NEWS

The GMC in court

The General Medical Council, which once found itself in court only when a doctor appealed to the privy council against a finding of serious professional misconduct, is facing a growing readiness of dissatisfied doctors to mount legal challenges to its practices and rulings.

Dr Sidney Gee, the Harley Street slimming doctor cleared of charges of misconduct last April, started the trend when he took the first ever challenge to charges by the GMC—before they were even heard—all the way to the House of Lords. Now the GMC is embroiled in court proceedings on two fronts, over its restrictions on advertising and its procedures for registering overseas doctors.

The council says that it will "in all probability" appeal to the Court of Appeal against a ruling by the employment appeals tribunal on 9 July that the GMC is covered by the Race Relations Act 1976. The council contends that as a statutory body it is exempt under section 41 of the act, which gives a general exemption for things done "in pursuance of any statute, subordinate instrument or Order in Council."

The question is a preliminary point that arose on a complaint to an industrial tribunal by a 43 year old doctor from Sierra Leone, Musa Goba, that the GMC's treatment of him was racially discriminatory. Dr Goba has failed the council's professional and linguistic test several times. Both the industrial tribunal and the employment appeals tribunal ruled that the GMC is covered by the act. If the Court of Appeal agrees the case will go back to the industrial tribunal for a ruling on whether the council did, in fact, discriminate unfairly against Dr Goba.

This week the high court reserved judgment on a challenge by Dr Richard Colman, a general practitioner in private practice, to the GMC's rules on advertising. Dr Colman, who practises holistic medicine, including counselling for cancer, is seeking judicial review of the GMC's guidance on advertising and of advice from the president that an advertisement in the local press could give rise to justifiable complaints from other doctors which the council would be bound to consider.

Dr Colman, a member of the Royal College of General Practitioners who studied medicine at Cambridge and Barts, says he decided in 1985 to practise outside the NHS because he believed that NHS practice, geared to a high turnover of patients, prevented him from devoting the time he thought was necessary to help patients gain a better understanding of their problems and make the choices necessary for their health.

He emphasises that the decision was not motivated by financial considerations. In fact he says that he had an income of only £7260 in the year ended 30 April 1987, of which only £1468 came from his practice. A father of three small children, he receives family income supplement, and the Medical Defence Union has agreed to pay his legal costs. Letters to local general practitioners telling them of his services produced no replies; the local library refused to display his information sheet with those of NHS doctors; information sheets left at the citizen's advice bureau and the community health council are not available for public inspection; and British Telecom refuses to distinguish between private and NHS doctors in *Yellow Pages*.

Dr Colman argues that the General Dental Council has recently authorised low key advertisements and that other professions, such as solicitors and accountants, have also dropped long standing prohibitions on advertising. Private hospitals and clinics are free to attract patients through advertising.

The GMC argues that newspaper advertisements about doctors' services are similar in principle to the indiscriminate or unsolicited distribution of practice leaflets. Under the recently revised guidance on advertising, which appears in the April 1987 edition of the GMC's "blue book," leaflets may be made available in libraries and "other information centres."

There was wide consultation with professional and patients' bodies before the guidance was adopted, says the GMC, and none of the bodies advocated putting notices in newspapers. The consequences for a patient who is misled by advertising into choosing an inappropriate doctor may be disastrous, and money alone would not compensate. This does not apply to accountants, solicitors, and other professionals and would be rare even in dentistry.

The court challenge comes as the Monopolies and Mergers Commission is investigating whether the medical profession's rules on advertising are an unfair restraint on trade. Proceedings were halted briefly last week while the two judges, Lord Justice Mann and Mr Justice Auld, considered whether they should decline to hear the case while the investigation was proceeding. The court was told that the commission had no views on the point, and the hearing went ahead after the GMC refused an offer by Dr Colman's solicitors, Bindman and Partners, to stop on condition that the GMC agreed to pay Dr Colman's costs in the event that the commission upheld his right to advertise.

—CLARE DYER

Pilot scheme for The London

An emergency helicopter service is to be introduced at The London Hospital for a trial period. If it is a success then changes in the way serious trauma is managed in Britain may follow.

Current problems include ambulances travelling no faster than 20 miles an hour through heavy traffic, immediate resuscitation not being done by doctors or paramedical staff, and the frequent need for the onward transfer of patients from the admitting hospital to specialist centres. In other countries helicopters have reduced deaths during transport to hospital to below 3%; here about one third of the patients who are transported by ambulance could be saved.

United Newspapers have provided a Dauphin helicopter, the Wolfson Foundation has donated £125 000 towards upgrading the hospital's resuscitation equipment, and the Department of Health and Social Security has agreed to fund a pilot study of two intensive care and six multidisciplinary surgical beds.

