Social services select committee v the government

The government has rejected the social services select committee’s claims that since 1981 the hospital and community health services in England have been cumulatively underfunded to the tune of £1900m.

The select committee made four recommendations in reports this year:

- Pay review body awards for this year should be met in full.
- Adequate funding should be provided this year to allow for a 2% increase over and above inflation.
- Last year’s shortfalls to cover inflation should be made good. In addition, £1000m should be provided over two years to go some way towards meeting the cumulative underfunding since 1981.
- Improved measures of the effectiveness and outcome of care and treatment in the NHS should be developed.

On pay awards the government reasserted its line that advanced commitment to fund pay rises would pre-empt pay negotiations within the review bodies as well as those within the Whitley councils for non-clinical staff. The government’s recent agreement to meet the awards made by the review bodies of doctors, nurses, and those in professions allied to medicine (an addition of £538m to English health authority budgets) is tempered by Tony Newton’s proviso that this would apply not to the full nursing establishment but to the number in post on 1 April 1988.

The 2% increase in funding for development that was asked for by the select committee is dismissed by the government on the grounds that the underfunding calculation on which it is based ignores some forms of productivity increases in the NHS. Although the select committee took account of cost improvements to release cash, the government argues that reductions in length of stay, for example, have enabled health authorities to treat more patients without a proportionate increase in funding. This ignores the problem faced by many health authorities of rising total costs as more patients are pushed through the system.

The government’s acknowledged underfunding of £95m for prices and pay awards last year has largely been made good, the government states, by the one-off addition of £75m at Christmas. This still leaves, however, the not insignificant sum of £20m.

The select committee’s compromise recommendations of £1 billion spread over two years for funding of development is rejected on similar grounds to the request for a 2% real increase in funding. Greater and more ambitious programmes to reduce costs, it is implied, will meet the committee’s implicit objectives for the NHS. These are to satisfy the growing demands on health care from an increasingly elderly population, to allow for advances in medical technology, and to meet the government’s policies on, for example, care in the community and AIDS. The government’s response to the select committee does not, however, provide any hard evidence as to how large cost improvements that do not release cash should be. Neither does its response address the medium to long term problem posed by the policy of meeting growing demands by productivity increases alone: What happens when all reasonable productivity gains have been made?

In welcoming the final recommendation of the select committee on improved measures of effectiveness the government reiterated the DHSS idea of a “health index” as an aid to health service policy. In concluding that “factors such as diet and smoking . . . are to a considerable extent a matter of personal choice” the government restates its wider economic and social view of personal rather than collective responsibility—a view which will no doubt form a central plank of the Prime Minister’s current review of the NHS.

— JOHN APPLEBY

Food poisoning up

In the first five months of this year 7436 cases of food poisoning were statutorily notified in England and Wales, 2029 more than in the first five months of last year. These figures, together with a report from the Food Policy Research Unit in Bradford, have stimulated articles in the press on the increase in food poisoning and the decline in standards of hygiene. So is the increase real and what might be its causes?

Only about one in 25 cases are reported, but the rise cannot be explained simply by increased notification or improved isolation techniques. Over four fifths of cases of bacterial food poisoning are caused by Salmonella species; the other three main isolates are Staphylococcus aureus, Clostridium perfringens, and Bacillus cereus. Although it may be spread by poor food handling, the most important source of salmonella food poisoning is livestock and poultry. According to Dr Richard Gilbert of the Food Hygiene Laboratory at Colindale, up to four fifths of raw chickens on sale may contain salmonella.

Recent outbreaks of food poisoning in the United States have now been attributed to Salmonella enteritidis isolated from foods made with raw eggs: the organisms may unusually have been inside the eggs.

In Denmark an aggressive programme of sterilising feeds and eliminating the carrier birds has led to a dramatic fall in outbreaks of salmonella food poisoning.

In addition, isolates of Campylobacter continue to rise—to over 25 000 in 1987. Most of these are likely to be foodborne infections. Some of this rise may be attributable to improved isolation methods and media, says Dr Sally Millershaw, senior lecturer in bacteriology at the Hammersmith Hospital. Food poisoning may be serious in the very young, the old, and the sick: in 1984 there were 48 deaths from bacterial food poisoning in England and Wales, 19 of which occurred in the outbreak at Stanley Royd Hospital. The economic costs of food poisoning are enormous. In the United States Dr Santanta Miller, director of the Centre for Food Safety and Applied Nutrition, estimates that it costs $164 billion a year.

Outbreaks of food poisoning usually occur because people have broken the simple rules of food hygiene and have, for instance, prepared food too far in advance or kept it at the wrong temperature. The increase in mass catering means that a single contaminated source may affect many more people.

