Middle Articles

MEDICAL EDUCATION

The New Clinical School: An Independent Foundation?

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There has, as yet, been little discussion of the feasibility of financing a new medical school by private donation and of running it on a basis of economic fees.

There are many factors which have brought about the present crisis in medical manpower and the shortage of places in medical schools. These are well known and do not require discussion here. Two factors, however, have a particular bearing on the question of independently financed medical education: the Government's difficulties in finding the money needed for new medical schools and the emigration of doctors. That these are two problems of major significance is, of course, well recognized. What is not so well recognized is that they are problems without an end; they are often discussed as but temporary difficulties which economic resurgence and the passage of time alone will allay. This is not the case. In an era where the claims of public welfare are continuously extending, every Government will face a problem of competing priorities, and medical education is only one of these. It is expensive, and it seems inevitable that realization will fall short of expectation. Medical emigration is not an unfortunate fortuity confined to this country. There will always be a desire of many young professionals to move to fresh places, and the vast centres of scientific and technical excellence in countries like America will continue to act as magnets. That a substantial proportion of the output of our medical schools will go abroad, often for their professional lifetime, must be fully allowed for in the conceptions which underlie our medical education.

In counterbalance it is to be recognized that the profession of medicine is a thrilling one. There have always been large numbers of vigorous and able young people ready and willing to join it. The supply of candidates far outruns the provision of medical school places the world over.

Whatever the future trends in this country, whether there is to be evolved a system of student loans and whether the scale of fees is to be brought more in line with true cost over higher education generally, and without any comment on the position of existing medical schools, there is at this stage every reason why the feasibility of financing a new school independently should be considered. That is the purpose of this article. The purpose, let it be emphasized, is to discuss the *feasibility*, not the *desirability*. Feasibility is a matter of organization and arrangement; desirability is a matter of politics and social values—those can be discussed elsewhere.

There are three factors that must shape the problem of independent financing of medical education in the United Kingdom today.

(1) British universities have a substantial measure of independence on how they will use the money allocated to them in the normal course of their expansion under the Robbins proposals.

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It is therefore open to a university, particularly if it be one already strong in the biological and social sciences, to develop a faculty or school of human biology and basic medical sciences as part of its planned growth.

(2) The "3-2-1" system (a three-year first degree, a two-year M.B., B.S. clinical course, and a year of preregistration work) is now widely accepted. The new draft regulations of the General Medical Council incorporate recommendations to make this pattern possible.

(3) Preregistration appointments are working posts as well as training posts. Hence they attract a salary from the hospital service, and at this stage the student is self-supporting.

The B.Sc. Human Biology (the three-year preclinical course, whatever it be entitled) must be run on the same basis as are all other degrees. The student then is an ordinary full-time enrolled student, and the costs of his course, both capital and recurrent, can only be met through the same channels as all other university courses. It is the two years of the clinical course and the costs of the undergraduate clinical school that present themselves as a subject for independent finance. It is with that phase alone that this article is concerned.

Shape for a New Clinical School

In an article entitled "Shape for a New Clinical School" (*B.M.J.*, 1966, 2, 879) I outlined a plan for a decentralized clinical school that could use existing hospital resources. If this were to carry the same staff/student ratio as is general in other university departments, it would be possible to build and run such a school at the same order of financing as applies in the other scientific and technological faculties. Such an approach to the costs of medical education is not only feasible, it is desirable. The situation where the training of a doctor consumes vastly more of the scarce finances than are used for the training of other equally skilled and important professional groups is one that can redound only to the disadvantage of medicine.

Capital Costs

For a two-year clinical school with an annual entry of 80 students, and on a basis of £7 per sq. ft. (£75 per sq. m.), the capital cost was estimated at £½m. To allow an adequate margin and to leave a balance for running during the initial phases, an independent clinical school would need to raise some £1m. by public subscription. This is a large sum, but if it was sought in a prosperous area with a high level of civic pride and involvement I believe that it would not be too difficult to obtain.

From the viewpoint of attracting substantial sums from foundations and from industry, the decentralized pattern of the

school has advantages. It requires a major central administrative and teaching building, four clinical group buildings with attached residence at a local hospital, and eight professorial unit buildings. Each of these buildings, different in size, cost, and design, could be subscribed separately and could be named after and built in co-operation with the principal benefactor. This, I believe, would prove an important incentive.

In Appendix C of the previous article, while disclaiming any prior approval by the local university and medical profession, I gave the area of Brighton and the University of Sussex as a possible example where a decentralized clinical school could well be sited. With the same disclaimers, I believe that this too might be a feasible site for a new clinical school developed as an independent foundation.