Schemes like this exist elsewhere: until The London's is evaluated, argues consultant surgeon Richard Harlam, one of the service's instigators, "it would appear rather difficult for anyone in the United Kingdom to make a rational decision about their necessity or their effect"

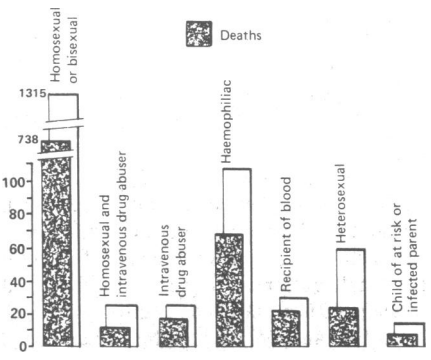
AIDS update

By the end of June 1988, 1598 cases of AIDS, of which 897 were fatal, had been reported in the United Kingdom. The doubling time of numbers of cases of AIDS is about 11 months.

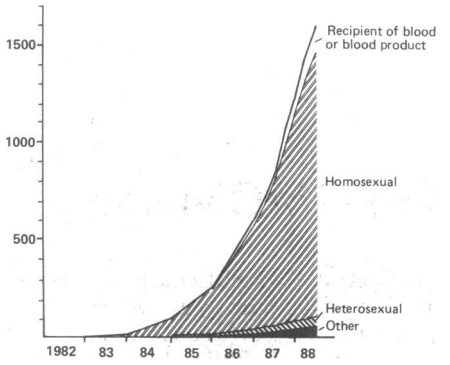
Of the 31 recipients of blood who have developed AIDS, 12 received the blood in the United Kingdom, and of the 60 heterosexuals with AIDS, six women and four men are presumed to have become infected here.

Three quarters of all cases were notified in the four Thames regional health authorities. In Scotland 55% of people positive for human immunodeficiency virus (HIV) abused drugs intravenously compared with about 8% in the rest of the country.

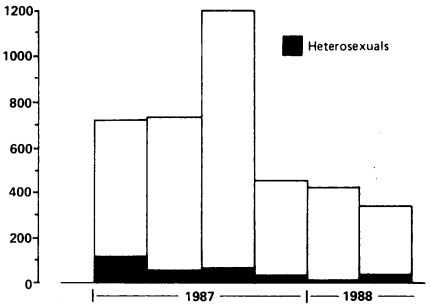
Cases of AIDS and associated deaths in the United Kingdom by patient characteristics (cumulative totals 30 June 1988)



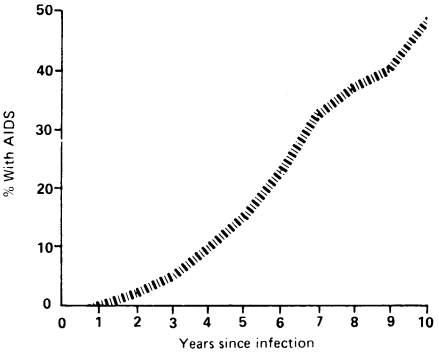
Cases of AIDS in the United Kingdom by patient characteristics (1982 – 30 June 1988)



New reports for patients positive for HIV in the United Kingdom by quarter (1987 – 8)



Proportion of men developing AIDS by estimated duration of HIV infection (San Francisco City Clinic Cohort Study)



Blood donors

Of 5 840 520 donations screened for HIV between October 1985 and December 1987 92 (0·0016%) were positive. Around 400 000 new donors were tested in both 1986 and 1987: positive results were confirmed in 18 in 1986 and in 12 in 1987.

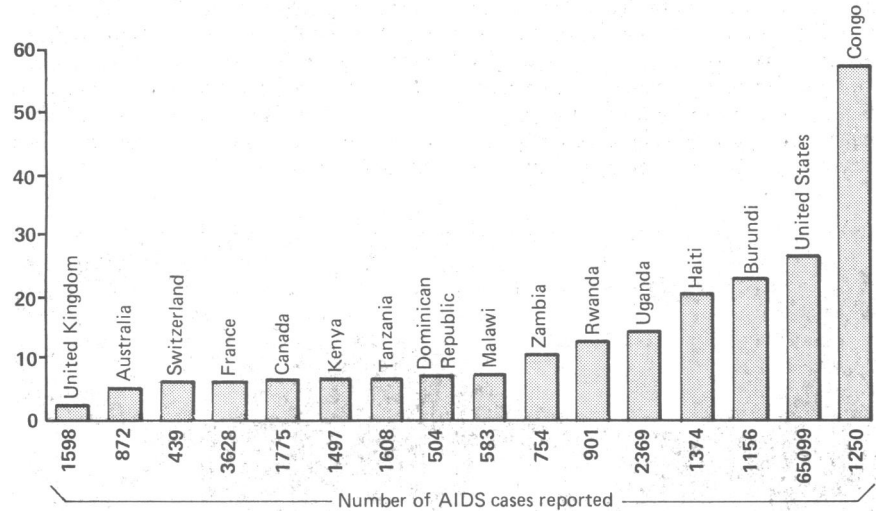
Of the 92 donors with confirmed positive results, 80 have so far admitted to being in a group currently considered to be at high risk. More than half the men in 1986 and 1987 were either homosexual or bisexual. In 1987 none abused intravenous drugs compared with nine in 1986. The proportion of women is small: almost all have been infected by sexual contact with men at risk.