Some of the current increase in food poisoning in Britain may result from the understaffing and underfinancing of environmental health departments. Their officers manage to visit less than two thirds of the premises for which they are responsible at least once a year. And, although crown immunity has been removed from hospitals, it still stops the officers inspecting prisons, army catering facilities, and other establishments. So while outbreaks of food poisoning are increasing prosecutions are falling. The report from Bradford argues that the current legislation is outdated and lacks teeth. It wants a review of the law, particularly on the licensing of premises.

The Department of Health and Social Security together with the Health Education Authority will shortly be producing a leaflet on food hygiene for the public.—MARY E BLACK, registrar in bacteriology, London
Booth leaves CRC: what now?

Yesterday Sir Christopher Booth left his post as director of the Clinical Research Centre. He has left because he thinks 10 years as director is enough and because it does not make sense for him to be director when he opposed the decision to fuse the centre with the Royal Postgraduate Medical School on the Hammersmith site. There is, he says, no bitterness in his departure.

Many might think that this is the end of the arguments over fusing the two institutions (the story so far is summarised in the box), but huge problems still exist. These are:

- Money. The Medical Research Council cannot fund the changes out of existing income; it needs an additional £60m. Understandably the Treasury will not release this money without looking closely at the case for a new centre on the Hammersmith site. The council has not yet made its formal case to the Treasury, but the Prime Minister is well aware of this issue—and is said to be asking some hard questions.

- Space. New ground and new buildings are needed, and complicated negotiations are in train to try to buy new land, most probably that currently occupied by a school.

- Range of clinical services. Comprehensive clinical research will not be possible if specialties like infectious diseases, clinical genetics, psychiatry, public health, and epidemiology are not provided in the new centre. Some of these services are provided elsewhere in the region, some are provided by the other teaching hospitals close by, and some cannot be adequately provided at Hammersmith because the population base is too low.

- Staffing. Finding staff in central London is becoming increasingly difficult, and the predictions are that it will get worse. Such a large centre will require many new staff and the regional health authority is anxious that it will not be possible to find enough.

- Neighbours. Hammersmith is only a few miles away from other teaching and postgraduate hospitals. Will there be enough patients and staff to go round without compromising the clinical service, teaching, and research of some of these institutions?

- Governance. One reason why the Medical Research Council opted for the Hammersmith site was that it preferred the management arrangements at the Royal Postgraduate Medical School. At Northwick Park the research centre and the hospital are separately managed, whereas in Hammersmith the heads of departments for research and education are also chiefs of service in the hospital. Another difference between the two centres is that research in Hammersmith has been more "bottom up" while that at the Clinical Research Centre was more managed. To have more bottom up and less managed research would, however, be against the current trend.

All these hurdles must be cleared before the new centre can open, and the Medical Research Council might fall at any of them.

Sir Christopher Booth, who was knighted in 1983, has worked in both the Royal Postgraduate Medical School and the Clinical Research Centre. He joined the Royal Postgraduate Medical School as a lecturer in 1959, became professor of medicine in 1966, and then left to become director of the Clinical Research Centre in 1978. Primarily a gastroenterologist, his research interests have included the function of the small intestine in health and diseases and the nutritional sequences of malabsorption. Currently he sits on the Medical Research Council, and he has served on the Advisory Board to the Research Councils and been president of both the BMA and the Johnson Society. After stepping down as director of the Clinical Research Centre he will continue as a physician at Northwick Park Hospital and will also become chairman of the BMA's board of science and education.

Examing the problems is a steering group under the joint chairmanship of Dr Dai Rees, the secretary of the Medical Research Council, and Lord Dainton, chairman of the council of the Royal Postgraduate Medical School. Whatever happens the new centre is unlikely to open before the late 1990s.

Both the clinical and the research staff at Northwick Park accept that the Medical Research Council has decided to move the Clinical Research Centre to Hammersmith, but many are aware that there may be a substantial (even unbridgeable) gap between making the decision and implementing it. Scientific direction of the centre is to be taken over by a committee that is being chaired by Dr Dai Rees.

Even before the report recommending merger was published the North West Thames Regional Health Authority and Harrow Health Authority had recognised that changes were needed at Northwick Park, and one aim has been to increase the specialist units in the hospital. They have

The story so far

The amalgamation of the Clinical Research Centre and the Royal Postgraduate Medical School on the Hammersmith site may be viewed either as an orderly procession of distinguished committees making rational decisions or as a bitter struggle over philosophy and management. The committee in the chain was the remit committee, which was set up by the Medical Research Council in March 1984 because of unhappiness with the performance of the Clinical Research Centre. Reporting in January 1985, it advocated a detailed and more wide ranging review of the centre. Many of those on the original committee were retained on the second committee; both were chaired by Sir Michael Stoker, FRS.

