Current Dilemma

The starving of the medical schools

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British medical schools are beginning to be badly hurt by cuts in public spending on university education. Stringent cuts in public spending on universities were announced in the summer, and these were against a background of an estimated fall in real spending on university education of 21% between 1977 and 1982.¹ Medical schools have until now been relatively protected from severe economies, although many had already had to cut back somewhat before the summer's announcement. Consequently these latest cuts—from which medical schools are not to be protected—are likely to have severe effects on teaching, research, and (something the Government and University Grants Committee (UGC) seem to have forgotten) service work.

Summer cuts

At the beginning of July 1981 the UGC sent letters to all 51 universities informing them of their grant for the academic year 1981-2, which began in August. The letters also gave the universities provisional figures for their grants for the next two academic years and provided them with instructions on how many students they would have and "advice" on how to make economies. (The universities are theoretically autonomous, but it is a brave institution that ignores the "advice" of the body that provides it with more than three-quarters of its income.) The total grant to universities was to be cut by 17%, from £972m in 1980-1 to £808m in 1983-4, and numbers of British and EEC students were to be cut by 5% from 260 970 in 1979-80 to 248 720 in 1983-4.

British Medical Journal, London WC1H 9JR

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The cuts were very selective: seven universities—including four of the new technological universities (Salford, Aston, Bradford, and Surrey)—were to lose more than a quarter of their grants. Table I shows how universities with medical schools fared: Aberdeen had the biggest cut—23%. The UGC gave general advice on medicine: "The Committee regrets that it is no longer able to include in grant funds to enable universities to offer to clinical medicine the protection which it has hitherto enjoyed in relation to the general decline in resources." Individual universities were also given more specific advice on how medicine should be treated, and table I shows the universities that were asked to make greater than average cuts in the funding of medicine.

The UGC could not give instructions on the number of medical students, as it is not empowered to do so: that is the job of the Department of Health and Social Security. Medical schools should, the UGC said, be able to maintain 1980 intakes as there had been "some funding ahead of numbers." Overall there was to be a change of distribution of students studying arts, science, and medicine from 50:41:9 in 1979-80 to 48:42:10 in 1980-4.

How did the UGC make its decisions? Nobody knows: it does not have to explain itself. It did, however, state that it had "weighed many competing claims . . . between subjects, between institutions, between teaching and research, between innovation and the continuance of existing areas of work, between provision of student places and likely demand, and between student numbers and quality of education." There was, of course, it pointed out, "no definitive solution."

The final reason for the cuts is Government policy, and although it has never said so specifically this Government, and probably the public, has little sympathy with academia. Rebellious students, and idle bearded sociologists criticising government stupidity in new campuses overlooking country

TABLE I—Cuts in grants to universities with medical schools, universities asked to make above average cuts in medicine, and costs per medical student

University	Grant £m			% Cut from 1980-1 to 1983-4	Costs per medical student in 1979-80 £'000	Universities asked for above average cuts in medicine
	1980-1 (est)	1981-2	1983-4			
Aberdeen	19.75	17.24	15.19	23	6.0	
Birmingham	30.81	27.83	25.69	17	4.1	
Dundee	12.64	11.41	10.53	17	4.2	
London	200	181.02	165.03	17	6.5	
University of Wales	57.2	51.85	47.67	17	4.6	
Bristol	23.05	20.91	19.43	16	3.4	
Liverpool	31.18	28.21	26.13	16	3.3	
Manchester	38.2	34.53	31.93	16	4.2	
Leeds	33.93	30.86	28.72	15	5.8	*
Nottingham	21.39	19.49	18.36	14	6.2	*
Sheffield	25.4	23.25	21.72	14	4.7	
Newcastle	23.97	22.03	20.85	13	4.8	
Oxford	34.0	31.33	29.74	13	13.5	*
Southampton	18.91	17.47	16.6	12	5.1	*
Edinburgh	30.81	31.50	30.2	11	6.1	*
Glasgow	33.68	30.76	29.56	11	6.1	*
Cambridge	32.27	30.03	28.91	10	8.9	*
Leicester	13.12	12.29	11.95	9	4.7	

Source: UGC.

towns are probably the targets that the Government imagined. Yet with its blunderbuss cuts it may have missed such targets and hit others that might be considered more valuable. Statistical attempts to discover the criteria that the UGC had used in making its decisions have mostly proved fruitless; the only factor that seemed constantly to relate to a university's cut was whether or not the university was represented on the UGC.²

After the cuts were announced individual vice-chancellors argued their cases with the UGC, and the Committee of Vice-Chancellors and Principals, the only communal voice that the universities have, told the Government that these cuts would be "disastrous" for university education. Apart from general criticisms that the cuts would deny opportunities to young people and would decrease the excellence of higher education, the Committee of Vice-Chancellors and Principals and others pointed out the folly inherent in the speed with which the cuts were being imposed. If cuts were made so fast, redundancies would be inevitable and enormous sums might have to be spent compensating those many academics with tenure. Dr Edward Parkes, the chairman of the UGC, in 1980 estimated that £200m would be necessary to compensate redundant academics, and yet the Government had set aside only £20m. The legal status of tenure remains a moot point as no cases have yet come to court, but the Government has now set aside £50m for "reorganisation" of universities.

