and water from the joints of the steam pipes, and that Deakin had "committed the radical error of having no returning pipes" in the system. Deakin hurriedly corrected these defects, and Professor Brand pronounced himself satisfied that the apparatus would keep the hospital temperature at the recommended 55°F. The apothecary, male and female keepers were instructed to measure the temperature around the hospital every two hours; and after a fortnight of such recording, the committee accepted that with the exception of some of the basement rooms which were too hot, the apparatus worked well. Deakin was requested to place guards around the steam boxes in the galleries to protect the patients from burning themselves. Continuous monitoring of the temperatures around the hospital by the apothecary and keepers was showing satisfactory levels. However, a new and alarming complication of Mr Deakin's steam apparatus emerged. The boiler flues that passed up the walls of the stock and waiting rooms had been fixed to the wall directly over pieces of structural timberwork. A consequence of this was that when the steam apparatus was in operation, "an emission of woodsmoke is perceptible", causing the steward "some apprehension for the safety of the building", as he reported to the building committee. Deakin was hastily recalled to change the route of his flues.

There are no further references in the building committee minutes to Mr Deakin or his steam apparatus, so we must assume that, to the amazement of everybody involved, it appeared to function well. For those who have been in the past, or may be currently, involved in the planning of new hospitals, the exploits of Mr Deakin and his heating company may strike a familiar chord. If there is a lesson to be learnt for the future, it must surely be that cheapest is not necessarily best!

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The times

Who owns money?

M. R. EASTWOOD, Professor of Psychiatry, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario M5T 1R8, Canada

In my medical year there was a student who had been in the RAF in World War II. After the war he worked for Beaverbrook and the Express newspapers and went on to become a publisher. He studied medicine, while a publisher, and then came the crunch. To be a publisher or a doctor? On the first day of house jobs he inadvertently drove his Jaguar into the consultant's reserved parking spot, which caused no amusement. To add to his disquiet he found that his salary of £35 per month, after income tax, and then surtax on top, only paid for his pipe tobacco and refreshments. The rest of us were less egregious and embarked upon life with even less fiscal fun. A bottle of Woodpecker Cider on Saturday night was nirvana. Was this really the reward for all that education? (Most specialists had at least 28 years of formal education: from starting at age four to leaving postgraduate school.) Like many before me, particularly Edinburgh graduates, I crossed the high seas, at the age of 32. My naval forebears would have been surprised that it took so long, especially my father, who went to sea at 14 in World War I. There were many surprises, not least of which was that of money. In a career sojourn, from the UK to Australia and finally Canada, over 18 months, there was a tenfold increase in income.

Was it all worth it? Hard to say in the light of the astonishing financial changes of the last 20 years. In North America, while salaries have increased, the real value has not, due to inflation, but the distribution of wealth around the world certainly has. Ambitious doctors in Western Europe, North America and Australasia may now earn similar amounts of money. Private practice, government service and academia nestle alongside each other, albeit often uneasily, in all western jurisdictions. Moreover, there is comparability. At a conference breakfast recently in Rome, several of us contrasted incomes. It was clear that around $70,000 to $80,000, be it US, Canadian or Australian, or whatever currency multiple, was what academics earned around the world. With little difficulty North

American doctors may increase this hard funding twice or thrice through private practice and this option is becoming available to European and Australasian doctors. So doctors, apart from in Communist countries, are becoming the highest average professional earners everywhere. They are not only 'worthy' but 'prosperous'! All physicians have gold-handled canes. Nevertheless, calculations have to be made. Doctors in 'capitalist' sytems seem to have higher earnings but often do not have formal pensions, while in 'socialist' systems doctors are the opposite. Earnings and pensions have to be calculated from graduation to death.

How did these worldwide gains come about? Obviously, much was inflationary. Wages and prices multiplied, but so did assets like land. This does not generally explain the improved lot for western doctors. The main reason is that the public everywhere demanded 'good' health care and governments, in different ways, paid for it. Doctors were not shy and delivered 'procedures' and 'services' on demand. Those with 'procedures' did much better than those giving 'time' to their patients. So the rugby-playing surgeons did better than the crossword-completing physicians. Many doctors became rich in the last 20 years, particularly those who invested in real estate.

Will this continue? Likely not. Doctors' incomes, being the highest average in most western societies and paid out of the public exchequer, are envied. They incur the wrath of newspaper columnists, nurses, hospital administrators, left-wing health ministers and corporate accountants. As a result they are doomed. Right and left-wing politicians do not see doctors as guardian angels of the 'sacred trust' of health but rather as health service technicians. Even specialities with limited technology, like psychiatry, are vulnerable. Thus, treatments may be given more cheaply by those without medical training. Fiscal 'giants' from among the health care administrators will govern from now on. Every society will forge its own destiny in this matter. Thus, North American medicine is not socialised but is rather contained by corporate medicine and the insurance companies. It is worthwhile remembering that the right wing is generally more efficient, although not more morally correct, than the left wing. Corporate medicine says that medicine must behave like business and law. These have 'excellence' and 'accountability' as the key words in their lexicon. How this may translate best into better care of patients and innovative research is not yet apparent but these are undoubtedly words to reckon with.

To complicate matters, every western country is girding its loins, in the light of health care costs, to control expenditures. The foremost targets have been physicians' salaries and physician generated costs. These are prime targets, because physicians have high incomes and seem to want to promote new and expensive technological toys. It is hardly that simple since, regardless of what doctors want, administrators are the real controlling 'estate' in medicine. Furthermore, the public has great expectations. Doctors, while no longer managing medicine, are still expected to organise their traditional mandate of research, education and patient care. (Doctors have become like opera stars. They remain acceptable until their voices crack.) However, mainstream medicine has become increasingly complex and, perhaps, only by choosing *one* of the following – research, clinical practice, education or administration – can individuals hope to function well and survive.