The second Stoker committee decided that the Clinical Research Centre "had not developed into a truly national centre as was originally intended." It thought that the deficiency of specialist clinical services and the emphasis on research into common clinical conditions militated against the best research because that was not how scientific knowledge in medicine had developed. The director of the centre had not enough influence in appointing senior hospital staff. Hospital medical staff were not sufficiently available for research because of private practice and a heavy clinical workload within the hospital. The centre did too little teaching and training, making it more difficult to find recruits. Finally, there was insufficient basic science at the centre.

Oddly omitted from the Stoker committee's terms of reference was any examination of the scientific excellence of the Clinical Research Centre—in many ways the central question. The committee could not, however, hold itself back and commented on the centre's scientific standing, noting that many leading researchers were unwilling to move there and that many witnesses thought that the centre had not established itself as a major force in clinical research. That the committee commented on the scientific standing of the centre in this rather offhand way—without a visit to the site or any analysis of published or continuing work—may have been what caused Sir Christopher Booth to call the report "naive and superficial."

Some people at Northwick Park think that the centre was cursed from its beginning by a Lancet leading article that referred to "murderings about guinea pigs and monstrous white elephants." They think that powerful men in academic medicine have all along resented a national centre for clinical research that was not attached to a university, particularly one that was committed to research on
What ever happens the fusion of the Clinical Research Centre and the Royal Postgraduate Medical School into one centre is likely to take at least a dozen years from the start of the inquiry into the Clinical Research Centre. And the fusion with the National Institute of Medical Research, which the Stoker report also proposed (see box), may take another dozen years.—RICHARD SMITH

A new tool in the fight against AIDS?

Amid the scientific advances announced at the fourth international conference on AIDS last month in Stockholm was an equally radical one on information—a database on AIDS held on compact disk. The Compact Library: AIDS contains references on AIDS from Medline together with the AIDS Knowledgebase, an electronic textbook written and maintained by physicians at San Francisco General Hospital, and the full texts of articles on AIDS from the Annals of Internal Medicine, the BMJ, the Lancet, Morbidity and Mortality Weekly Report, Nature, and the New England Journal of Medicine. The disk’s creators are the publishing wing of the New England Journal, and they hope that it will be first of a series of information sources distributed on CD-ROM, the computer readable version of the compact audio disk. The CD-ROM’s advantage is its robustness and enormous capacity—the information on the AIDS disk fills only about a quarter of its capacity, leaving plenty of room for sophisticated search software and for future expansion. The disk can be read by a personal computer with a compact disk drive, and the software allows the user to search the entire disk for only a subset of the data, to search for information through keywords or through tables of contents, and to follow a reference from its bibliographic citation to the full text or from its citation in one article to articles that have subsequently cited it. The results can then be viewed on screen or printed out.

CD-ROM databases are fast catching on, offering libraries and others relatively cheap access to vast amounts of data, most of it bibliographic or reference, without the costs and complications of accessing remote databases. Over 300 disks are now available world wide, including the Oxford English Dictionary, the Science Citation Index, and Universal health insurance in the United States?

In April Governor Michael Dukakis signed a law guaranteeing health coverage for nearly everyone in Massachusetts. This is the first universal health insurance plan in the United States, and Governor Dukakis hails it as a model for the whole country. “Forty years after Harry Truman first proposed it we are finally on the road to basic health security for the citizens of this state,” he said. “It’s something which is long overdue for Massachusetts and long overdue for the country.”

A national programme modelled on the Massachusetts plan would extend medical coverage to nearly all residents of the United States who do not have any private or government health insurance. The Massachusetts law, which takes full effect in 1992, is, however, a far cry from the sweeping proposals of the 1960s and ’70s and from the systems already in place in most other industrialised countries. It relies on tax incentives to encourage employers to offer insurance to full time employees and sets up a state fund financed by a payroll tax to help those who are unemployed to buy health insurance for themselves.

The law nearly failed to be passed several times in the past year and was watered down considerably from its original version to preserve a fragile coalition of supporters.
Michael Dukakis is the man most likely to be the Democratic candidate in the next US presidential election. After attending Harvard Law School he was elected to the Massachusetts House of Representatives on a "good government" platform, and in 1974 he became state governor. He lost the election four years later but was re-elected in 1982 at the beginning of an economic boom in his state. He is now fashioning a national agenda based on the economic success of Massachusetts.

Not least among the factors that enabled its passage was Michael Dukakis, who as governor championed the issue and made it part of his campaign for the Democratic presidential nomination. He said that he did not want the United States to stand alone with South Africa as the only two industrialised nations that do not provide basic health security.

