

The Hunter School of Medicine: plans for a new independent medical school

RICHARD SMITH

If all goes to plan, a new independent medical school, the Hunter School of Medicine, will open within a year within a quarter of a mile of BMA House in London. The time seems ripe. Firstly, the private medical sector has been expanding rapidly over the past few years, and its expansion has been accompanied by ever louder and more justified accusations that it robs the National Health Service of staff trained at the State's expense. Many people in the private sector admit that they need a medical school. Secondly, the existing medical schools, which receive most of their income from the University Grants Committee, are experiencing a lean time. Finally, "privatisation" is the word of the year, and the present Government is enthusiastic about breaking State monopolies and encouraging private sector initiative. Why shouldn't British medical education follow the same path as British Telecom, British Airways, and, maybe, British Rail?

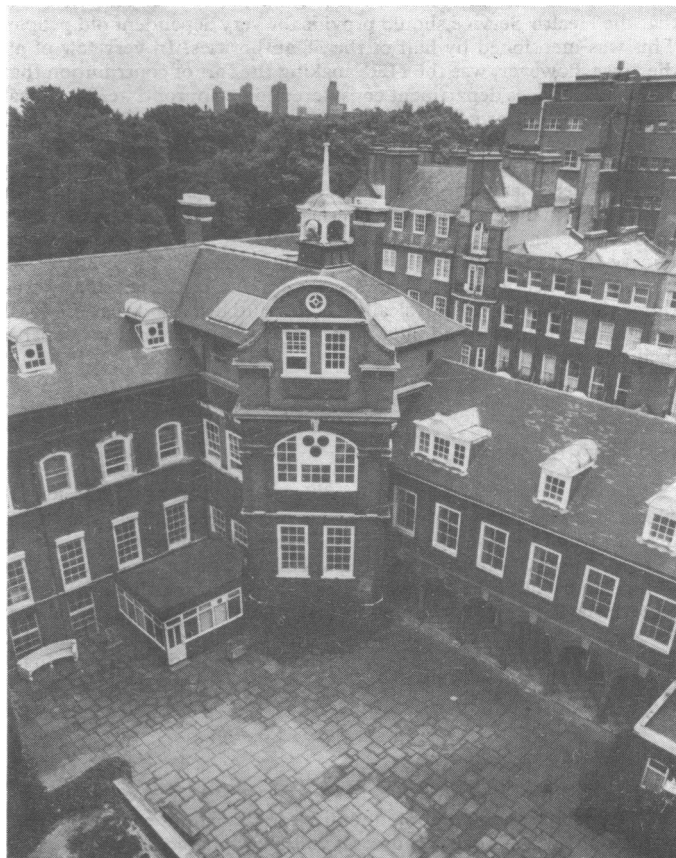
One man's vision

The Hunter School of Medicine is the brainchild of Dr P V A MacLoughlin, a Harley Street doctor who has been working on the idea for two years and who has put a great deal of time and effort into the project. Although he has written or spoken to over a thousand people in his search for support, he has until now been largely a "one-man band," which has caused the project to falter at least temporarily. Many eminent doctors, academics, members of the Government, businessmen from the private medical sector, and spokesmen from various charities have given their support, but few have given money. Many legitimately wonder if he might be a little too much of a visionary and wait for others to make the first moves.

His plan was to buy the premises of his old medical school the Royal Free Hospital Medical School in Hunter Street (figure), which will be finally vacated by the Royal Free at the end of this year, and then approach charities, individuals, and institutions for money. He thought that actually owning a building would give greater credibility to his plans, but he had insufficient funds to complete a contract earlier this year. The building is still available, however, and he plans to collect more money and have another go. In order to impress potential sponsors with the soundness of his ideas he is now gathering together a collection of trustees who support his ideas. The school, he emphasises, will not be a money-making concern but a charity.

