Contemporary Themes

The Flowers Report: a personal view

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The Faculty of Medicine of the University of London is perhaps the largest in the world. It comprises no fewer than 34 undergraduate and postgraduate institutions, all of international distinction; its undergraduate schools produce 1200 doctors a year—one-third of the total output of United Kingdom medical schools—and, as evidence of the high academic attainment achieved, nearly one-half of the consultants in the National Health Service are London graduates. Students from all over the world come to the London postgraduate institutions for advanced training in very large numbers. Even I, a product of a provincial medical school, must concede these facts.

One would think, therefore, that an edifice such as this would be worth a good deal of trouble to preserve, especially in times when, apart from North Sea oil, Britain has (as Oscar Wilde said) nothing to declare except its genius. On 26 February, however, Lord Flowers, a distinguished physicist, a Fellow of the Royal Society, and Rector of the Imperial College of Science and Technology, presented his proposals to the Vice-Chancellor of the University of London in a document entitled *London Medical Education—a New Framework*, which, if implemented, will be an act of academic vandalism.

The University of London, like every other university, is finding medical education an increasingly heavy and rather unpopular financial burden. The UGC grant to the University of London is some £160m per year, of which £51m, over one-third, goes to the medical schools. Cutbacks in allocation of funds to the university combined with spiralling increases in costs made it essential for a search to be made for economies.

The Flowers Working Party was therefore set up by the Vice-Chancellor (see p 731). In blunt English, the working party was asked how London could produce the same numbers of undergraduates as hitherto without receiving any further increments of money—which, with 17% annual inflation, means more cheaply.

The detailed proposals of the working party amounts to a pattern of fewer but larger schools on the familiar but discredited grounds that “centralisation” and “rationalisation” is cost effective: that larger is cheaper.

Megaliths

Similar arguments were brought forward to justify the re-organisation of local government and the formation of megaliths such as British Leyland. The report also proposes (and indeed devotes no fewer than 16 lines to this) that Westminster Medical School should close entirely—a specific feature to which I shall return in a moment.

From the academic point of view, there can be no question

that educational standards must suffer from massive amalgamations, particularly when these are to be achieved without extensive and costly building programmes. No one can argue that medicine is better taught to an annual intake of 250 students than to an intake of let us say 100 or 120; the experiences of teachers and students at schools of these proportions throughout the world are proof enough. Those of us who have seen massive classes on the continent being taught in overflow lecture rooms by closed-circuit TV shudder at the thought, particularly when the report specifically states that only additional building expenditure of a minor nature will be envisaged to improve departments and lecture-theatre accommodation to cater for a larger number of students (page 61).

Surely to compensate for this destruction of high academic standards we must expect very worthwhile economies of money to be achieved? The report hopes (page 60) to make savings on maintenance costs, on centralisation of administration, and on “academic services” (which are not defined), each of which, it is stated, will save £1m a year. How this magical round figure is arrived at is not stated in the one page of the report devoted to this vital topic. We may be surprised that an eminent scientist of the status of Lord Flowers should make a claim of this kind without any proof; a paper thus submitted to the *British Medical Journal* would certainly be rejected by its expert assessors. Those of us who have watched other attempts to economise by centralisation of administration are hardly reassured by a bald statement such as this. To jeopardise the teaching of medicine in London on such flimsy evidence of money savings would be foolhardy to say the least.

The Westminster

Turning now specifically to Westminster Medical School, of course my views are coloured by deep feelings of loyalty and affection towards it. I hardly relish the prospect of making both academic history and entering the *Guinness Book of Records* as the only foundation professor who was also the last incumbent of the post. Westminster produces 100 good doctors a year. Its academic record, whether measured as pass rate in examinations, distinctions gained, higher degrees won or what you will, are as high as any in the land. Moreover, it is one of the most cost-effective medical schools in the country and requires less in total expenditure than the fuel bills of some of the larger new skyscraper medical schools. To close it would engender enough money to keep the British Steel Corporation going for about 12 hours. I cannot really believe that people in their right minds would countenance such wanton destruction.

Lord Annan, the Vice-Chancellor of the University of London, in a note on the report states, “those who want to oppose any of the recommendations in Lord Flowers report are asked to put forward alternative solutions.” All of us have come to realise the grave economic facts of life in the past few years: we know very well that things cannot go on as they have done in the past. I am convinced that with good will significant economies

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and indeed sacrifices could be made throughout the Faculty of Medicine. Since the proposals of Lord Flowers are said to save 6% of the allocation of University Grant Committee monies, *I will volunteer to set an example and to accept a 6% cut in my salary.* Negotiations between individual schools could certainly lead to the sharing of expensive facilities and teaching obligations, particularly in the smaller departments, and I am sure that here and there economies can still be made in staffing.

But there is a much more positive side to the picture. It is time that we academics went into the market place and started to earn our own way. Already I provide the "soft money" for the bulk of surgical research at my medical school by fees from private patients. If the immense medical expertise contained within the medical faculty of the University of London were to be mobilised, if the private beds now closed were to be re-

opened, if full-time staff increased their private practice load, and if part-time staff contributed a proportion of private fees earned in university hospitals to the running expenses of their schools, then the financial situation would soon show a healthy swing away from the red. Moreover, we should not hesitate to use the enormous good will of the public towards medicine to support the funding of teaching and research. Perhaps the student rag days should once more bring some colour to the streets of London!

It is said that when William Morris (later Lord Nuffield) was faced by the slump, his colleagues advised either doubling the price of the Morris car or halving production. He halved the price, doubled the production, and saved the industry. Perhaps the medical faculty of the University of London can also save the day by positive action.

Does timolol maleate have any advantage over pilocarpine in treating glaucoma?