In its emphasis on employee health insurance the Dukakis plan follows the same approach as a bill introduced in the past year in Congress. This bill, the Kennedy-Waxman bill, would cover employees who work at least 17 hours a week; its supporters give it only a "fighting chance" of passage this session but say that its prospects would improve with a Democrat—particularly Dukakis—in the White House. Both the Dukakis law and the Kennedy-Waxman bill do not expand and reform government insurance programmes such as Medicare and Medicaid but build on the health insurance system provided by employers that has traditionally provided most of the cover of non-poor Americans under 65. The Kennedy-Waxman bill and a comparable plan in Hawaii—where employers have been required since 1974 to provide health insurance for their employees—do not, however, address the problem of the unemployed.

Of the 211 million Americans under 65 in 1987, 18%—or over one in six—had no health coverage at all, according to the congressional budget office. This uninsured group has increased by a quarter since 1980. A survey by the Employee Research Institute found that nearly half of the uninsured Americans under 65 were employed, about one third were children under 18, and only 19% were unemployed adults. Surveys have shown that a lack of insurance stops people getting medical care except in an emergency: uninsured Americans are almost twice as likely as those who are insured to be without a regular source of health care and have a higher rate of medical emergencies. A lack of insurance has been linked with a higher mortality in general and higher infant mortality in particular. The increasing numbers of uninsured Americans also indirectly affects even those who are insured by raising hospital charges, insurance premiums, and taxes to cover the costs of uncompensated care and public insurance programmes such as Medicaid.

The fact that the Dukakis law focuses on those who are working and have no health insurance—with the private sector bearing much of the cost—makes efforts to expand access to health care more politically palatable: it meets a need without spending a great deal of money. Some critics say, however, that Massachusetts, with its comparatively low rate of unemployment and generous Medicaid scheme, may not be the best model for reforming the United States' health insurance system. A state by state survey in 1987 showed that Medicaid excluded between one third and a half of all poor Americans and that coverage for the 23 million included was patchy and variable. The total yearly expenditure per person ranged from $400 in Mississippi to $3200 in New York. Thus the Massachusetts law applied nation wide would leave millions of poor people "at the mercy of a safety net full of holes."

Finally, health insurance has been declining in the 1980s because much of the growth in jobs has occurred in small companies and service industries, in which insurance is less likely to be offered as a perk to employees. If employers now offer health insurance the problem of the numbers of uninsured people will be improved, but it is not known how employers will respond to the mandate. They may, for example, take on fewer people; many small businesses opposed the Dukakis plan, even though it exempted companies with five or fewer employees and established a hardship fund for companies with 50 or fewer employees. The main impact could be on those who work part time and those who receive the minimum wage.—DON COBURN, staff writer, Washington Post (adapted from "As Massachusetts Goes, So Goes the Nation?" published originally in the Washington Post).

Lawyers against tobacco companies

Amid the ballyhoo over the first court verdict pinpointing some of the blame for a smoker's death on a tobacco company, another court finding has gone virtually unnoticed. The day after a New Jersey jury awarded Antonio Cipollone $400 000 damages against the Liggett Group for the death of his wife, Rose, at 58 from lung cancer a federal appeals court in Cincinnati, Ohio, threw out a claim against R J Reynolds Tobacco Company.

The Ohio ruling upholds the manufacturers' argument that the health warnings that have been compulsory in the United States since 1966 protect the companies from most liability claims for deaths caused by their products. The Liggett Group believes that it has a good chance on appeal of overturning the New Jersey jury's verdict, which was based on advertisements in the 1950s, including one headed: "Just what the Doctor Ordered." The jury decided that the early advertisements contained an express warranty of the cigarettes' safety and that the warranty was a contributing factor in Rose Cipollone's death. The finding that the company was 20% liable for her death—she herself bore 80% of the blame, the jury held—has broad implications throughout the industry as most manufacturers ran similar advertisements 30 years ago. One R J Reynolds advertisement claimed: "More doctors smoke Camels than any other cigarette."

Apart from some early cases in the 'fifties, the Cipollone case is the fourth to go to a jury verdict in the United States and the first win against a tobacco manufacturer anywhere in the world.
the world. In two cases the plaintiffs lost—a case of oral cancer allegedly caused by tobacco teabags and a case of heart disease in which the evidence showed that the cause was not smoking. The third case, in which there was a hung jury, is to be retried. A verdict is imminent in a case in Pennsylvania about the death of an asbestos worker in his 50s. The case, which went to trial on 6 June, hinges on the manufacturer's failure to warn of the synergistic reaction between tobacco and asbestos.

Over 100 cases are pending in the United States, including 23 against the wholly British owned British American Tobacco. Two cases have been filed in Finland with the backing of the Cancer Society, and, according to Professor Richard Daynard, founder and chairman of the Tobacco Products Liability Project in Boston, claims are likely to be brought in Canada. The tobacco industry is shrugging off the award, at least publicly. Antonio Cipollone's lawyers—acting, as American lawyers usually do in these cases, on a "no win, no fee" basis—spent over $2m to collect $400 000 for their client. But they expect to use the documents and depositions (writings statements) in six other pending cases. "No one gets into this for one case," says Professor Daynard. "You get into it because you expect to spend a substantial amount of your life bringing these cases."