Background to cuts

Since the Robbins Report of 1963,³ which argued that university education should be available to all those who wanted and were capable of it, the number of students in British universities has more than doubled. As table II shows, medical education has grown fast: new medical schools have opened; the numbers of students and medical academics have increased; and more money has been spent on medical education. This was, of course, all in line with the recommendations of the Todd Report.⁴

TABLE II—Growth of medical academia

Academic year	No of medical students admitted	No of full-time academic staff in preclinical medicine and dentistry	No of full-time academic staff in clinical medicine	Total UK expenditure on preclinical medicine and dentistry in £m adjusted to 1965 figures	Total UK expenditure on clinical medicine in £m adjusted to 1965 figures
1964-5	2407				
1965-6	2478			5.7	8.5
1966-7	2502			5.8	9.3
1967-8	2560			5.4	7.9
1968-9	2693			5.9	10.3
1969-70	2695			6.5	11.2
1970-1	2878			6.6	13.0
1971-2	3032			6.9	13.4
1972-3	3123			7.8	14.2
1973-4	3276	996	618	7.7	14.3
1974-5	3281	1215	2528	7.9	14.8
1975-6	3468	1204	2766	8.1	14.9
1976-7	3654	1303	2869	7.9	14.3
1977-8	3778	1377	2933	7.7	14.1
1978-9	3810	1341	2851	7.8	14.5
1979-80	3841	1365	2974	7.8	15.9
1980-1	3857				
1981-2	3919				

Despite this expansion over 20 years the medical schools have been feeling the pinch for several years. For example, before this summer Edinburgh Medical School had lost 20 academic posts, 41 technical posts, and 16 secretarial posts since 1976, and the Royal Postgraduate Medical School since 1976 has had nine full-time and four part-time academic posts, 21 technical posts, nine clerical posts, and six manual and domestic posts frozen. Obviously, before they were forced to freeze posts the schools had made all the marginal economies that they could.

The other background factor that is important is the increase in the fees for overseas students. These were increased in 1979,

and the effect (combined with the strength of the pound and the rapidly increasing price of living in Britain) was to reduce the number of overseas students and so the universities' income. Postgraduate institutions were particularly badly affected.

Medical school reactions

As medical schools have cut all marginal costs and as more than three-quarters of their expenditure is on staff, they have no choice now but to cut staff. Hard choices have to be made as to how this will be done. By freezing posts that are vacated and by encouraging early retirement the economies may be achieved without too much individual agony, but inevitably such a policy results in haphazard staffing cuts. A particular problem for many medical schools is that they have had imposed on them a university policy of freezing posts. As medical faculties have a higher turnover of staff than most other faculties (except engineering), this has meant that far from being protected from cuts medical schools have been hit especially hard.

If medical schools try to plan where cuts must fall then their first problem is the unsolved one of how much they will have to pay academics made redundant. As one of the important considerations in determining compensation is how easy it will be for the sacked academic to find another job, medical schools may have less to pay than other faculties, as doctors should be able to find another job. But if the schools are willing to make academics redundant what criteria should they use for deciding who goes? Should individuals or whole departments go? Should research, technology, or service commitments be considered first? Should the excellent be kept, and if so how can excellence be measured? These are the difficult questions that deans and faculties are considering, but in many places they seem to be following the easiest option of relying on natural wastage.

Another option open to deans is to try to get the NHS to pay more for the service work done by university employees. The links between the NHS and the medical schools are considerable but ill defined: much undergraduate teaching is done by NHS

staff in NHS institutions, and in return much service work is done by university staff. This "knock-for-knock" arrangement, as the Royal Commission on the NHS called it,⁵ has worked well but is now threatened as universities and health authorities renegotiate their agreements. The problem has been particularly acute in Scotland, where about 25% of hospital-based services are provided by the university in cities such as Dundee and Aberdeen. The Scottish Home and Health Department has now agreed to make some money available to replace that lost by the universities. But how exactly the money will be provided is not yet clear, and the danger is that teaching and research will suffer

because the SHHD will provide money only for service work. A final option for medical schools is to try to raise money from outside sources—the public, industry, and charities. Many have already begun to do this.