What about the money? The formula for academics seems to be university salary plus private practice (with 50% often going to the chairman's or the Dean's fund) plus benefits. There appears to be an invisible consensus between the Dean's offices across the world regarding the formula. However, outside academia there is free licence depending upon the paymaster. There are, however, paradoxes! In the bastion of medical capitalism, some US doctors may earn only $40,000 with HMOs; and in the bastion of medical socialism, some UK doctors may earn millions and buy houses in Harley Street. Generally, however, in the free market system there has been an inverse relationship between academic involvement and monetary reward. This is true across the English-speaking world, except for the UK where there is an arcane system based upon the so-called merit award. However, in some North American medical schools a reward system has been introduced. This gives hard cash to those who hold grants, present and publish papers and run programmes.

What does cost accounting make of all this? Treasured phrases like 'cost effective' and 'cost efficient' are almost meaningless. In most medical practice the patient complains, is examined and is investigated. Medicine has spent 300 years developing the art of diagnosis and it is not going to give up the chase. Unfortunately, there is little value for money, that is medical time versus outcome, in medicine. If most illnesses were trivial then doctors would be seen as successful but, as it happens, many conditions are recurrent or chronic. This results in repeated enquiries into patients' illnesses. It has been estimated, for instance, that 50% of lifetime medical costs are spent in a person's last year of life. So the true value of a doctor's pay is hard to estimate. If not based upon cost-accounting or prestige, then what should it be dependent upon?

Relative to other professions, physicians in the last half century have been paid well in socialist and capitalist (not Communist) systems. However, the health economists have taken over. Doctors' extensive education, and relatively short working life, is ignored and, unless in privileged private practice, they no longer control their own incomes. This

information has already percolated through to the next generation. Traditionally, medicine used to run in families, but no longer. While fresh blood is welcome, there seem to be relatively few in medicine who have a child following suit. The pay, the lengthy education, the hours and the loss of autonomy do not fit. Is this a shrewd eye to the main chance or a transfer of idealism to something worthier? Applications to medical schools in North America have become underwhelming compared to law and business schools. Salaries, or variants, are on their way in and enterprising youth wants no truck with it. 'Alternative' medicine hoots with laughter and says that lifestyle is more important than doctors anyway. A recent survey over a six month period found that one in five Canadians use some form of 'alternative therapy', only slightly less than the one in four who visited a regular health professional. This included visits to chiropractors, herbalists, naturopaths, acupuncturists, homeopathists and health food stores. Three per cent had even visited a faith healer. Bearing in mind the state of the lady doctors, as described by Solzhenitsyn, in the *Cancer Ward* we need to attend to our rewards and political strengths. Either as would be opera stars, political activists, clinicians or traditional academics we need to decide which of the answers to one of life's great multiple choice questions is correct: Is it "Let all the learned say what they can, 'Tis ready money makes the man"[1] or "The love of money is the root of all evil"[2] or "A good reputation is more valuable than money"[3].

[1]Somerville William (1727) *Ready Money*.
[2]The First Epistle of Paul the Apostle to Timothy 6: 10.
[3]Publilius Syrus (1st c. BC) Maxim 108.

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Family Courts Consortium*

JEAN HARRIS HENDRIKS, Honorary Consultant in Child Care and Adolescent Psychiatry, Royal Free Hospital, London NW3

This Consortium has a distinguished political-legal history. Its predecessor, the Family Court Campaign, was launched in 1985 by Lady Faithfull, then chairman of the all party parliamentary committee for children. Its aims were those of the Finer Committee (1974).

Key features include: a unified court system; trained and experienced judges and lay people; accessibility by families and their representatives; a proper forum for dealing with the very sensitive area of care proceedings and child abuse; and providing a focus for the development of specialist welfare services and conciliation.

This campaign, concomitant with the pressure for a comprehensive revision of a tangled mass of law relating to children and adolescents, obtained the support of virtually every health, legal and social work body, academic and professional, and of a wide range of voluntary associations.

It has been a matter for regret that the Children Act, good in itself, although under-resourced and underfinanced, does no more than set the theoretical, potential ground work for a family court system.

Within the terms of the Children Act 1989, jurisdiction in all proceedings is concurrent and cases may be transferred, and rules made, by the Lord Chancellor, between tiers of court or between courts in the same tier. The aim is to create a flexible system where cases may be heard according to their complexity and length and to enable all proceedings affecting the same child, or children in the same family, to be heard in the same court and at the same time and to make sure that magistrates and judges who do this work have made a special study, and are experienced, in family law. However, draft court rules have been circulated separately by the Home Office for the magistrates' court and by the Lord Chancellor's Department for the County and High Court. The tangle of support services for a family jurisdiction is unchanged. Guardians-ad-litem and reporting officers work in an unclear framework and are unrelated, structurally and as regards training, to the heterogeneous divorce court welfare and conciliation services. The precariously established framework for the transfer of cases between tiers of courts is as yet untested.

In 1990 the Family Courts Campaign, briefly thought unnecessary with the establishment of the Children Act, reformed itself as a Consortium with charitable status. It now has an office within the National Institute of Social Work, London, and a coordinator, Lady Butterworth. It is chaired as before by Lady Faithfull and the vice-chairman is Lord McGregor, deputy chairman of the original Finer Committee. As before, the Consortium offers, and

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