For other lawyers as well some of the expensive groundwork has been laid by the Cipollone trial. Key documents collected in the case are being distributed for $100 by the Tobacco Products Liability Project, which is funded by the Rockefeller family fund.

Such a move would be impossible in Britain, where the rules of litigation ban documents used in one case from being supplied to plaintiffs in other cases. The 1·3 million documents disclosed in the benoxaprofen litigation, now settled, cannot even be used by the plaintiffs in the second benoxaprofen group—that is, those who issued their writs too late for inclusion in the first group. Professor Daynard predicts that the smoking cases will eventually run into thousands, with the litigation repeating the pattern of the string of lawsuits over asbestos, which drove the Johns-Manville Company into bankruptcy. "There will be some wins and some losses and then eventually plaintiffs' attorneys will work out how to handle these cases."

In Britain plaintiffs face more and more hurdles. A 33 year old victim of Buerger's disease who lives in Northern Ireland has already surmounted the first: he has been granted legal aid to prepare the case up to the point of trial, with the extension of aid to cover the trial to be reviewed at that stage. But the inevitable defence—that the smoker who knew of the risk and puffed on regardless cannot blame the manufacturer—is likely to prove a bigger obstacle in the British courts. Lawyers have put forward as the ideal hypothetical plaintiff someone who gave up smoking when the health warnings were issued and many years later developed lung cancer. But such a plaintiff would probably face great difficulty in convincing a court that his or her illness was caused by smoking. Other lawyers suggest that a baby harmed in the womb by his or her mother's smoking would have the best chance of success in our courts.—CLARE DYER

**Sir Hugh Cairns remembered**

Last month a plaque was unveiled at St Hugh's College, Oxford, marking its conversion to the Military Hospital for Head Injuries during the last war. The plaque also commemorates Professor Sir Hugh Cairns, his staff, and the patients treated at the hospital (two of whom commissioned the plaque). Cairns, Oxford's first professor of surgery, was responsible for setting up and directing the hospital. He was also responsible for the formation of mobile neurosurgical units, often manned by former staff of the hospital and currently regarded as one of the great medical achievements of the second world war. (Between 1914 and 1918, 90% of penetrating head wounds were fatal; between 1939 and 1945, 90% of the injured survived.)

**Owen wants alcohol under the Medicines Act**

Alcoholic products should be included under the Medicines Act, said Dr David Owen, leader of the Social Democratic Party and former minister of health, giving the Cyriax lecture at St Thomas's Hospital, London. The 1968 legislation would mean that a specialist committee could be established to give expert medical and scientific advice on the health risks of alcohol. The drink industry might be obliged to stop or curtail specific advertising and promotion of alcoholic products. "There would," said Dr Owen, "be the opportunity of applying a comprehensive strategy of discussion operating not just on price but on promotion."

Dr Owen also advocated a levy on the drink trade to finance alcohol services and research. This levy, he said, could make up for the excise duties and VAT on alcohol that will have to be reduced with harmonisation in the European Community in 1992. The levy

**Independent college for ophthalmologists**

The newly formed College of Ophthalmologists was granted a royal charter on 1 April 1988. This marks the combination of the Ophthalmological Society of the United Kingdom with the Faculty of Ophthalmologists to form a college to unite and expand the activities of the two bodies.

The College of Ophthalmologists will establish its own training criteria and examinations. The Royal Colleges of Surgeons in the United Kingdom and Ireland currently set various fellowship examinations for ophthalmologists. The establishment of an independent college also gives ophthalmology the right to be represented separately on government committees.

The college's first president is Professor Wallace S Foulds, Tennent professor of ophthalmology, University of Glasgow, and the journal Eye is its official scientific publication. The address is Bramber Court, London W14 9PQ.

---

Mr Day: To try to reduce tumours on the backs of mice.

Lawyer: It had nothing to do with the health and welfare of human beings? Is that correct?

Mr Day: That's correct.

Lawyer: How much did that study cost?

Mr Day: A lot . . . probably between $15m and more.

Lawyer: And this was to save rats, right? Or mice? You spent all this money to save mice the problem of developing tumours, is that correct?

Mr Day: I have stated what we did.

Source: *Wall Street Journal*, 4 April 1988.
might go to an alcohol related special health authority that could be advised by the specialist committee set up under the Medicines Act.

The new BMJ

The new design of this BMJ, the first major change since Stanley Morison's new look 50 years ago, has three main aims: to make it easier for readers to find their way around, to end strongly rather than petering out, and to place new emphasis on various aspects—in particular the major news stories. All this is happening in a journal that will still be instantly recognisable.