Of the 14 donors identified as positive for HIV antibody in the six months from July to December 1987, eight were new donors. Four of the remaining six had previously been tested and found to be negative. Their previous donations were checked from stored serum samples, and it was confirmed that these donations did not contain antibody to HIV; the recipients are being followed up.

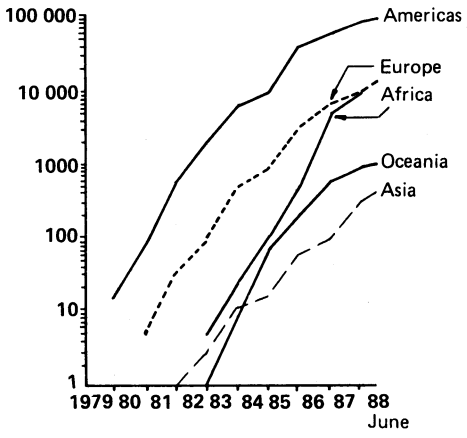
From the start of testing to the end of June 1987 four donors positive for HIV antibody had been negative on a previous occasion (in one other the result had been equivocal on the first test). The seroconversions had occurred during an interval of three to six months between donations.—H H GUNSON and V I RAWLINSON, *North Western Regional Transfusion Service, Manchester M1 3BP*

Figures prepared from voluntary confidential reports by doctors sent directly to the Public Health Laboratory Service Communicable Disease Surveillance Centre (01 200 6868) and to the Communicable Diseases (Scotland) Unit (041 946 7120).

AIDS cases per 100 000 population



Number of AIDS cases reported to World Health Organisation, 1979 – 30 June 1988



● 100 000 cases of AIDS have been reported to the World Health Organisation by 138 countries. The WHO estimates the true number of cases to be more than 150 000 and the number of those infected with HIV to be between 5 and 10m.

● 26 health care workers world wide are positive for HIV without any reported non-occupational risk factors, 15 with documented and 11 with presumptive seroconversion. Prospective surveillance studies suggest that the risk of seroconversion after needlestick exposure to blood infected with HIV is about 0·5%.

Centers for Disease Control, Atlanta, and WHO

Cinderella of the cinderella services

Although physically disabled people, the mentally ill, the severely mentally handicapped, and the elderly were all designated priority groups in 1981, all four seem in practice to be of low priority. If anything services for people with physical disabilities, a new report suggests, might well be called the cinderella of the cinderella services—pressures from the closure of large institutions and the increasing number of elderly people mean that people with physical disabilities find themselves at the end of the queue.

Last on the List: Community Services for People with Disabilities by Virginia Beardshaw looks at health and social support services for the 16-64 age group within the framework of social and community care policy, attempting "to piece together an overview of current provision and practice from a wide variety of sources." It includes statistics and a good, up to date bibliography. Services for disabled school leavers and for those with multiple handicaps (notably from brain injury) and incontinence services are given special attention, the last illustrating how better management of a service need not mean extra cost.

The report shows how services are underfunded, patchy in their availability, and badly coordinated: a complex, confusing system that individuals have to struggle with, which, moreover, often fails to meet "the actual needs of real people" (see box). Even information, let alone advice and counselling, can be hard to come by.

As they become less segregated disabled people themselves are asking for better and different services, which could foster autonomy rather than dependence. Thus the need is to develop flexible, integrated forms of help that enable such people to live as independently as possible, with more emphasis on the "holistic" approach to the individual person.

The report points to the need for change in the way services are planned, managed, and monitored and highlights principles set out in the recent Wagner report *(Residential Care: A Positive Choice)* and Griffiths report *(Community Care: Agenda for Action)*. Firstly, "No one should be required to change their permanent accommodation in order to receive services which could be made available to them in their own homes" (Wagner), and, secondly, social service authorities should be the arrangers and purchasers of care services tailored to individual needs and not the monopolistic providers (Griffiths).

