No apples for the teachers

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Although most of Britain was joyful on the day last week when fighting ended in the Falklands, undiluted misery prevailed among the academics assembled on 15 June for the joint BMA/BDA conference on the effect of financial cuts on medical education. The occasion was reminiscent of a meeting of Alcoholics Anonymous as long-faced academic after long-faced academic stood up and told his sad story of the awful effects that cuts were having on his school or specialty. Yet, as Mrs Renée Short, who chaired the meeting, said, it was really a nonsense that all this damage should be done for want of only £10m and that academics should have to desert their podiums and ivory towers to fight for their livelihoods.

The slowly unfolding story of university cuts should be known to most journal readers. We published last year an open letter from Sir John Walton to the Secretary of State for Education and Science (4 April 1981, p 1150) in which he predicted the serious effects that cuts would have on teaching, research, and service work in the medical schools. Nevertheless, in July 1981 the University Grants Council announced that there would be a 17% cut in the total grant to universities between 1981 and 1984, and medical schools were not to receive any special protection. Early this year (30 January, p 335) we assembled as much information as we could on the effects that cuts were having. Then last month Mrs Short's Select Services Committee published its "minireport" on the cuts (5 June, pp 1658 and 1720), recommending that a further £10m should be made available to medical schools over the next three years. The Government's reaction to the report is eagerly awaited.

Continuing destruction

Sir John Walton gave the first presentation at last week's conference and said that his direst predictions of last year were coming true. Those very British institutions "the knock for knock agreement" (whereby without money changing hands university staff do NHS work and NHS staff teach) and "the dual support system" (whereby a body like the Medical Research Council puts up money for research and then the university pays for accommodation, secretarial support, etc) are both falling apart. The effect on medical research may be so bad that a whole generation of medical scientists will be lost, while service work, particularly in specialties like pathology where academics do much of the work, is suffering badly. Sir John produced some figures as to how many posts he thought were frozen, but he had no sooner put them up than others shot them down. Trying to work out how many posts are frozen is difficult, mostly because events are moving so fast that the figures are no sooner produced than they are out of date. Professor R E Coupland, dean of Nottingham Medical School, pointed out that whatever the figures are at the moment catastrophe will befall the medical schools in 12 months if more money is not made available.

Nottingham and Newcastle (both with new medical schools at different stages of development) were well represented at the conference, and Professor Tony Mitchell from Nottingham came out of his corner like a prizefighter when he gave his dramatic talk on the plight of the new medical schools. His

punches were aimed particularly at the Government, which he suggested had acted almost immorally by setting up new medical schools in deprived areas and then not giving them adequate resources. (A "previous minister of health" was particularly taken to task by Professor Mitchell. When this "previous minister" visited Nottingham and was shown the problems he responded by suggesting that the school had brought these on itself by accepting so many students. Professor Mitchell pointed out that it was the minister's department—the DHSS—that set the number of students.)

Nottingham Medical School was set up in a region with one of the lowest health expenditures, fewest beds, and fewest doctors per head of the population. The idea was that the medical school would attract high-quality doctors and raise standards. This it had done to a large extent, but the region is still not getting its fair share of NHS resources, and now the UGC has asked the university to make "above average" cuts in medicine. Professor Mitchell thought that instead of making arbitrary cuts the DHSS and the DES should get together and look at how much NHS money and how much university money any one teaching area got. Several speakers spoke on the failure of communication between the two departments, although Dr M E Abrams from the DHSS insisted that communication was good.

The audience listening to one of the speakers at the conference.

After Professor Mitchell's presentation the floodgates opened and sad stories were heard from every quarter. Smaller departments, as Mrs Short's committee said, are being hit very hard. The department of therapeutics and clinical pharmacology in Edinburgh, for instance, is likely to disappear altogether after its professor retires later this year. Anaesthetics, which is mostly a postgraduate subject, is suffering badly, and Professor M D Vickers from Cardiff suggested that rather than cuts there should be improvements in postgraduate anaesthetic training to ensure the safety of patients being anaesthetised. Preclinical medicine, meanwhile, may lose most of its 350 medically qualified teachers. Another very vulnerable plant is academic general practice, which at the moment receives no NHS money to support its undergraduate teaching, and Dr S E Josse suggested that several departments of general practice may go under.

Dental woes

The future is bleak for academic medicine, but it is even bleaker for academic dentistry. Sir Robert Bradlaw, vice-

president of the BDA and formerly dean of dentistry in Newcastle, explained that it had been only in his lifetime that dentistry has come to be taught in universities. Dental schools have fought for years to gain a solid academic basis, which now might be swept away. Dental schools have much less NHS support than medical schools, and at the moment dental teachers are spending almost all of their time teaching on the job. They have no time for research, and dental research in Britain is accordingly very poor. Yet dentistry is currently trying to modernise itself. Ironically, in this time of decimation, a DHSS study group has called for a lengthening of the dental course (yet another example of poor communication). Dental educators want to include more basic science and prevention in their teaching, but this is now impossible.