The first aim has been achieved by creating a full table of contents at the beginning of the journal, introducing This Week in the BMJ, a page to explain why each of the papers may be important for the general reader. The strong finish is provided by three of our most popular features: Opinion, such as Letter from Chicago and Scientifically Speaking; Personal View; and Minerva.

The new News section follows the pattern in Nature and Science, where signed articles feature contemporary issues in more depth than is possible in a note. And, though the size of the journal has been reduced to A4 (so enabling us not only to buy cheaper paper but also to waste less in printing), the colour of the cover, the Eric Gill logo, and the typeface are still all the same, including the famous capital j, with its "descender" specially cut by Stanley Morison.

All these changes were based largely on a small workshop held two years ago in Stratford upon Avon, where some 16 doctors spent two days discussing what they most liked, disliked, and wanted to see in the journal. All except me were under 40 and had come from various disciplines and from all over Britain; they had been asked to find out the answers to these questions from as many colleagues as possible. From this and many discussions in the editorial and publishing offices we drew up a blueprint and then held a competition among three invited designers. Advised by Herbert Spencer, professor of typography at the Royal College of Art, all of us found that Eiichi Kono's design was a clear winner: not only did it have the clarity and zest of Stanley Morison's original but it also allowed the maximum of flexibility and saving of space, enabling Ray Fishwick—our brilliant designer, responsible for the house style of our journals and books for the past 15 years—to realise it in practice.

Changing designs should no more be occupational therapy for editors than changing the undergraduate curriculum is for deans (as the late Henry Miller alleged). Nevertheless, we believed that the time was right for a change and the new design meets our aims admirably—a view confirmed by the verdict of outsiders who have been shown dummy issues. Today's version is hardly likely to be final, of course, and we will welcome any comments on it together with suggestions for suitable changes.—STEPHEN LOCK

Researchers group to resist DHSS

On Monday this week a large group of researchers affected by changes in the contract of the Department of Health and Social Security got together for the first time and formed a working party to coordinate their response to the department.

The change in the contract, which gives the DHSS the power to prevent the publication of research it has sponsored, was introduced in February 1987. The issue came to prominence only at the end of last year because most researchers are on rolling contracts and it took time for the potential importance of the changes to be recognised.

The organisers of the meeting had contacted all the directors of DHSS units and as many researchers on individual contracts as they could, and only three had signed these. One of those who signed admitted that he had not read the small print. Only one of the 58 respondents had said that he would sign the contract as it was. After telling the meeting that he would not accept the contract even if it meant losing his DHSS funding, Dr Gerald Draper, director of the Childhood Cancer Research Group, referred the arguments against the change in the contract: the implication that research was done to inform the government's interest rather than the wider interest; the threat to academic freedom; the loss of credibility for the research; and the threat to collaborative research. Another problem, said Professor David Miller of St Mary's Hospital Medical School, was that researchers might not be doing research if they thought publication might be vetoed. Professor Barbara Tizard of the Institute of Education thought that this was already happening. Another difficulty was that the wording of the contract does not make clear what is meant by publication, and the meeting was told of a researcher who had been telephoned by the DHSS after he had displayed some results without permission at a conference in Dublin.

The issue has been taken up by the Committee of Vice Chancellors and Principals, the Association of University Teachers, the BMA, the Royal College of Nurses, the House of Lords Select Committee on Science and Technology, and other organisations. But the department has not yielded an inch. It says that there have been no examples of publication being blocked and that publication would be stopped only in exceptional circumstances—for example, when legal problems arose.

Several researchers at the meeting have delayed signing their contracts for a long time and have quickly to decide what to do. One faction said that nobody should sign and that together the researchers should confront the department. Prominent in this faction were Dr Luke Zander of the division of general practice at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals and Dr Ann Cartwright of the Institute for Social Studies in Medical Care. Invoking the plight of German scientists in the 1930s Dr Zander said that an ethical line had to be drawn at some point. Many of those at the
meeting said that the problem with this strategy was that only a few researchers were having their say and that those would be the ones who would suffer the consequences of such a stand.

A second faction, in which Professor Gerry Shaper of the Royal Free Hospital of Medicine was prominent, wanted to sign the contract, carry on as if nothing had changed, and then wait for a particular case to arise. That, said Professor Shaper, would be the time to fight.

A third faction, which includes many of those who are under pressure to sign now, opted for a compromise in which they insist that the DHSS makes explicit in a letter covering the contract just what is meant by exceptional circumstances. Some of the directors of units had received such letters, which said that the department envisaged publication being blocked only if the law was being broken—as, for instance, with libel— or if there was an important factual error. The letters also say that a decision will be given within 28 days (or if not an explanation will be given) and that there will be no minor amendments. Professor Tizard said that she regarded this as a "miniscule advance" but thought that there was little chance that the DHSS would give any more. Legal advice suggests that the covering letters would not amount to a legal commitment by the DHSS.

