Letter from Westminster

UGC defends its actions

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A strong warning that the cuts imposed by the University Grants Committee on the universities will mean jobs shed by medical schools in a whole range of specialties that the Health Service cannot afford to lose—in anaesthetics, geriatric medicine, and mental illness—was given by the University Hospitals Association in its evidence to the Commons Social Services Select Committee. "Clinics will have to stop, emergency cover will get worse, and waiting time will increase," Dr R I Keene, a consultant anaesthetist from Manchester claimed.

As well as the UHA, the committee also took evidence from the UGC as part of a short, emergency investigation into the impact of the Government's cuts on medical education. The evidence of the two groups was in fairly stark contrast. While the UHA was in no doubt that the picture was bleak, the UGC insisted, perhaps a little too *shrilly*, that things were by no means as black as they were being painted. According to Dr Edward Parkes, chairman of the UGC, the cuts the universities were imposing were in almost every single case significantly higher than the UGC had envisaged. He pointed out that these were, however, only plans, which the universities might modify. Professor K M Clayton, the vice-chairman, was rather more direct. He said firmly that the universities were being "far too pessimistic. . . . They are talking about what may not come to be. Financial people always forecast the worst possible scenario. There is a good deal of bargaining and decision making going on."

Dr Parkes said that if there were to be further cuts the UGC might have to ask itself whether in these circumstances it should reduce the medical intake below the present figure and possibly close a medical school. But so far as the likely impact on the shortage specialties was concerned, about which the select committee had fears, he said he was "not too worried." The problem, he thought, would sort itself out.

That was not how the UHA saw things. Sir Douglas Ranger, dean of Middlesex Hospital Medical School, said that so far the effect on clinical medicine was unclear, but every medical school in the country was deeply worried. Mrs Renée Short, the select committee's chairman, said that the committee had received a large amount of evidence from nearly all the medical schools painting a very serious picture. Were they being too pessimistic? They were not, Sir Douglas replied, if the cuts went ahead as forecast. If there was some alleviation perhaps they were being too gloomy, but not on the evidence of the forecasts. Asked by Mr David Ennals, the former Social Services Secretary, what one thing the UHA would wish the committee to include in its recommendations, the UHA said it wanted protection for clinical medicine to be restored. Asked if it would have been possible for the UGC to have provided this when making the cuts on the universities, Sir Douglas said that as he understood the way the UGC operated it would.

In a letter to the committee Mr G F Cockerill, the UGC's secretary, had said that to have allowed the proportion of medical students to increase at a time of severe financial

stringency would itself have placed a severe strain on the rest of the university system; this was why the UGC had not felt able to protect the unit cost in clinical medicine. It would have caused unacceptable damage to the rest of the system, and clinical medicine must share in the general reduction.

Sir Douglas told the committee that the cuts would mean medical schools being placed in a position where posts on the clinical side that became vacant would have to be frozen because there was no cash to fill them. As for the impact on research, essentially a long-term enterprise, he feared there would be a significant cut that would mean that the people left would have to do more teaching. Dr Parkes said that any laboratory-based activity was extremely expensive and to save one medical place would probably cost six places in sociology. The UGC argues that medical education is expensive; in 1979-80 the average departmental unit cost of a clinical medical student was £4126—over twice the average for all subjects of £1889.

Sir Douglas insisted that the cuts imposed on the faculties at present were greater than they might have been and agreed with Mr Ennals that freezing posts would damage the health side of the partnership because it would mean a reduction in the number of consultants helping patients. As to whether those who lose research posts could look abroad, he held out no great hopes.

The message for the select committee was clear: if the universities do not have the money the NHS, if it wants the doctors and the services, will have to pick up the tab. But the NHS, as officials from the Department of Health and Social Security had made clear at a previous session, does not have any extra money either. As for the UGC, the argument is that in making allocations to individual universities account was taken of the level of funding of their medical schools and also, so far as possible, the relation of those schools with the NHS.

Junior doctors' hours

The Bill to restrict the hours worked by junior doctors came up for its second reading in the Lords last week but was withdrawn at the end of the debate. It has, of course, been overtaken by events, since there has been the conference of all those concerned called by Sir Henry Yellowlees. Lord Richardson, ex-president of the General Medical Council, quoted the view of the BMA's Hospital Junior Staff Committee that there should be no legislation at present and that a maximum of 80 hours was reasonable. He argued that the real purpose of junior doctors was to convert their long years of academic training, teaching, and learning into practical activities. He suggested that the hours of work were less important than the experience gained. Doctors expected and should expect to work long hours.

Lord Elton, the junior Health Minister, said that the Government fully accepted that the hours of work of some junior staff were excessive. As for the conference, he said that there had been no agreed outcome but a general recognition that something had to be done. The first step was the abolition of the so-called one-in-two rota in the acute specialties. There had also been agreement that, while targets could be set nationally, implementation must be a local matter.