Effects of cuts

Most departments in a university have commitments not only to teaching and research. The UGC may have forgotten that clinical medical departments have an additional commitment—to treating patients. Quite what the effects will be on these three commitments it is hard to say and impossible to measure. The cuts are only just beginning to hurt as the medical schools were given next to no warning of them, and planning has been very difficult. The schools still do not know how much exactly they will receive in the next few years. The difficulty of planning is one of the biggest headaches for deans.

Better data on the effects of cuts should become available over the next few months, but for now some examples can be discussed. (The National Association of Health Authorities is conducting a study of the effects of academic cuts, the results of which should be available in the spring.)

EFFECTS ON SERVICE WORK

Service work will most probably suffer least as a result of the academic cuts: patients must be treated, whereas students can be taught in larger groups and much research can be put on one side. Some service work, however, is provided mainly by university departments—for example, laboratory-based services such as pathology and clinical chemistry. And in Aberdeen, for example, a quarter of adult surgery is done by university staff. As cuts affect these departments service work will inevitably suffer, waiting lists will lengthen, and clinics will have to be cancelled.

A particular problem is that some new and highly specialised services depend almost entirely on universities: examples include cardiac surgery, medical genetics, child psychiatry, medical oncology, neuropathology, neurosurgery, and cardiology. Freezing a post or destroying a small department may mean that a service disappears from a whole region. In Southampton, for instance, the loss of a cardiology lecturer has meant that there is now no cardiac ultrasound or 24-hour cardiac tape service.

If whole departments are to disappear they are likely to be the newer and smaller departments, many of which are in shortage specialties such as geriatrics and anaesthetics. So just as the Department of Health and Social Security is trying to encourage the development of these specialties by creating academic departments the university cuts may be closing them down.

EFFECTS ON TEACHING

Effects on teaching are even harder to put into figures than effects on service work, but staff:student ratios will inevitably fall and with them the quality of teaching. Small and new departments may vanish altogether, and medically qualified people are likely to disappear from preclinical teaching as they are more expensive than non-medical staff and their turnover is faster.

One group that may suffer particularly are departments of general practice, most of which are relatively new. Hospitals that provide teaching receive extra money from the NHS through the service increment for teaching (SIFT) in England and Wales and the additional cost of teaching (ACT) increment in Scotland. Departments of general practice have produced good arguments to show that they too should receive NHS money, but at the moment they do not. Their extra dependence

on university funds makes them especially vulnerable, as well as poorer.

EFFECT ON RESEARCH

Producing examples of research that has not been done because of academic cuts is obviously impossible, but when academics' time is short research is likely to be the first commitment to go by the board. The traditional dual-support system, whereby money is given for research by the Medical Research Council (which has not had its funds cut), the medical charities, or other groups and then buildings, equipment, administration, some salaries and the like are provided by the universities, is beginning to be eroded. Smaller charities are being charged by the universities an extra 10-15% for administration of their grants. The MRC and the larger charities refuse to pay this extra sum, but as all research grants do cost something to administer those medical schools that attract the most grants may be financially penalised.

EFFECTS ON INDIVIDUALS

The individual misery that will be suffered by those made redundant must not be forgotten. This is one of the main concerns of the BMA and the Association of University Teachers, and long and ugly legal battles are likely to occur in defending the interests of staff.

FUTURE EFFECTS

The most profound effects of medical school cuts may be on the future of British medicine. If medical students are given a poorer education, research is inhibited, and centres of excellence such as the Royal Postgraduate Medical School are left no spare capacity to experiment with the new, then the future for British medicine looks bleak. There are few activities in which Britain plays a leading world part but academic medicine (along with rock music) is one of them, and destroying that excellence would be very short sighted.

References

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- 2 St John Brooks C. Redundancies on the campus. *New Society* 1981;58: 273-4.
- 3 Committee on Higher Education. *Report*. London: HMSO, 1963. Cmnd 2154. (Robbins Report.)
- 4 Royal Commission on Medical Education. *Report*. London: HMSO, 1968. Cmnd 3569. (Todd Report.)
- 5 Royal Commission on the National Health Service. *Report*. London: HMSO, 1979. Cmnd 7615.

In the absence of breast milk, would it matter whether full-cream or half-cream dried cows' milk is given to a preterm or a light-for-dates baby (who can suck) in the neonatal period?

Half-cream milks are no longer considered necessary, and most premature babies in Britain are fed either expressed breast milk or one of the low solute milks used for mature and older babies. The terms full-cream and half-cream milk are in fact now obsolete in paediatric practice in Britain, and the older milks to which the terms were applied should not be used for infant feeding because of their high sodium, protein, and phosphate contents. There is some uncertainty about the optimum composition of feeds for very small premature babies, but a baby who sucks well will be at least 35 weeks' gestational age and will do well on either breast milk or a routine low solute formula. Small-for-dates babies in particular need relatively large volumes in relation to their weight in the first few days to minimise the risk of hypoglycaemia.—D P ADDY, consultant paediatrician, Birmingham.