This approach, says Virginia Beardshaw, could give disabled people and their families and organisations a greater part in the design and delivery of services, with wider options and ultimately a more real partnership with the professionals; given community care allowances, there would also be the possibility of direct control of services. But without proper funding, the report points out, this approach of "managed care" (as distinct from direct care provision) will be "less about developing packages of services tailored to individual need and more about strict rationing of inadequate resources." Further development of flexible domiciliary care arrangements is an important way ahead but needs much more coordination among health and social service authorities and voluntary bodies.

Changes in community care policy, however, must not lead to "further atrophy" of medical rehabilitation services. These call for a national network of facilities rather than the present hotchpotch, as well as more assessments of approaches and techniques; the widespread development of local rehabilitation policies based on district health authorities—as recommended by the Royal College of Physicians' report *Physical Disability in 1986 and Beyond*—would help here.

We need a change of focus from agencies to individuals, concludes the report, with leadership at both government and agency level and with new skills for health and social service managers and case workers; but change for the better is still possible even without such a "cultural revolution."—DAPHNE GLOAG

About 47 000 children in England and Wales are confined to wheelchairs, only half of them electrically powered. Helped by pop celebrity, Rick Astley, Mecca Leisure is backing a campaign by the Variety Club of Great Britain to increase this number

> "Community care is a matter of marshalling resources, sharing responsibilities and combining skills to achieve good quality modern services to meet the actual needs of real people, in ways those people find acceptable and in places which encourage rather than prevent normal living."
>
> "My personal living circumstances do not take into account my future needs, changes and choices. The care support I have available to me is an exception, not the rule. What happens if I want to live somewhere else? Social mobility is an option to most people, even if they choose not to exercise it. Would it mean starting from scratch all over again? Probably so. What are the implications with regard to continuing support if I wish to live with a partner? Must they accept the role of unpaid carer as the price for a relationship? How do we make such normal living choices part of normal provision?"
>
> From *Last on the List: Community Services for People with Disabilities.*

Thrombolysis: a good buy?

Thrombolytic treatment for acute myocardial infarction is 10 times cheaper than treatment for mild hypertension in terms of the cost to save a year of life, said Dr Paul Hugenholtz, a Dutch cardiologist and president of the European Society of Cardiology, at the European Congress on Diseases of the Chest in Dublin last week.

The cost of a year saved is just over $2000 for thrombolytic treatment, over $23 000 for treatment of mild hypertension, almost $27 000 for heart transplantation, and over $44 000 for coronary artery bypass grafting. Furthermore, because so many of the costs are unavoidable costs (such as staff) it does not make much difference which thrombolytic agent is used—even though tissue plasminogen activator produced by genetic engineering probably costs about 10 to 15 times as much as streptokinase.

With the data he has produced on the cost effectiveness of thrombolytic treatment Dr Hugenholtz has persuaded the Dutch government to foot the bill for such treatment. But he and other speakers at the conference emphasised that the cost effectiveness of treatment falls dramatically if patients are treated late (more than two hours after their infarct) and if patients at low risk of actually having had an infarct are treated. Dr Sylvan Weinberg, a cardiologist from Dayton, Ohio, and past president of the American College of Chest Physicians, supported this notion and pointed out that some of the most cost ineffective treatment in American hospitals was applying intensive care to those who either did not need it in the first place or were beyond being able to benefit from it.

Medicare in the United States will pay for thrombolytic treatment with streptokinase but not with plasminogen activator. "They say treatment with plasminogen activator is not proved," said Dr Weinberg in a speech that deplored the many pressures in the United States that are stopping doctors giving their patients the best treatments. And he did not mean only the tendency of government agencies and insurance companies to cut costs and dictate what treatments are acceptable: he meant, too, the commercial pressures that oversell treatments.

He told the conference of a billboard he passes regularly that says: "Do you have headaches? Come to our headache clinic. It could be serious." Plasminogen activator has been sold, he said, "as the penicillin of heart atacks." Industrial companies are using the media to create these sorts of images. He particularly deplored the trend to talk about a 25% drop in mortality when it is falling from, say, 4% to 3%. "I asked an intelligent woman what a drop of 25% in mortality meant and she thought that it meant a drop from 50% to 25%."—RICHARD SMITH

Wide variations in hospital death rates

Mortality ratios standardised for age show nearly a threefold variation in hospital deaths among health authorities. North West Hertfordshire has death rates 51% higher than the national average while Hammersmith and Fulham have death rates 25% below the average.

In a paper from the Centre for Health Economics at York University research fellow Paul Kind argues that although "the public dissemination of such information may be awkward to handle . . . this should not be accepted as justification for its continued suppression."