How the school will be different

Dr MacLoughlin has clear ideas on how, apart from being independent, the Hunter School of Medicine will be different from existing medical schools. Being free of government and bureaucratic control it will, he believes, be more flexible and intellectually adventurous, and more able to entertain new ideas on medical student selection and training than the State schools. Academic standards will not be lowered, but slavish adherence to A-level results will be avoided, and all candidates will be interviewed. At least a third will be mature students with



The Royal Free Hospital Medical School in Hunter Street, London, potential site of the Hunter School of Medicine.

previous experience in the armed Forces, commerce, industry, or nursing, who find it difficult to compete with those straight from school. Many deans believe, Dr MacLoughlin says, that the preclinical course could be greatly improved, and such ideas as bringing in clinicians at an early stage, although agreed to be good in principle, rarely occur in practice. Then, is a five-year course necessary? If students are paying their own fees they may prefer to do away with the long vacations. Dr MacLoughlin sees himself as the catalyst and the Hunter School of Medicine as a clearing house for those with new or unusual ideas about the direction that British medical training should be taking. He hopes that when the school is established many, better qualified than he to decide that direction, will come forward and take advantage of the opportunities he is trying to create.

He is anxious that the medical school should not be limited to the wealthy. The estimated fee at the moment is £6500 a year, which is based on current fees charged to foreign students in British medical schools, but this will inevitably prevent many from attending the school unless the local authorities, charities, and other institutions provide considerable sums for scholarships and assisted places. Dr MacLoughlin is, however, confident that once the school is established such funds will become available.

Here again the problem is getting started. While the school exists largely in one man's imagination, people and institutions

are unenthusiastic about putting up money and sending students to a school the quality of which is unknown. The General Medical Council, for instance, would take five years at least to approve the school, and to begin with the students would have to take an external London degree or the Conjoint or Apothecaries' exam.

Dr MacLoughlin recognises that the final form of the school and the content of the course cannot be determined until teaching and consultant staff are appointed. His hope is that once the premises are bought, the trustees appointed, the money flowing in, and key figures appointed the details of the curriculum can be worked out. Many doctors in the private sector will, he believes, be enthusiastic to contribute to the teaching, as will some retired doctors, and academic refugees from the State system will find attractive the freedom offered by the school. The academics may also be attracted by the research foundation that Dr MacLoughlin hopes to set up to run in parallel with the school. Many businessmen with whom he has spoken have shown more interest in this foundation than in the school. They think that there is room for a commercial research foundation that would concentrate on new topics such as bioengineering, in-vitro fertilisation, and computerised teaching with an eye to simultaneously doing pure research and exploiting the results commercially. The foundation would, Dr MacLoughlin hopes, provide not only teachers but also funds for the school.

Particular problems

Apart from money the planned school has two other serious problems that may be its undoing: clinical teaching and a future Labour Government. Where will the students be taught? Dr MacLoughlin points out that there are about 1000 private beds in central London and also that the private sector is managing patients with an increasingly wide range of disease. But will private patients consent to being taught on? Dr MacLoughlin

believes they will, and he and some other doctors do it already to a limited extent. But he recognises that for students to see the full range of medical problems (acute medicine and psychogeriatrics, for example) much of the clinical teaching will have to be done away from the private sector. Some NHS hospitals, including some teaching hospitals, might, he believes, be willing to take students from the school in exchange for money. Alternatively, if "privatisation" continues to enjoy an ideological boom, whole hospitals, psychogeriatrics and all, might be contracted out to the private sector in the way that has been done in some hospitals for cleaning and catering. The problem of where students are to be taught their clinical medicine will surely need to be solved before students are admitted to the preclinical course.

The problem of a Labour Government that is passionately against the private sector is more theoretical, but it is something that makes potential sponsors nervous. To Dr MacLoughlin the prospect of a government that would abolish the House of Lords and nationalise the banks is so appalling that he can hardly consider it.

