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BMJ

Our feet set on a new path entirely

To the transformation of primary care and partnership with patients

NHS's 50th anniversary
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For doctors there are comforting accounts of the birth of the National Health Service, wise professionals defending their own child against meddling politicians.[1] But, however you look, BMA leaders, with massive support from general practitioners, stridently opposed participation until three months before the appointed day, and then came grudgingly. An overwhelming majority of patients wanted it, but doctors thought they knew their patients' best interests—as they always did in those days.

In parliament on 9 February 1948 Nye Bevan grieved "that this great Act, to which every party has made its contribution, in which every section of the community is vitally interested, should have so stormy a birth. I should have thought, and we all hoped, that [the doctors] would have realised that we are setting their feet on a new path entirely, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilized thing in the world—put the welfare of the sick in front of every other consideration." Fifteen years later Lord Platt, president of the Royal College of Physicians, agreed: "The methods of the BMA were those of trades unionists, not appropriate to the leadership of a great profession .... A generation of doctors had been taught to disparage British medicine, to regard the Ministry of Health as its enemy, and to speak of the health service in terms of contempt."[2]

Hospital specialists knew self employed status was no option. They needed the teams, buildings, equipment, and planned and managed framework which only the state could provide. Serious opposition came from general practitioners clinging to minuscule private provision of public service.

Nazi bombing in 1940-41 briefly created confidence in social solidarity and participative democracy. The BMA created a medical planning commission to discuss postwar health services, including three leaders of the Socialist Medical Association. Its draft interim report in 1942, drafted by Charles Hill, secretary of the BMA, provided ample evidence of progressive intentions for revisionist historians, but no firm commitments.[3 4] Two years later a *BMJ* editorial discussed reactions from Political and Economic Planning, a centre-left think tank, to the 1944 white paper on a future NHS:

> The new doctor will, according to PEP, find his proper place in the Health Centre, which should be "pervaded with an atmosphere of friendliness." "Doctors," it says, "would learn to treat their patients not as irresponsible children but as adult fellow-citizens, and the old fashioned mystery man would gradually disappear." The doctor in the Health Centre will also have to give lectures on "health topics" and this discipline "will equip doctors and other health workers with that intimate knowledge of the 'consumer' of the health service which they often lack today." This is the kind of nonsense to which the medical profession is at the moment being subjected. The medical profession has every reason to suspect the motives of people who write like that .... When a project has the blessing of the Communist Party a liberal profession may well feel apprehensive about the future.[5]

On these fears of 1944 was built the hysteria of 1948. Full time salaried general practice was considered seriously only by coalition health minister Ernest Brown, National Liberal, in his shortlived report of 1943.[6] For the next 55 years all government and opposition parties evaded the political costs of opposing medical trade interest and the financial costs of paying adequate salaries and providing the added resources primary care needed. Instead they left the foundations of the NHS as a whole to the imagination, enterprise, and investment assumptions of corner shopkeeping.

However, our feet really were set on a new path. Fifty years of a free NHS, undistorted by fees, have indeed taught our profession to know better—not than our patients, but than we ourselves once did. We have learnt that we can't produce health—healthier births, lives, and deaths—by ourselves, or without continuing care. We need collective teams, collectively funded buildings and equipment, collectively organised learning and research, and cooperative patients constraining their personal demands within what they themselves can see, through streetwise experience, as the limits of what real communities can afford. And this includes primary care.

In 1948 Bevan took specialist care in hospitals seriously. So he employed salaried specialists, providing the teams, equipment, and buildings that they needed but neither could nor would provide from their own pockets. As a realist, he let them continue part time trade, simultaneously compensating them for losing it by distinction awards. General practice he left undisturbed as a high volume, low cost, apparent solution for all the problems either beneath the notice of specialists, or too difficult for them to solve, adrift from medical science but providing a sheltered home for unmeasurable art.

Despite and partly because of their exclusion from hospitals, general practitioners discovered and explored hitherto neglected fields of effective work. Cure sometimes, comfort often, care always, in

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measurable terms. Though episodic cures can be applied rationally and economically only in contexts of continued comforting and caring, "cures" compete successfully against these less glamorous, more labour intensive preconditions. Television viewers prefer dramatic body repairs in emergency rooms, and so do politicians committed to their own re-election. Evidence based primary care must increasingly recognise patients as equals, bringing their own expertise to the coproductive processes of care.

The worst fears of 1944 are now being realised. Most doctors have learnt to treat their patients not as irresponsible children but as adult fellow citizens. Old fashioned mystery men are at last disappearing. Perhaps we might even start taking primary care seriously, by employing salaried general practitioners on the same footing as other members of primary care teams—which have hitherto led an almost entirely rhetorical existence.[7] For the past five years annual conferences of community generalists in training have voted for salaried service by increasing and now overwhelming majorities. Why not?

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1 Fulton WW. *Br J Gen Pract* (in press).
2 Platt R. *Doctor and patient: ethics, morale, government.* London: Nuffield Provincial Hospitals Trust, 1963.
3 Murray DS. *Why a National Health Service?* London: Pemberton, 1971.
4 Medical Planning Commission. Draft interim report. *BMJ* 1942;i:743-53.
5 The planners of medicine. *BMJ* 1944;ii:47-9.
6 Wilcocks AJ. *The creation of the National Health Service: a study of pressure groups and a major social policy.* London: Routledge and Kegan Paul, 1967.
7 Hart JT. *Going for gold: a new approach to primary medical care in the South Wales Valleys.* London: UNISON/Socialist Health Association, 1997. Available from SHA, 16 Charles Square, London N1 6HP, £1.00.