Taking data from the national 1985 Hospital In-Patient Enquiry (a 10% sample of inpatient records), Kind has analysed some 500 000 patient records and calculated age standardised death rates for both regional and district health authorities as well as for specialties and diagnostic groups. Death rates for specialties and diagnostic groups were given by regional health authority and showed that Mersey region had the highest death rates for general medicine (12·6) and general surgery (4·0). Oxford region, on the other hand, had the lowest death rates for these two specialties. Nationally, 18% of patients diagnosed as having heart and other circulatory diseases died in hospital; North East Thames region had the highest mortality for these diagnostic groups at just over 20%. Heart and other circulatory diseases, malignant neoplasms, and respiratory diseases had the highest death rates in the country.

When it comes to individual district health authorities the variation in hospital deaths seems large when expressed as excess deaths. North West Surrey, for example, recorded 50% more deaths than expected given the age structure of its hospital population. This represented 333 "excess" deaths. For Oxfordshire, with a mortality of just 0·75, there were 803 fewer deaths than expected. When district health authorities are grouped together according to death rates defined as low (mortality below 0·85), average (mortality between 0·86 and 1·14), and high (mortality above 1·15) the differences among regions can be seen in terms of their composite districts (table). Northern region, for example, has no districts rated as low and six out of 16 rated as high. South West Thames, on the other hand, has five districts rated as low and only three rated as high.

Numbers of district health authorities rated as having low, average, and high hospital death rates according to regional health authority

Regional health authority	Category of hospital death rate		
	Low (n=26)	Average (n=120)	High (n=46)
Northern		10	6
Yorkshire	2	10	5
Trent	1	7	4
East Anglian		8	
North West Thames	3	6	5
North East Thames	1	9	6
South East Thames		12	3
South West Thames	5	5	3
Wessex	1	9	
Oxford	1	7	
South Western	3	7	1
West Midlands	6	12	4
Mersey		6	5
North Western	3	12	4

Explanation requires caution

Although these mortalities seem to show quite startling differences among health authorities, their explanation and interpretation remain problematic. Kind says that there are reservations about the structure and quality of the data from the Hospital In-Patient Enquiry, on which his calculations are based. For example, it is not possible to identify the mix of hospitals in a district from the data. For Halton Health Authority, where one in seven patients died in hospital, part of the explanation for this high death rate lay in the fact that Halton mainly provided long stay geriatric care beds. Kind also raised doubts about the randomness of the sampling used to construct the inquiry's database and the variable quality of the skilled coding work that must be done to convert patients' medical notes into the inquiry's dataset. Some of those problems have been overcome, however, by the new nationally coordinated statistical systems introduced last year.

How death rates are to be interpreted raises many questions. Kind recommends that they should form part of consultants' peer review as well as an integral part of authorities' assessments of their own performance. (Senior managers and health authority chairmen supported this view at their National Association of Health Authorities conference in 1988.) How, or even whether, the public are to use these indications of health authorities' success or failure is a difficult one. Whether hospital death rates say more about the quality of the care a district provides than the population it serves is questionable. Drawing the link between variations in mortality and inequalities in housing, education, employment and so on, Kind questions the "legitimacy of requiring health authorities to correct for deficiencies which result from other areas of welfare activity."—JOHN APPLEBY

Computer viruses

Some time ago an intensive care unit in Glasgow found that its normally well ordered computer network was becoming erratic: data were being corrupted and files were being lost. Recently a general practitioner who used an IBM compatible computer for his repeat prescriptions discovered that important files were being corrupted. In both cases a computer virus was at work. Eventually the viruses were identified and exterminated, but not quickly and not without the loss of data.