Fees

If a new clinical school were to be run as a private trust with its staff and students affiliated to the local university, the cost to the student would be of three kinds.

- (1) Student maintenance; say £450 per annum.
- (2) The university fee; covering costs of enrolment, examinations, Union fees, and the general benefit of access to the campus, say, as now, about £100 per annum.
- (3) The true economic fee to the clinical school. In the previous article this was calculated at £1,100 per annum, but to arrive at a true cost an item should be added to represent interest on £½m. capital, and a sinking fund for normal growth and replacement; at 10% for 160 student places this would represent £310 per annum.

The first and second items are standard for medical education today and are to some extent recoverable through local education authority grants. The item to be considered, therefore, is only the economic cost fee for the two clinical years, which amounts at present prices to £2,820—let us say £3,000. No one likes paying for things that others sometimes get free; a fee of this order cannot prove welcome. But for those who are keen to be doctors and, though adequately qualified, have failed to gain admission to an existing school, such a sum is unlikely to prove prohibitive. Many middle-class families can raise the whole or part of it without too much difficulty; comparable sums are commonly spent on ordinary school fees. In America it is common for medical students to call heavily for support upon their parents and to borrow money for education. If they marry young they usually have their wives working to help get through medical school. There is no evidence to suggest that young English people wanting to be doctors would manage less well than their American counterparts.

Proposals for Fees

It cannot be expected that the local education authority should bear fees of £1,500 p.a. under the present system; that, indeed, would simply constitute an indirect form of Government finance. It is, however, possible that where a parent pays such fees they can be treated as a commitment comparable to the school fees for his other children and can thus substantially reduce the parental contribution towards the cost of items 1 and 2 above currently paid by middle- and high-income families. It might be that in a school of this kind it would be possible to have a number of endowed scholarships available for competitive entry so as to avoid deterring the most brilliant from enrolling. These factors, however, can only be marginal, and for the majority of students the problem of raising £3,000 as fees must be faced squarely.

For students with limited family resources who would be obliged to meet part or all of the fees themselves on a fully commercial basis, the best method would probably be to raise a loan covered by a life insurance, and to start a further endow-

ment insurance a few years after qualifying so as to repay the principal. Such a loan would be lawfully recoverable in the U.S.A. and in Commonwealth countries, so emigration should not lead to default. In addition, collateral security, as by a second mortgage on residential property, might be available in many cases. Given the medical school or some other responsible body were to stand as a further guarantor, it should not be too difficult to develop a regular and satisfactory arrangement with a commercial bank and/or insurance company. On such an arrangement, the final amount that would be paid in interest and insurance premium would, of course, be greater the longer the time scale in which the doctor chose to repay. Even on a 25-year basis, however, the net cost would be well under 10% of the net life income of the average doctor. The position, both in method and in amount of payment, would be similar to that involved in the purchase of a small house.

Other Costs

On the costing set out in the previous article, some 30% of the annual expenditure at the clinical school could be regarded as devoted to research rather than to teaching. Nevertheless this cost has been included in the amount of the student's fee. If we believe that good teaching and research, in reasonable degree, are inseparable, it is right that this research should be paid for too. However, to protect students against the snowballing of research expenditure it could well be written into the constitution that not more than this proportion should ever be recoverable in fees and that any extra would have to be found from other sources: the Medical Research Council, charitable foundations, and the like.

On the plan set out in the previous article the hospital costs were, and can remain, entirely separate. There need not be any substantial hidden subvention from the hospital service to the clinical school.

A Possible Organization

There are many forms of organization that would be possible for a clinical school as an independent foundation; their merits could be decided only in the light of practical issues. Nevertheless a discussion of feasibility would not be complete without a tentative proposal.

The clinical school would be an independent non-profit-making company limited by guarantee and registered as a charity. Its governing body could be composed of the university, the hospital service, the local authority, representatives from a convocation of the faculty staff, a convocation of alumni, including current students, and a convocation of founder-donors. The finance of the school could be in the hands of a board of trustees, perhaps made up by one each from the organizations mentioned above.

The school could be run by an executive council, elected by the governing body, with the dean as the chief officer. It would need an academic board elected by the school and by the university equally. For the sake of protocol there might need to be two academic boards, one being an organ of the school, the other an organ of the university; these might function best if constituted from the same personnel, with the dean of the clinical school and the university's vice-chancellor alternating as chairman and vice-chairman as appropriate.