So will the school come to exist? Will it be different and adventurous? Will it prosper? Formidable problems remain, but the ideological climate is right and many powerful individuals find the idea attractive. Some have suggested that one way of avoiding the slide of British medical education into an impoverished mediocrity is to encourage the development of an independent medical school.¹ Furthermore, many would agree with Dr MacLoughlin that if the private sector is to continue to expand then it will have to sponsor a medical school. Finally, although to those who have known only State medical education the whole idea may have a ring of fantasy, there is a precedent—the University of Buckingham. It was set up in 1976 in an atmosphere of hostility and controversy, but it is now well established and its law degree is recognised by the Bar Council.

¹ Anonymous. Death by a thousand cuts. *Br Med J* 1982;285:1-2.

What food articles and drugs are (generally speaking) contraindicated (or best avoided) in people with atopy or their family members? Are there any articles of food that (1) facilitate non-specifically the mast-cell-degranulation or (2) contain tartrazine, histamine, or substances that mediate allergic manifestations?

Cows' milk and eggs are the foods most often responsible for food-allergic reactions. Infants of atopic parents should therefore be breast fed, if possible for six months. In older allergic subjects there is no reason to avoid particular foods unless there is good evidence to show that they cause symptoms. (Normally, this evidence would depend on food avoidance and re-challenge.) Histamine effects are not invariably caused by allergy. Shellfish and strawberries are among the foods that can stimulate histamine release non-specifically, and so can lectins of vegetable origin. In addition, some foods such as cooked pork, tuna fish, and fermented cheeses are themselves a rich source of histamine.¹ Tartrazine and other artificial colours or preservatives are a well-recognised cause of urticaria, but not necessarily by the same pathway. They are present in a wide range of processed foods and are also present in the coloured coating of many drugs (including some antihistamines).²—M H LESSOF, professor of medicine, London.

¹ Moneret-Vautrin DA. False food allergies. In: Lessof MH, ed. *Clinical reactions to food*. London: John Wiley & Son (in press).

What is the basis and importance of classifying dried cows' milk into formula milks? What are the indications of the different formula milks? Does the mineral content of the water matter in preparing feeds from formula milks?

The word formula has no special significance: it is an American expression which has been taken up in Britain and is applied to any commercially manufactured artificial milk for infant feeding. The

infant formulas currently used in the United Kingdom have been classified into three types¹—(1) cows' milk with added carbohydrate such as Cow and Gate Baby Milk Plus, Improved Ostermilk No 2, and Ostermilk Complete Formula; (2) skimmed cows' milk with added carbohydrate and mineral fats such as Milumil and SMA; and (3) skimmed cows' milk with demineralised whey and mixed fats such as Cow and Gate Premium, Osterfeed, and SMA Gold Cap. All the milks have reduced amounts of protein and minerals compared with cows' milk. Milks of types 2 and 3 have a fatty acid composition which more closely resembles that of human milk than that of cows' milk, and milks of type 3 most closely approach breast milk as regards mineral content and have a casein to whey protein ratio which is near to that of human milk. All the milks are acceptable for infant feeding, and the DHSS working party¹ concluded that there is no firm evidence that one is generally better than another. Generally, in the United Kingdom the mineral content of water is relatively low and does not contribute appreciably to the mineral content of reconstituted infant feeds. There may, however, be some areas where the mineral content of tap water is quite high; this particularly applies to bore-hole water. Doctors can get information about their own areas from their local water authorities. In July 1980 the Council of the European Communities issued a directive indicating maximum admissible concentrations of various substances in drinking water.² For sodium the maximum admissible concentration was to be 175 mg/l from 1984 and 150 mg/l from 1987 (sodium in human milk 150 mg/l and in cows' milk 500 mg/l). Milk given to babies should have a sodium content not exceeding 350 mg/l.¹ Water that has been artificially softened or repeatedly boiled should not be used to reconstitute infant feeds.—D P ADDY, consultant paediatrician, Birmingham.

¹ Department of Health and Social Security. *Present day practice in infant feeding: 1980*. London: HMSO, 1980. (Report on health and social subjects, No 20.)

² Council of the European Communities. Council directive of 15 July 1980 relating to the quality of water intended for human consumption. *Official Journal of the European Communities* 1980. (No L229/11, 30.8.80.)