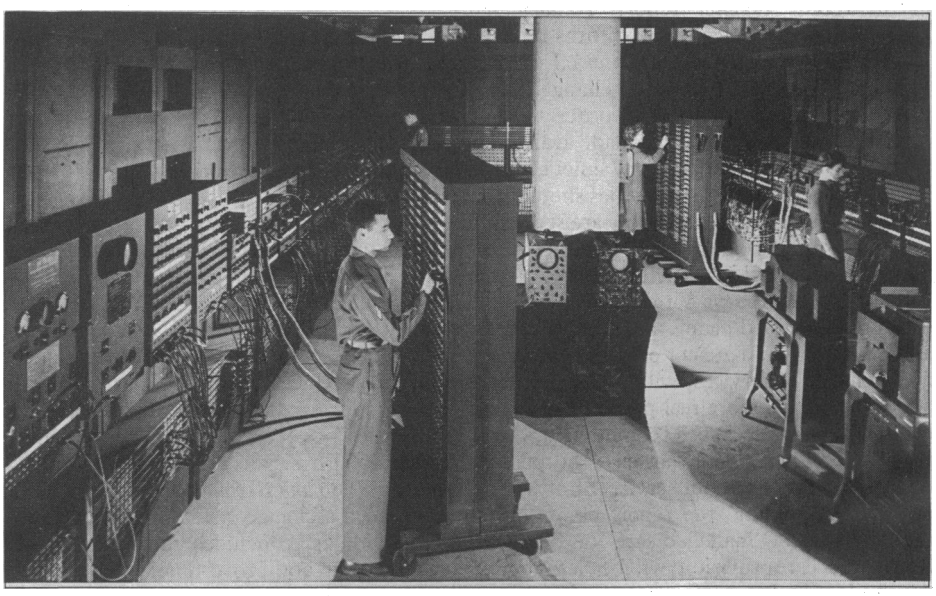
A computer virus is a small piece of computer code which has been maliciously inserted on computer storage media such as floppy disks to corrupt data. Like their biological equivalent computer viruses can infect other computers and their storage media, and a mechanism of self replication is built into the code.

Viruses have become complex as computers have developed and become widespread in the past few years. They work in many ways. Some append themselves to the directory track of a floppy or hard disk. Others insert themselves into the battery backed random access memory in a computer and infect any disk that is inserted thereafter. All the viruses can be readily communicated by floppy disk, as the users of some Macintosh games software found a few months ago.

Viruses can spread through computer networks; whenever files are copied from a central source, such as a bulletin board, the virus may be copied as well. This happened recently when a virus that displayed a seasonal greeting was downloaded by thousands of users of the IBM international network; within hours it had swamped the network.

Viruses can also spread when software on floppy disks is exchanged among the computer fraternity. Some viruses have been found embedded in games and only become activated when the game is used.

How do you know when you have a virus in your computer system? Unfortunately just losing a file or a small degree of data corruption is not diagnostic of the presence of a virus. With modern hardware, however, such



BBC HULTON

Not at risk. ENIAC, the first electronic computer

events are uncommon and should prompt the user to keep a record of the software associated with the event and look out for further occurrences. Some ingenious viruses randomly corrupt computer data and at an extremely slow rate; thus users might have viruses in their system and be unaware of them for months. Viruses are exceedingly difficult to detect and recent specimens have shown an ability to change their code as they pass from host to host.

How can we deal with the problem of viruses? There are several computer programs designed to detect viruses or plot their paths. Unfortunately at the moment the advantage lies very much with the viruses as they can infect faster than they can be detected, and the modern ones can lie dormant within obscure parts of a computer for months before doing any damage. At the moment prevention is better than cure.

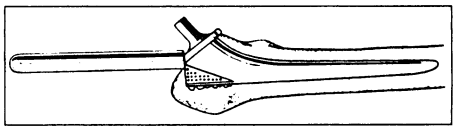
The main cause is that the computer system has received software from outside sources—for example, a floppy disk or network. So with an uninfected system the first step is to buy software from reputable sources. This is not complete protection, but at least users can hold the producers responsible if their system becomes infected and loses data.

Secondly, if a user does obtain software from other sources it is important that the software has a probationary period through several cycles of use when time specific precautions must be taken such that it cannot possibly infect other media. The software must be run only on computers that do not have other media such as hard disks, and precautions must be taken to ensure that the battery backed random access memory is fully erased so that if a virus has been inserted it will be exterminated. In addition, a log should be kept of the use of the program so that suspect disks holding the code can be identified.

Computer viruses can and will continue to do enormous damage, and we must be aware of where they might appear next—for example, in major defence systems, credit rating agencies, or banks. There may even now be dormant viruses in large computer networks awaiting only the right moment for them to be activated—for example, the dismissal of a disgruntled employee. Currently technology is not adequate to detect viruses and therefore prevention is the only cure.—JOHN ASBURY, *senior lecturer in anaesthetics, University of Glasgow*

Norwich hip

About 20 000 total hip replacements are performed in the United Kingdom each year, and the expected survival time for a total hip prosthesis is about 12 years. Although this may be acceptable for elderly patients, many younger people will need at least one revision operation. Improvements in operative techniques and materials will increase the life of the prostheses, but aseptic loosening at the cement-bone interface will remain a main cause of failure.



Perfect calcar-collar contact must be achieved with the cementless hip. The femoral head is then punched on to the neck of the prosthesis with a head impactor

The scientific meeting of the BMA's annual representative meeting at Norwich (p 294) heard from Messrs H Phillips and J K Tucker, consultant orthopaedic surgeons there, about a new joint that they have been investigating. The Norwich cementless total hip replacement provides a stable benign surface between the implant and bone or fibrous tissue. The system is designed to transfer the load through the proximal femur and restore the anatomy with correction of soft tissue contractures and restoration of leg length. Its biggest advantage is that because there is no aggressive macrophage response any revision operation will be easier and less likely to fail.