The meeting heard of a case of a "modest paper on child abuse" that had recently been sent to the DHSS. The department had answered that all papers on this topic needed to be resubmitted and recirculated. The author had done this, and she is still waiting to hear after the 28 days have passed. What, she wondered, should she do now?

Although a consensus could not be reached over the best strategy there were no dissenters from the view that an organisation of DHSS researchers should be formed—with links to other organisations campaigning on this issue. Dr Zander is coordinating the working party and can be contacted at Lambeth Road Group Practice, 80 Kennington Road, London SE11.—RICHARD SMITH

Self financed chair in health policy

Nick Bosenquet, senior research fellow at the Centre for Health Economics at the University of York, has been appointed professor of health policy in the University of London based at Royal Holloway and Bedford New College at Egham, Surrey. The chair will be financed partly through contract research—believed to be one of the first such arrangements in the country. Professor Bosenquet is currently a special adviser to the House of Commons select committee on social services.

The Week

Nooks, crannies, and canyons of general practice

For anyone, like myself, seeking enlightenment about the nooks and crannies, and, yes, the canyons too, of general practice a visit to the annual conference of representatives of local medical committees—to give the occasion its full front title—is a must. So there I was, not, admittedly, for the whole two days of 22 and 23 June but for much of them and the evening dinner as well—the best for some years—imbibing the essence of the eighties in medicine and general practice.

But is it still family doctoring? Is it not today a computer invaded, receptionist dominated, management oriented, money interested collection of small businesses that happen to be providing Britain's citizens with a primary care service? There may be elements of some—or occasionally all—of these to be found in many practices, but having listened inside and outside the conference hall for two days, I have concluded that general practitioners are still delivering a friendly family service. Representatives may have had their customary bashes at the government, carped at their terms of service, and moaned about ever more demanding patients, but essentially they impressed me as being committed to providing a caring and effective service to those patients.

Firstly, the conference reaffirmed its commitment to a health service that is free at the time of use, funded essentially from taxation, and available to all citizens. On a similar theme, underfunding of the NHS, speakers showed the same commitment to the service, warning that investment of new money was needed to achieve excellence in health care. Secondly, the take cash limits now proposed for parts of general practice. Those outside the craft might cynically conclude that of course general practitioners would oppose such financial restraint because it would compel them to be more efficient. Well it might do that, but at what cost? Hear the words of Dr Peter Holden, a relatively young doctor and thoughtful medicopolitician: "Promoting Better Health [the government's white paper on the future of primary care services] is full of references to improving standards of delivery and prevention, most of which the conference will applaud. But these improvements in primary health care require the investment of new cash. An open ended commitment to patients is not consistent with a cash limited budget."

Not a new argument, I know, but it bears repeating because it is a truth that the government is unwilling to confront.

Thirdly, the conference overwhelmingly confirmed "the principle that general practitioners should accept 24 hour responsibility for the care of their patients." A fundamental principle that was the cornerstone of general practice, was how the proposer (Hertfordshire's Dr J L I Jenkins) described it, while Dr M F Hudson from Cheshire argued that its loss would weaken the relationship between the doctor and patient and create the image of a 9 am to 5 pm doctor.

Then there was an outstanding debate that concluded with few dissenters that advertising by doctors was not in the best interests of patients. It was a debate that the members of the Monopolies and Mergers Commission inquiry team should read, in particular the comments by Dr T M John from Redbridge and Waltham Forest, whose arguments, though familiar to doctors, were succinctly marshalled. More information yes: advertising no. He made two points new to me: firstly, advertising costs money, which would probably have to be deflected from vital areas of practice; secondly, the British Institute of Practitioners in Advertising defined advertising as presenting "the most persuasive possible selling message at the lowest possible cost." Doctors, declared Dr John, "should go for the best possible medical standards with the highest possible professional etiquette."

Of those nooks and crannies there were many, as to the canyons, there were debates on AIDS, in which the BMA council's revisionist line on testing was approved (p 74), and one of those seemingly bland motions that carry a between the lines message for the platform.

In his opening address (p 74) Michael Wilson, GMSC chairman, had set a target of
summer 1989 for the completion of the negotiations on the white paper, had said that definitely no, no, no, and had confessed that the negotiations were tough going, with too much time spent giving tutorials to civil servants on how general practice operated.

Dudley Local Medical Committee—in the determined shape of Dr Jim Milligan—sought an interim report on progress "so that local medical committees may be kept informed of developments." Leaks from the "other side," claimed Dr Milligan, were causing anguish in the local medical committees, with the profession's trust in the centrally held negotiations being rapidly undermined by the lack of news.

