Professor C J Dickinson (2 February, p 337) is timely. Threats to academic medicine in Britain originate from many quarters, and many well informed observers believe that deteriorating quantity and quality of research are evident now and likely to continue inexorably and indefinitely. Financial pressures on the Medical Research Council, University Grants Committee, and other patrons of research are producing their predicted effect. This destruction of the seed corn of British medicine is deplorable and must be resisted, but success, certainly over the next four or five years, seems conjectural. One technique, however, is available to encourage academic medicine but it is so innovative, indeed revolutionary, that we fear it may produce some cultural shock among purists and conservatives.

The idea is that we should simply reward researchers roughly according to their ability, responsibility, and output. Ever since the Phoenicians invented money most people have realised they do not have enough of the stuff; this particularly applies to young people with high mortgages and growing families to support. There can be little doubt that there is a greater need for money between the ages of 30 and 40 than thereafter; it is this age group which should be producing, and usually does produce, the most important research in medical subjects. In our view these workers should be given a small percentage, say 2% or 3%, of the gross amount of any research grant which they have worked for, won, and are prepared to supervise. After all, they bear most of the burden of the inception, execution, and final realisation of important research projects. In what other walk of life would such entrepreneurs not be rewarded? It is no good saying