The Norwich hip should be used with caution when there is osteoporosis or impaired bone remodelling. Cemented hips remain the best system for the elderly, but in a young person this system should ensure that the almost inevitable revision operation will pose fewer problems.—STELLA LOWRY

The Week

"Tunnel tendency" hazard for BMA

Once the BMA's annual representative meeting has finished the inhabitants of BMA House relapse into a state of suspended animation until the autumn. True or false? False if my random luncheon survey in the members' dining room at BMA House on 14 July was anything to go by. I noted the animated presence of the top echelons of the General Medical Services Committee, the Central Committee for Hospital Medical Services, and the Central Committee for Community Medicine and Community Health—their siting at widely separated tables was surely just chance—as well as a block of the BMA's regional staff (attending a day's briefing session at headquarters), the chairman of council, the secretary, and sundry other medicopolitical luminaries. This assembly reflected a busy day of medicopolitics, and many of the remaining days of (so called) summer will be just as busy: the politics of health are rarely far below boiling point nowadays.

* * *

Now that I am away from the hothouse politics of the annual meeting it is easier to assess the week in Norwich. It was certainly a calmer meeting than many I've attended, though I think the description boring, which I heard used by some representatives, was unfair. Calm and constructive would be my considered judgment, and the fact that it did not generate the usual volley of front page headlines was not necessarily a bad thing. I'm not against a high media profile on appropriate occasions—indeed it is of immense advantage to the profession—but in recent years a tendency to plan a steady output of press sensitive material during annual meetings has sometimes been at the expense of an order of business that might better suit the wider needs of the association.

* * *

The BMA will need to watch the balance between medicopolitics and science. If the latter takes too much of the association's resources—and I don't mean just money—it will encourage what I sensed during the conference as a potential hazard for the BMA. I dub it the "tunnel tendency." Craft committees are in danger of developing tunnel vision, seeing only the problems of their own constituents. Looking after their own is a perfectly reasonable characteristic; after all, the committees are there to represent those constituents. Furthermore, the crafts are facing severe medicopolitical hazards that are bound to generate a defensive response: the much leaked threat of short term contracts for consultants; the unacceptably long hours and snail like career paths of junior doctors; cash limits and competition for general practitioners; the uncertain future for the two sets of "community" doctors; and the financial squeeze on research and teaching staff are some obvious examples.

The interests of all these crafts are, however, served as well by taking a broad view of medicine, with craft cooperating with craft in overcoming the hazards, as by adopting a narrow sectarian view with keep off signs posted round the boundaries. I believe that the sum of the parts, in the shape of the BMA, is greater than any isolationist efforts of separate groups, however cohesive their members may be. This government wants to contain what it sees as the excessive powers of the profession. Arguments about that controversial judgment apart, the government will get its way more easily if it is allowed to deal with each sector of the profession separately. The politicians and staff at the health department may not be in

the Treasury's league of Whitehall warriors but even they must spot the advantages of divide and rule. The profession should not oppose necessary or desirable changes in health care, but doctors' unmatchable experience means that they can make constructive contributions to ensure that changes produce genuine benefits for the patients. That said, the profession's representatives have every right to ensure that changes do not damage their constituents' fair and reasonable interests. A disgruntled profession is no asset to the NHS.

Mention of disgruntled staff brings me finally to the nurses, who seem to be in danger of finding that this year's much heralded 15% award for qualified clinical nursing staff is a mirage. Even Margaret Thatcher uncharacteristically stumbled and fumbled at Prime Minister's question time on 14 July when the deputy leader of the Labour party searchingly questioned her about the full funding of the nurses' 1988 pay award. It seems increasingly doubtful that the extra money the government put aside for the award will be sufficient, and rumours are rife in the NHS that some district health authority budgets will not stretch to paying for fair regradings of qualified clinical nursing staff. It may be too early to make a fair judgment on what is happening at unit level, but if it turns out that even a few appropriately experienced nurses receive 4·2% instead of the expected 15% the effect on nursing morale will be devastating. I hope that doctors will do the best they can to see fair play for the clinical nurses.

SCRUTATOR

Letter from Westminster

Exploring Moore and Field

If you have tiers, prepare to shed them now.

John Silkin's classic comment on the structure of the NHS is about to come into its own again. MPs will have it in mind when they disperse for the summer recess next week.

