undergoing a revolution. The economic stranglehold on the NHS is shifting power from doctors to administrators (the change to the new term "manager" exemplifies this). Fifteen years ago in discussions between doctors and administrators the bottom line was clinical need; the decisive language was therefore medical and the administrators had to bow to the clinicians. Now the bottom line is cost, the decisive language is financial, and therefore clinicians must bow to managers.

Total quality management has to be seen in the context of this battle. Do not be fooled by the fact that some of the leading advocates of total quality management are doctors. They are playing a dangerous game, hitching a ride on the tanks of the rebels as they enter the city, hoping to outmanoeuvre their colleagues.

Hart states that "quality management should ensure lower surgical complication rates, fewer unplanned readmissions, and safer treatments."¹ The unfortunate implication is that before the introduction of total quality management these aims (that is, safe, effective treatment) were not part of normal medical practice. Perhaps it is stating the obvious, but the aim of medical education is to produce safe, effective doctors.

The question at the heart of the matter is who should make the final decisions on medical care. Doctors (before 1948)? The state guided by health professionals (1948-89)? The state alone (1989 onwards)? The bottom line being cost, the state and its lieutenants must hold the citadel. Fair enough. But to dress this up as a quality exercise is an abuse of language worthy of George Orwell.

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Clinical freedom and drug dependence

Treatment of American was legitimate

EDITOR,—It is unfortunate that John Strang and Michael Farrell¹ suggest pandering to American prohibitionist fundamentalism in exactly the same way that led Willis to bemoan the demise of the British System (practice recommended by the Rolleston committee of the Ministry of Health in 1926);² also at the behest of Maudsley psychiatrists. Temporarily resident foreigners have always been able to get treatment in Britain and hopefully always will. In the case of drug dependency, particular concern had been expressed by the government to prevent the spread of AIDS and avoid the sort of dreadful consequences now seen in American cities.³ In the case cited care was taken, including urine analysis, to establish the nature of the case and monitor the response.

Although methadone and diamorphine have similar pharmaceutical strengths, the effect of methadone lasts several times longer. Thus, in a tolerant subject daily doses of 80 mg methadone and 900 mg diamorphine are about equal. Incidentally, 900 mg is far less than the dose prescribed by earlier Maudsley psychiatrists to addicts when they did operate the British system. Their cases included daily doses of 1-2 g to Americans.⁴ But the real question is why do Strang and Farrell not use the doses of drugs allowed under the Dangerous Drugs Act 1920 and the Misuse of Drugs Act 1971?⁵ London might be a safer and healthier place with fewer addicts if they did.

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No rationale for prescribing cocaine to addicts

EDITOR,—John Strang and Michael Farrell draw attention to the remarkable case of the cocaine commuter, an American citizen who regularly visited Britain to receive, from a doctor, a prescription for 900 mg heroin daily and an unspecified dose of cocaine.¹ In my view, this is not only a criticisable exercise of clinical freedom but is also unethical.

Treatments for drug dependence should broadly conform to national guidelines² and the generally accepted tenets of usual medical practice. The guidelines state that it is "undesirable to prescribe substitute stimulant drugs." There is no accepted rationale for prescribing stimulants such as cocaine. It should be remembered that in the 1960s cocaine was prescribed in large doses to some heroin addicts. This had disastrous results: a retired chief inspector of the Home Office Drugs Branch reported, "The heroin dose never came down and the cocaine went up."³ It is an ethical imperative that medical treatments should lead to some health gain by the patient.

There are several reasons why the apparently inadvisable treatment of one patient should arouse concern. Firstly, the profession has to respond to medical practice that amounts to a questionable use of clinical freedom and which may be unethical. Secondly, the national press has started to take an interest: on 19 September the *Sunday Times* reported that a clinic near Liverpool was prescribing crack cocaine and aired local concerns that other crack users would be attracted to that area to get similar treatment. Lastly, as Strang and Farrell point out publicity surrounding this issue may lead to a call for international harmonisation that could restrict our prescribing responses. If medical practitioners are neither influenced by their peers nor subject to self regulation then the profession's status becomes open to question.

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- 1 Strang J, Farrell M. Drug regimens that break a country's drug laws. *BMJ* 1993;307:1010. (16 October.)
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Undergraduate medical education

Teaching deserves better recognition

EDITOR,—The problem with changes is that they occur at times of need when resources to implement them are scarce. This is true of the health care reforms and the Tomlinson rationalisations and is probably true of the General Medical Council's recommendations on undergraduate medical education.¹ To some it is perfectly reasonable to look to medical teachers, whose bread and butter it ought to be to translate the vision into reality. As

most academics know, however, teaching counts for little with regard to recognition and promotion. While teaching is often said to be taken into account in some vague way, there is little doubt that research achievements are what really count.

In 1984 the American Academy of Medical Colleges recognised that educational reforms were unlikely to advance unless the contribution of staff to medical education received appropriate recognition. Since then several American medical schools have established career tracks for educators.^{2,3} These schools have adopted the general principle of promoting staff who are of value to the institution whether in teaching, research, or administration. They generally lack the pyramidal structure of academic departments in British medical schools, where educators and research workers may compete for a small number of senior posts. Another factor is their willingness to capitalise on the strengths of their staff rather than to pick at their weaknesses.

A major objection to the promotion of staff on the basis of their contribution to medical education is that measurement of quality is a matter of judgment. This objection, which is equally true of research, has effectively been overcome by implementing detailed assessment procedures and publishing the results, which include records of achievement, evidence of scholarly activity, and extensive peer and student review.^{4,5} With such information, schools have been able to recruit and retain the staff they need to implement curricular reforms.

If any useful reform is to occur in Britain, medical schools will need to value and develop the educational expertise they already have. This will remain an unattractive option, however, if it diverts staff from maintaining research ratings. Nevertheless, medical schools primarily exist and are mainly funded for the education of students. Until this priority is accepted the General Medical Council's latest recommendations risk having as little impact as previous ones.

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- 2 Parris ML, Stemmle EJ. Development of the clinician-educator track at the University of Pennsylvania. *Journal of Medical Education* 1984;59:465-70.
- 3 Kelley WN, Stross JK. Faculty tracks and academic success. *Ann Intern Med* 1992;116:654-9.
- 4 *Procedures for making permanent, term and annual appointments*. Boston: Harvard Medical School, 1993.
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Too many facts, not enough innovation

EDITOR,—Stella Lowry has acquiesced in the notion that British medical education may prosper through accelerated adoption of the "core and options" model.¹ There is nothing novel about the deceptive allure of a core curriculum, but those tempted by it should be aware of generic arguments against this particular solution² or of voices that counsel moderation in the definition of foundation medical knowledge.³ Warnings about the "restrictively fat core"⁴ and the elusiveness of defined objectives in core medical education⁵ have not yet been countered.

Implicit in the core and options approach is the acceptance of an illusory degree of homogeneity in medical education and practice. There is now consensus that a curriculum centred on facts will not serve well in the future: the cascade of biomedical knowledge is already overwhelming. Mastery of concepts and skills will probably