What now?

Towards the end of the conference Mrs Short, a woman of action if ever there was one, wagged her finger like a schoolmistress at the assembled ranks of academe and told them that they were spending too much time listing their woes and not enough time thinking what action to take. She thought that the only route forward was to put pressure on the Government to come up with more money, and one way to achieve this was for all of the academics to badger their local MPs. Many of the academics were unenthusiastic, however, saying that they had tried it and got nowhere. If your MP doesn't come to your meeting or is not interested then get on to your local newspaper, Mrs Short replied. Dr John Havard weighed in at this point and said that the "new BMA" with its professional relations unit, its press and information department, and its parliamentary liaison officer would be able to campaign vigorously on behalf of medical education.

Another suggestion was that a "mini Royal Commission" ought to be set up to look into the effect of cuts on medical education. But most people thought that this would be too slow and a better suggestion was a "task force" composed of academics and the BMA which would work "in parallel" with Mrs Short's committee. Talking and reporting was not, however, enough for many: they wanted action. One suggestion that gave rise to disagreement was "earmarking" (asking the UGC to specify funds for medical schools). Many delegates thought that medicine was a special case and should be protected, while others were anxious not to set one university faculty against another. A way round the problem was suggested by Professor G P McNicol of Aberdeen University, who thought that medical schools might be offered "semi-encapsulation" along the lines of the Welsh National School of Medicine.

Mr Anthony Grabham, chairman of the BMA Council, and out of the same active mould as Mrs Short, had some more positive suggestions. He said that in his experience governments responded much more to pressure than to logic, and he saw two ways in which the medical schools could pressure the Government. Firstly, they could refuse to take so many students. A better way, however, would be to work through the General Medical Council and to ask it to refuse to approve the degrees of medical schools where cuts had lowered standards of teaching to an unacceptable point. Indeed, the Conference of Medical Academic Representatives had the previous day (p 1964) sent a telegram to the GMC calling on it to concern itself with the dire effects of academic cuts. It will be interesting to see whether such a stately body as the GMC will descend to political pressurising. But, certainly, the threat to academic medicine and to future standards of medicine is sufficiently serious for the profession, including the GMC, to do all it can to persuade the Government to change its damaging policy.

Data protection legislation

Cautious welcome from Central Ethical Committee

The Central Ethical Committee, which met on 10 June, has cautiously welcomed the Government's intention to introduce legislation on data protection but it has put in several markers about the proposals in the Government's White Paper (17 April, p 1200). At the meeting, chaired by Dr M J G Thomas, comments on the proposals were consolidated for submission to the Home Office. The Government has proposed that most users of data systems which process automatically information relating to identifiable individuals should be registered. The EMA would have preferred an independent data protection authority as envisaged by the Lindop Committee but it will support the proposal for an independent registrar, provided that his powers and duties are specified in any legislation and that he is given powers to take initiatives.

Mr David Kenny, who chairs the group G on confidentiality (part of the Körner Working Party on Health Services Information) and who attended to help with the discussion, believes that the Home Office has failed to understand the complexity of the NHS. The BMA wants a code of practice with the force of law to protect access to medical records, whether held in manual or

automatic systems—such a code to be drawn up by a health team to which the medical input should be made by the BMA. The Government does not think that the codes should have the force of law, though in some cases it accepts that the general principles would need to be supplemented by regulations.

On sanctions for breaches of confidentiality the BMA believes that there should be a statutory general duty supported by criminal sanctions. This duty would impose on any person who keeps data in a computer and/or manual system a statutory obligation to ensure that, so far as was reasonably practical, the information would be safeguarded so that it was not disclosed or used contrary to its specific purpose. Breaches of those principles in the Younger Report dealing with unwarranted disclosure or unauthorised access should attract criminal sanctions. Deliberate misuse of data should be a punishable offence, as well as the making of false statements to the registrar, who will be responsible for the public register of data users. In other words, a breach of confidentiality, rather than any damage caused by such a breach should be the basis for proceedings against a data user. The registrar must have the power to inspect where a complaint is made of a breach of

confidentiality.

Mr Kenny told the committee that he thought that legislation designed to include criminal sanctions would take too long to achieve and that the initial aim should be for civil law liability.

The National Association of Health Authorities had something to say about the White Paper at its recent annual meeting, particularly about the confidentiality and security of medical records. The White Paper states that medical records "will need to be covered by regulations which might, for example, place special restrictions on the collection, processing, holding, or disclosure of information from such records." The NAHA wants special care exercised. It pointed out that a patient would normally supply data in confidence to a doctor yet it would often be essential for aspects of that information to be subsequently shared with other health professionals—for example, in hospital care, with radiographers and pathology staff. It was important that the purpose of recording data in the health environment should be seen as the overall treatment of a particular episode, by a complete health care team, though normally under the leadership of a doctor.