Timolol maleate is a potent beta-adrenergic blocking agent, and its efficacy in lowering the intraocular pressure when applied topically to eyes with chronic open-angle glaucoma has made it a valuable addition to the drugs available for treating glaucoma. The advantages include its long duration of action (12-24 hours) and the absence of any effect on the pupil and accommodation. It is reported to be more effective than pilocarpine.¹ Occasionally treatment with timolol results in important side effects, such as a slightly reduced pulse rate, asthmatic attacks, adverse effects on the central nervous system,² and superficial punctate keratitis associated with varying degree of corneal anaesthesia.³ Topical timolol alone is not effective in controlling the intraocular pressure in acute closed-angle glaucoma.⁴ Eyes with potential angle closure need miotic treatment and should not be treated with timolol alone, although it can be added to miotics such as pilocarpine for additive effect when required.

¹ Boger WP, Steinert RF, Puliafito CA, Pavan-Langston D. Clinical trial comparing timolol ophthalmic solution to pilocarpine in open-angle glaucoma. *Am J Ophthalmol* 1978;68:8.

² McMahon CD, Shaffer RN, Hoskins HD, Hetherington J Jr. Adverse effects experienced by patients taking timolol. *Am J Ophthalmol* 1979;88:736.

³ Van Buskirk EM. Corneal anesthesia after timolol maleate therapy. *Am J Ophthalmol* 1979;88:739.

⁴ Airaksinen PJ, Saari KM, Tiainen TJ, Jaanio E-AT. Management of acute closed-angle glaucoma with miotics and timolol. *Br J Ophthalmol* 1979;63:822.

What are the contraindications to the first-aid administration of effervescent activated charcoal, such as Medicoal, before or during transport to hospital of patients suffering from overdose or accidental poisoning?

Effervescent-activated charcoal differs from previously available preparations of activated charcoal only in that it is more palatable and has greater adsorbance. Although there are few absolute contraindications to using it after ingestion of a poisonous substance, this may sometimes be either inappropriate or inadvisable. Activated charcoal is contraindicated if a patient is unconscious or has an absent or depressed cough reflex, because of the risk of aspiration into the lungs. The availability of an antidote to a poison renders the use of activated charcoal unnecessary. Moreover, theoretically certain oral antidotes may themselves be adsorbed by activated charcoal—for example, methionine and acetylcysteine, both used to treat paracetamol poisoning. Syrup of ipecacuanha is the treatment of choice for evacuating the stomach in young children who have ingested a toxic substance, and it is sometimes used in adults. Activated charcoal strongly adsorbs ipecacuanha, and thus it would be unwise to use it as a routine first-aid measure in children before arrival in hospital. Although activated charcoal reduces the absorption of many drugs that are taken in overdose—for example, salicylates, paracetamol, barbiturates, and tricyclic antidepressants—this has been shown only in animals and using therapeutic doses of these drugs in man. Furthermore, there is little evidence that activated charcoal substantially reduces absorption if administered more than one hour after ingestion of a drug. The ideal charcoal:drug ratio for maximum adsorption is 10:1, and substantial quantities of activated

charcoal would be needed to adsorb an overdose of a drug such as aspirin, where the tablets are relatively large. Effervescent-activated charcoal will probably prove most useful in treating overdoses due to more potent drugs, where the tablets are smaller and only small amounts may cause serious toxicity—for instance, tricyclic antidepressants.

Medicoal (effervescent-activated charcoal) in the treatment of acute poisoning. *Drug Ther Bull* 1979;17:7-8.

Are IUCDs containing copper affected by vaginal preparations? If so should they be removed?

The chemical processes on the surface of the copper wire of an intra-uterine device inside the uterine cavity are complex, and there is considerable variation among individuals.^{1 2} For example, some form mainly a calcareous crust but others erode the metal, some more rapidly than others.³ The copper probably acts by forming a copper (II) oxide, from which cuprous ions are produced in an ambience of relatively low oxygen tension. These then inhibit various enzymes vital to the process of implantation. The erosion of copper in vitro was found by Oster to be accelerated by uterine secretion or cervical mucus.⁴ There is no clear evidence that material from the vagina reaches the copper or affects these chemical processes in any way. Some of the individual variation in copper chemistry in the uterus might be ascribable to specific courses of treatment used in individual patients. The careful analytical studies required to elucidate such an effect have not yet been completed, however, and it is unlikely that we will have such information for several years. There are definitely no clinical, statistical, or laboratory data at present suggesting that copper devices should be removed after vaginal treatment or at the time of it.

¹ Lewis KM, Archer RD, Ginsberg AP, Rosencraig A. *Contraception* 1977;15:93-104.

² Gosden C, Ross A, London N. *Br Med J* 1977;i:202-6.

³ Ross A, Gosden C, London N, Foxwell M. *Br J Family Planning* 1978;4:1, 6-9.

⁴ Oster GK. *Fertil Steril* 1972;23:18-23.

An 80-year-old patient who has been taking sotalol hydrochloride for four years for moderate hypotension and intermittent atrial fibrillation has cold arms and legs at night and irregular light brown rough patches on the forearms. Is there any possible connection and should she continue or change to, say, propranolol?

If the patient is indeed suffering from hypotension and not hypertension there would seem to be no good indication for sotalol in any case, and even if the patient is considered to be hypertensive I know of no evidence that lowering the blood pressure in an 80 year old improves well-being or prognosis. Only three cases of rash due to sotalol have been reported in the past five years, and none of them was in the form of irregular light brown patches on the forearms. Many patients taking beta-blockers feel cold. There is no good case for using a beta-blocker at all in this patient, and I should favour stopping the drug rather than changing to another. If any drug is given for the intermittent atrial fibrillation disopyramide 100 mg thrice daily or a small dose of digoxin is preferable, but it may well be best to do nothing.