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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Two nations at the MRC?

SIR,—Injury is the commonest cause of death among people aged under 40, exceeding heart disease and cancer combined. Consequently, one would assume that the reduction of death and morbidity from injury among this economically active section of the population would be a priority for the Medical Research Council. In reality the council spends about 0·5% of its budget on research into injury, and its sole permanent commitment is a 19 man trauma unit in Manchester. This unit is now threatened with closure allegedly because of difficulties in finding a director to replace Professor H B Stoner.

One has to ask why the MRC wants to close this productive unit despite protests from the presidents of the Royal Colleges of Surgeons of England and Edinburgh, the Faculty of Anaesthetists, the Association of Surgeons, the Casualty Surgeons Association, and the Surgeon General of the armed forces, all of whom regard the work of the unit as vital and relevant. To many surgeons and anaesthetists the council appears to be out of touch with the realities of everyday clinical practice. The answer may be found in the *MRC Handbook for 1984/85*, which lists the activities of the council and the membership of its committees.

Injury (and its consequences) is primarily a "surgical" subject and is usually managed by surgeons and anaesthetists. The council is unlikely to be aware of the problems of the injured unless surgical disciplines are adequately represented on the relevant boards and grant awarding committees. An examination of pages 1-6 of the handbook reveals that this is not the case. Of the 185 places on the committees that run the MRC, only nine are allotted to the surgical disciplines. These places are filled by 6 professors of surgery. There seem to be no anaesthetists on these committees despite the fact that they are the largest consultant body within the NHS. Of particular concern is the fact that among the 62 members of the five grant awarding committees there is only one surgeon. On one committee (cell board B) only one of its members seems to be medically qualified. Such a constitution will ensure the scientific credibility of any grants it awards but not necessarily their clinical relevance.

The figures quoted provide an explanation for the apparent lack of understanding by the MRC of the importance of research into surgical problems, a situation that has long been recognised by those seeking MRC support for surgically orientated projects. They also explain why only one of the 55 MRC units in the UK is devoted to a surgical problem and why only six of the 128 programme grants listed in the handbook are to departments of surgery or anaesthesia.

However, it is not only an antisurgical bias that is evident from this handbook. The United Kingdom has 30 medical schools, which are generally assumed to be of equal quality. Therefore they would be expected to be represented on MRC committees, and receive research funding, roughly in relation to their size. For it to be otherwise would imply that the quality of the staff of Britain's medical schools, and their research, varied to such a degree that would cast doubt on the previously mentioned assumption.

The best way of assessing the size of a medical school is by its student intake. The London medical schools train about 30% of UK students, Oxford and Cambridge about 8%, and Scottish schools 18%. The northern medical schools of Birmingham, Leicester, Nottingham, Sheffield, Liverpool, Manchester, Leeds, Newcastle, and Belfast train some 33% of Britain's medical students (more when one takes into account the St Andrews students, who have their clinical training in Manchester). On these grounds it would be expected that the northern medical schools would have, between them, one third of the membership of the MRC committees and receive one third of the MRC units and programme grants. The tables show this is not the case. The council of the MRC (table I) does not have a single member from the northern universities, whereas London and Oxbridge have 60% of the membership between them.

On the three major boards (table II) the situation is better but still out of line, with London and Oxbridge again having 59% of the places compared with 17% from the northern universities. On the all important grant awarding committees (table III) the situation deteriorates again, with London and Oxbridge maintaining their 60% domination while northern university representation falls to 10%. Throughout the committees Scotland manages to maintain its proportionate representation of 18%.

Perhaps the membership of the committees could be regarded as of little importance until one examines the distribution of MRC units and pro-

TABLE I—*Origin by university of members of council of Medical Research Council: number (and percentages)*

London	Oxford and Cambridge	Other south	Scotland	Northern universities	Lay	Total
9 (45)	3 (15)	1 (5)	3 (15)	0	4 (20)	20 (100)