To a sensitive conference ear this sounded like the early rumblings of "trouble at t' mill" for the negotiations, particularly as in my experience the midlands are a good barometer to national feelings among general practitioners. Michael Wilson defused—temporarily anyway—this platform time bomb by supporting the motion. But it adds one more dimension to his long and tenacious chess game with ministers on the future of general practice. But I'm sure he'll use the motion to good effect.

SCRUTATOR

Letter from Westminster

Bevan remembered as "the greatest socialist"

The National Health Service has outlived its political architects. Possibly the only survivor of Aneurin Bevan’s inner circle of politicians and civil servants responsible for creating the NHS 40 years ago is Lord Bruce of Donington. In 1945, as Major D W T Bruce, newly elected Labour MP for Portsmouth North, he became Bevan’s personal aid as his parliamentary private secretary.

As a contribution to the fortieth anniversary I interviewed Lord Bruce at the House of Lords, where he is an opposition front bencher on Treasury matters. I asked him if he thought that Bevan perceived the NHS as the achievement for which he would be remembered.

"Bevan never bothered about what posterity was going to think of him," Lord Bruce said. "To my knowledge, he did not see the health service as his memorial. He was not a nostalgic person."

Initially, Bevan had been more interested in foreign affairs and there was a suspicion that Attlee made him Minister of Health to remove him as a potential source of trouble on the back benches, though Lord Bruce doubts that: "Attlee wanted to use Bevan's experience in local government. Clem admired Bevan, despite rumours to the contrary."

Bevan began work by calling a staff conference to tell the civil servants what he wanted—a tax funded health service free to everyone at the time it was needed.

Lord Bruce recalls: "They came back with proposals based on the doctors becoming paid servants of the local authorities. He burst out laughing and said 'You cannot do this to me. Go away and think again.'"

A salaried profession seemed to him to conflict with the freedom of patients to change doctors, which he thought should be combined with the financial disincentive of capitation fees to keep doctors up to the mark.

According to Lord Bruce, "Bevan's proposals completely excluded a salaried service, though that was a principal plank of the BMA's opposition—in complete contradiction to what they knew to be the case. The BMA said doctors would become salaried by the back door later. The BMA fought him on grounds that were already covered. It was a phoney campaign from beginning to end.

"It became a question of whose nerve lasted longest. He was fortified by the support of the three royal colleges, and particularly Lord Moran. That broke the log jam. But the doctors held a referendum and announced that an overwhelming majority was against participating.

"That was extremely critical. There was some nervousness in the Cabinet about whether Bevan should back down. Herbert Morrison thought he should. He was anxious the new service would not fail. Surprisingly, it was Ernest Bevin who weighed in on Bevan's side and that was decisive."

Lord Bruce remembers Bevan's concession in allowing private patients in NHS hospitals: "He knew it was the price he had to pay. His concept was to regionalise the hospital service with each region based on a teaching hospital. He thought it best that the consultants should be at the apex of the hospital service."

Although Bevan's negotiations with the doctors were amiable, Lord Bruce thinks that the BMA had succumbed too readily to the public image of Bevan in which the press portrayed him as a loud mouthed miner from Ebbw Vale, whereas he was among the best read ministers.

From the start Bevan had placed "tremendous trust" in the medical profession and insisted on complete clinical freedom for doctors to prescribe and treat exactly as they thought fit. "He would have resented any endeavour to inhibit clinical freedom by today's hospital managers who are being pressed to measure the efficiency of doctors according to throughput. That puts undesirable pressure on the doctors and is an interference with clinical freedom. Bevan would have fought against that, I can tell you."

"He would never have worn the importation of efficiency experts into the structure of the service. He had a low regard for them, and was generally in support of matrons even though he was well aware of their imperfections. Matron would have survived, without a doubt."

Bevan was apparently dismayed by the extent of Conservative opposition to the NHS bill in parliament. "All the time they were fighting him on grounds that simply did not exist. If Bevan knew that today the Tory party would be claiming it is the party best able to safeguard the health service he would have burst into loud laughter."

But the funding of the NHS was in crisis from the start. "Bevan was well aware it was virtually impossible to formulate any estimates as to the annual cost of the NHS. He was very fortunate in having Hugh Dalton as Chancellor. He fully agreed with Bevan's concept, but said it would be very difficult. At an early stage Bevan criticised doctors for pouring cascades of pills down patients' throats. The drugs bills were considerable."

When Bevan resigned as Minister of Labour in 1951 over defence spending and health charges he called in Bruce—by then out of parliament—who typed the resignation letter.

Lord Bruce counts Bevan's widow, Baroness Lee, as the other survivor of the inner circle: "All through the battles he was well attended by Jennie Lee. She guarded his private life so that he could get some relaxation. It required an act of some political sacrifice for Jennie to subordinate herself to Bevan, since she was a formidable politician in her own right."

As for Bevan himself, he remains to Lord Bruce "the greatest socialist of this century."

JOHN WARDEN