The students would be enrolled at both the university and the clinical school, paying fees to both. The final examination could be set by the university; the degree given would then be a university degree. The students past and present, through their own convocation, could have a place on the governing body of the clinical school.

The professorial staff could be appointed by the university and be full professors in the normal sense. The clinical school

could make a block payment to the university to cover their salaries, etc., but need not hold "hiring and firing" rights. The professorial appointments, therefore, would have normal university security of tenure. The clinical professors could hold honorary contracts with the hospital service in the same way as in existing medical schools.

The other principal academic staff would normally be of consultant and senior registrar status and, for their clinical duties, would have paid contracts with the hospital service. For their teaching sessions they could have a paid contract for the clinical school and could well hold honorary lectureships or senior lectureships with the university.

All the technical and administrative staff would be the salaried employees of the clinical school. All staff, whatever their status, could have some representation on the governing body through the faculty convocation.

The buildings and plant of the school would be owned by the trustees, but would be sited on land loaned or leased by the university, the regional hospital board, the local authority, or other appropriate body.

The Future

For the foreseeable future it is believed such a scheme would be feasible. Beyond the foreseeable future one can only guess. In principle it can be said that there will be many changes in the patterns of higher education and of professional education generally. Such a school would adapt to those changes through the years. It might be that eventually it would lose its independence and be absorbed into the general system. But perhaps not. A degree of variety in the organization of its education could be a source of vitality to the medical profession in this country.

IS THERE AN ALTERNATIVE?

In his Tavistock lecture "Medicine and Government," which has recently been published,¹ the late Lord Brain called for one Parliamentary reform, saying "What is needed is a Standing Parliamentary Committee on the Health Service, drawn from all parties, with power to take evidence and question Ministers. This would develop an informed opinion on all aspects of the Service; its judgement would be of great value, and it would act as a curb on both ministerial intransigence and sectional exaggeration." In the article below Mr. Michael Ryle discusses the role of the existing committees of the House of Commons.

A Parliamentary Committee on the Health Service?

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The love-hate relationship between politicians and the professionals of all kinds within the National Health Service, as they prowl round the circle within which, as Mr. Enoch Powell has said, "medicine and politics are imprisoned," has been clearly demonstrated by the discussions which have followed the publication of Mr. Powell's book.² Yet there is surely much common ground between reasonable people on either side. Politicians, as elected representatives of those who use the N.H.S., must be as conscious as anyone of its deficiencies and long for its improvement. Those working in the Service, on the other hand, must be equally conscious that their professional needs must be matched with and weighed against many other needs of society. And there is one forum within which this recognition of common ground can, or should, find expression—namely, the House of Commons.

The opportunities for Members to consider the N.H.S. in the House of Commons are, however, fairly infrequent and haphazard. Though any Member may put Parliamentary Questions to the Minister of Health on any matter for which he is responsible, as in the hospital service there is "rationing by the waiting list." Many Members who wish to ask an oral question, with the opportunities that gives for more probing supplementaries, must be content with a written answer, for the Minister of Health may be up for questioning for only one hour every four or five weeks. Then there are several oppor-

tunities for debate. Occasional half-hour adjournment debates are a valuable means of going into specific problems in more detail than by Parliamentary Questions. There are sometimes debates on Ministerial Orders to do with the N.H.S.—for example, on pay-bed regulations. Perhaps once a year there will be a full day's debate on the Service generally, or on the hospital service, doctors' or nurses' pay, or whatever is causing current political concern. And, finally, there is occasional legislation concerning the National Health Service.

There is not, however, any official and public procedure whereby Members with continuing interest in the Health Service—and they include doctors, others who have worked in the N.H.S., lay members of boards and management committees, and even ex-Ministers of Health—can meet together and keep themselves regularly in touch with the evolving problems of the Service. Moreover, the techniques of public questions and debate tend to encourage political posturing and are totally inadequate for full and proper discovery, digesting, and publication of facts. A thorough examination of, say, the shortage of pathology-laboratory facilities cannot be done by the House as a whole.

The belief that there should be a more regular and better equipped forum for Parliamentary consideration of health matters has led some academic writers, some M.P.s and other Parliamentary experts, and some distinguished men in the medical world—for example, the late Lord Brain¹—to suggest that a Parliamentary committee should be regularly appointed to specialize in this field. Nevertheless, it is not the principal

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¹ *Medicine and Government*, Lord Brain, F.R.S., 1967. London. (See *B.M.J.*, 1967, 2, 45.)

² *Medicine and Politics*, J. Enoch Powell, 1966. London.