Rocking the foundations

The eighties have not been good years for academic medicine. At best, they will be judged to have created uncertainties that have been distracting and demoralising; at worst, so to have rocked the nation’s teaching and research foundations as to damage irremediably the health services of tomorrow.

In the first half of the decade the cuts imposed by the University Grants Committee diminished significantly the resources of the medical schools. No sooner were the 1981–84 reductions in staffing and services achieved than notice was given of the proposed revision of the system of allocation to universities and the dismal forecasts of their funding to 1991 were announced. Meantime their prospects of grant support from Research Councils were receding, although fortunately there was compensation for medical research in the increasing funding available from the charities and foundations.

The loss of posts resulting from the U.G.C. cuts inevitably affected clinical services, and health authorities found themselves under pressure to fill the gaps. Not unnaturally they resented this burden placed upon them without prior agreement and at a time when their own budgets were becoming strained. The anomaly of a vast and costly organisation funded by one government department with the basic training of its principal operatives and its main research infrastructure funded by another, was readily perceived; the fact that the future of the health service depended on the standard of that basic training and on the quality of the research was not. The essential nature of the partnership between academic medicine and the health service is a concept that is sometimes accepted with reluctance, but mostly ignored.

The reasons for this conceptual divide, until recently symbolised by the communication block between the two departments concerned, though hopefully to be reconciled by the establishment of the new steering group under the chairmanship of Mr M. J. A. Partridge, are complex and are not attributable solely to the attitudes of one or other end of the partnership. Obviously the separate funding streams discount the sharing of ideas and objectives and the recent initiatives on joint planning are to be welcomed. But there are powerful historical influences going back to the days of the Boards of Governors when developments in clinical medicine depended largely on the drive and determination of individuals rather than on a broader consideration of the needs of the populace. Specialised units in teaching hospitals flourished. They contributed handsomely to the advancement of knowledge and although this brought indirect benefit to the community at large, there was a lack of planning for its overall needs, and priorities in medicine were determined by inspiration and initiative rather than by calculation or design. Within the profession itself there were divisions. Fortunately these have now largely disappeared but there still lingers in some quarters a suspicion of extravagant self-indulgence on the part of teaching hospital doctors in their approach to the practice of medicine. The term ‘high tech’ is sometimes used pejoratively in order to devalue developments of today that may turn out to be the counterparts of yesterday’s discovery of X-rays, introduction of blood transfusion or defeat of the tubercle bacillus. Even the word ‘academic’ may be divisive; all who teach or enquire are engaged in academic activity regardless of where they work or who employs them. If there was one factor above others designed to perpetuate the notion of elitism it was the regrettable invention of that most presumptuous label, the ‘centre of excellence’.

Following the reorganisation of the NHS and the more recent advent of professional management, there has been a strengthening of strategic planning and a wholly appropriate resuscitation of parts of the service that were formerly neglected. Unfortunately the planning process is not immune to the influence of political imperatives which are usually based on short-term objectives and may compromise programmes aimed at more distant targets. Without the infusion of sufficient extra funds, the new priorities, coupled with the ever increasing costs of development and the provision of services for an ageing population, have necessitated the controls and economies with which those working in our hospitals are all too familiar. An inevitable consequence of the pressure on the health service has been a reduction in its ability to respond to the needs of teaching and a curtailment of its contribution to research at a time when so many problems are tantalisingly close to solution through the application of the rapidly evolving techniques of modern science.

The common denominator in the problems defined thus far is funding, with academic medicine caught on the twin prongs of NHS and UGC reductions in the places which matter to it. We are now also contemplating organisational changes which could represent an even greater threat: that could in fact be overwhelming. The first relates to the exercise of manpower controls through the JPAC operation which will substantially reduce the numbers of senior registrars and registrars, including those with honorary status who are in academic and research posts. Apart from the direct and obvious short-term effects of such reductions on teaching and research, there will be long-term consequences for the recruitment and training of the clinical scientists of the future. Given the existing manpower structure for hospital doctors the need for such a plan was unavoidable. The structure itself is probably without parallel; it ensures a maximum of security and a minimum of competition once the consultant level, based on a possibly outmoded concept of ultimate responsibility, is reached. It can be likened to a large platform on which there is little jostling but which is approachable only by a limited number of very steep ladders. Given the retention of such a structure, the only way to ease the crush on the ladders is to broaden the platform and reduce the numbers in the queue. There are, of course, other possible structures with sides less steep and stages more secure and permanent than the
Any and unrecognised SIFT in the teaching work and patients story in the considerations, such of services with funding are the development structure in other present workforce of change. It should be remembered that there is no SIFT in the budgets of private sector medicine.

In reviewing what we may see as the miscalculations and ineptitudes of others, we do well to examine our own professional practices with a view to possible modification in the light of change. The anomalies of our career structure already referred to have hitherto carried with them a lack of incentive for professional updating. New requirements for continuing education are probably imminent and they are likely to invite suggestions for the introduction of systems of assessment of professional competence which should not be resisted. We rightly uphold the principle of clinical freedom but if observed to the limit, it can inhibit the questioning of clinical practices and prevent the critical assessment of the outcomes of accepted procedures. In a perverse way the exercise of clinical freedom can result in a randomness in the setting of priorities and a limitation of the scope for their establishment on the basis of measured outcomes. The development of consensus conferences is an important step in a direction which must surely be followed if expenditure on health care is to be contained within reasonable limits.

Self-examination of research and teaching practices is also timely. The validity of present assumptions about the desirable breadth and universality of research experience needs testing, and teaching programmes and practices merit constant review. There has been surprisingly little examination of the ways in which research activities are organised and managed and there is certainly need for restructuring in many institutions to form larger research groups with greater scope for intellectual exchange and with more efficiency in the use of resources.

It is not for those with special interest in academic medicine to try to determine the future of the health services in this country, nor to presume to represent the views of the profession on matters that concern it. It is their responsibility to spell out clearly the implications of health service policies for teaching and research, areas in which they have knowledge and experience.

D. A. SHAW
Dean of Medicine, University of Newcastle upon Tyne

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