For example, do we really need the regional tier of the NHS in England? The question will be posed by the select committee on social services in its main report on providing resources for the health service, due to be published on 28 July. The fact that the committee does not actually recommend abolition of the regions points to a more tentative report than might have been predicted a few months ago.

Admittedly, no one is enthusiastic about yet another reorganisation of the NHS. The argument for retaining the regions is mainly one of convenience: the government finds it easier to consult 14 regional rather than 190 district chairmen. And it needs someone to adjudicate between local health claims.

Expect the demise of the regions, though later rather than sooner. In this respect the select committee accurately reflects the view inside the Department of Health and Social Security, which is that changing the structure should come last in the reforming process.

At the end of his first session as chairman Mr Frank Field can take credit for steering the committee to the pivotal point it now occupies in the health debate, doing in public what the government chose to do in private. The committee became the sounding board for the "fundamental review," which the Cabinet has clothed in secrecy. For six months the MPs have heard evidence from all comers about how to organise health care.

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The select committee's report next week will therefore be the first political distillation of the various nostrums that have come in such profusion. It will mark out, undramatically but in terms of practical politics, the extent of common ground. One feature above all will be endorsed by the committee. It is that the NHS should continue to be funded from taxation. From this it follows that the many alternative proposals for insurance funding, health vouchers, or opting out are rejected as political non-starters.

In positive terms, the report is expected to approve the development of an internal market for the exchange of treatment across health authority boundaries in cooperation with private hospitals. Initiatives to generate income will be welcomed, including charges to NHS patients who are willing to pay for extras such as telephones and television.

On the clinical front the select committee is not satisfied with the performance indicators available to the NHS. And although its members hold to their view that at least £1 billion of new funding is needed, they acknowledge that until there is a more accurate measure of the outcome of treatment it will be hard to tell whether, or by how much, the NHS is underfunded.

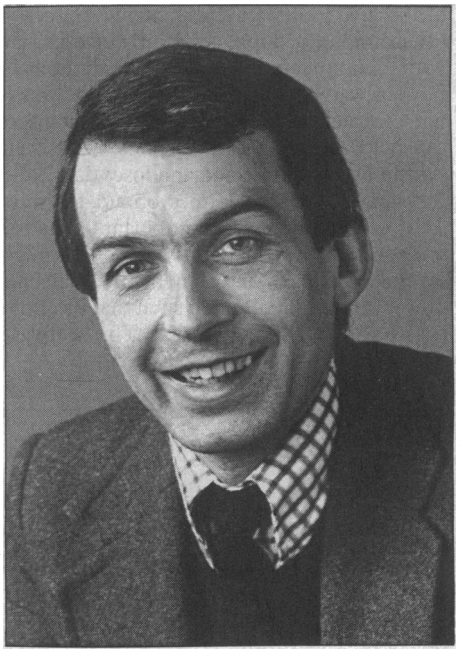
The report concentrates deliberately on short term issues rather than being an attempt at a grand design for the future. It will allow a summer of relaxed contemplation before the next instalment of the fundamental review—Mr John Moore's speech to the Conservative party conference at Brighton in October, when he gives the first outline of the government's intentions.

Mr Moore seems to have lowered his sights—or is it just that events have moved so rapidly that what was unmentionable a year ago is old hat today? In any case, a dividing line is now being drawn between what will happen in the course of this parliament and what will be consigned to the limbo beyond.

In the first category comes the internal market. It will probably require legislation to allow health authorities the necessary flexibility, together with a sizable investment in computer technology. Parallel with that will be the advent of medical audit—the process by which doctors can be made aware of how much their treatments cost.

Ministers have been bracing themselves for medical audit for months, if not years, and are still undecided about how much muscle they are prepared to use. Mr Moore would like peer review and medical audit to become a daily fact of life in British hospitals and soon. Doctors should not be too surprised: American doctors embraced audit years ago, and the *BMJ* has been advocating its introduction for a decade or more.

The internal market and medical audit are the limits of government ambition this parliament, along with token encouragement for more private health provision. The remainder of Mrs Thatcher's fundamental review will be for implementation after the next general election, presuming a fourth Conservative term. The process of consultation, manifesto, white paper, and legislation will take at least five years.



Mr Frank Field

It also brings us back to shedding tiers and, at a guess, the 1994 reorganisation of the NHS. Current ministerial thinking on the subject goes something like this: dispense with the regions and reduce the 190 district health authorities in England to around 100. Hospitals would become autonomous units under their own management, either singly or in groups of two or three. They would then compete for contracts to provide services required by district authorities, which would become the NHS equivalent of health management organisations. Similarly general practitioners would tender for contracts put out by family practitioner committees to meet practice needs of each locality.

On the real shape of things to come Mr Moore is running ahead of Mr Field.

JOHN WARDEN