The jewel in welfare's crown

The NHS will glisten still if it retains middle class support

"On Monday morning you will wake up in a new Britain, in a state which 'takes over' its citizens six months before they are born, providing care and free services for their birth, for their early years, their schooling, sickness, workless days, widowhood and retirement. All this with free doctoring, dentistry and medicine—free bath-chairs, too, if needed—for 4/11d out of your weekly pay packet. You begin paying next Friday."

Thus the *Daily Mail* in its leader column greeted the imminent arrival of the National Health Service on 5 July 1948. It is often forgotten that the birth of the NHS was not just an isolated event. It was part of the biggest single tranche of welfare state reconstruction that the United Kingdom has seen. Its arrival coincided with dramatic improvements to social security—the creation of family allowances, retirement pensions for all, new industrial injuries schemes, the raising of the school leaving age to 15, and the start of a great explosion in council house building.

It was just one part of the huge effort in postwar reconstruction presaged in the Beveridge report of 1942 and made possible by the immense sense of social solidarity generated by the second world war. And arguably the measures to improve housing and the incomes of the least well off, plus the achievement for close to 30 years after the war of something like full employment, did as much to improve health as the creation of the NHS itself.

Yet 50 years on the NHS, battered and bruised though in many ways it is, stands isolated and majestic as the remaining jewel in the crown of those reforms. After a strong period of postwar growth state pension provision is steadily withering away. Council house building has come close to being extinct, with home ownership now easily the dominant form of tenure. Benefits have become increasingly linked to prices, not earnings, producing a widening gap between those in work and those not. And while unemployment is currently low by the standards of the past decade or so, it is higher than in the years up to the mid-1970s and likely to remain so. School age education, it is true, remains a popular if controversial cause, second only to health in the British Social Attitudes Survey of areas where the public would like to see higher spending. But in higher education those who receive it are having to pay for more of it themselves.

Many forces have led to these changes, but among them are a growing resistance to higher taxes and widening income inequality, which has led to rising expectations about standards and service among the majority who make up the better off. Acceptance of standardised fare, or a basic minimum, is much less clearly the order of the day.

The NHS, remarkably, has survived these changes and managed to do so while Britain spends a smaller share of gross domestic product on health than most other industrialised countries. The belief that health care should be available to all regardless of ability to pay remains deeply embedded in the British psyche.

To some degree, the NHS has the private sector to thank for that. The numbers covered by private health insurance rose sharply in the 1970s and 1980s, notably at times when the NHS was under acute financial stress. But private health has proved less good at controlling costs than the NHS. Premiums have run well ahead of both inflation and the rise in NHS spending. Cover remains expensive. As a result, since 1990 and despite the end of recession, the numbers insured have remained flat while the types of cover have tended to become more restrictive. Patients have traded down to less comprehensive policies, or to ones offering a smaller choice of hospitals, a change which provides a reflection, albeit watery-weak, of the impact of managed care in the United States.

Over the past three or four years NHS spending has again been under strong pressure, running at appreciably less than the 3% a year rise in real terms which most of the service's advocates believe it needs to

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stand broadly still—to sustain, for example, the costs of an ageing population and reasonable medical advance.

The signs of strain are apparent. The government is trying to address a sharp rise in waiting lists and waiting times just as it introduces yet another reorganisation—arguably as sweeping as any that went before. Involving not just a change in purchasing or commissioning arrangements, the latest reforms represent an ambitious attempt to benchmark the quality of care and push doctors ever more firmly towards medicine which is not just evidence based but cost effective. As with general practice fundholding and the formation of NHS trusts, these ideas have attracted considerable interest worldwide as other countries struggle to contain even higher healthcare costs and to move to more evidence based and managed care.

The critical questions are whether the NHS can both improve quality and contain costs and whether the government will find sufficient funds to improve not just the quality of clinical care but the standard of amenity in the NHS and the waiting times for access to it. Both issues are likely to be critical to the question of continued middle class support for the NHS. In a sense, that has always been the underlying question about the service. On the NHS's 50th anniversary this question feels at least as acute as ever. The most noticeable difference between the United Kingdom's spending on health and that of other developed countries lies not in much smaller public spending but in much smaller private spending. The critical issue is whether the latest round of reforms can deliver a service which will satisfy nearly everyone for around 5.8% or a little more of gross domestic product. If it cannot, new charges or a renewed flight to the private sector will result.

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Imagining futures for the NHS

Familiar institutions might be revamped and strong

The future is unknowable. "Nothing in the world can one imagine beforehand, not the least thing," said Rainer Maria Rilke: "Everything is made up of so many unique particulars that cannot be foreseen." Nobody predicted the explosion of the internet, the faltering of the Far East economies, or the outlawing of the communist party in the former Soviet Union. But many people have predicted the paperless office, the leisure society, and the death of the book—none of which have happened. Yet paradoxically those who look to the future flourish, and the world's biggest and most successful organisations devote resources to imagining futures. The trick is not to predict (although the first box includes some predictions) but rather to gather data on recent trends, talk to lots of smart people to identify drivers of change, and then to relax and imagine scenarios of the future. You then use the scenarios to stretch current thinking and as a "wind tunnel" to test current practices and plans: will they still work in the new world?

The NHS Confederation, Institute of Health Service Management, and International Hospital Federation have been busy imagining future scenarios for the NHS, and the scenarios are due to be acted out at the confederation's conference to celebrate 50 years of the NHS. The team creating the scenarios* identified four drivers of change and imagined two scenarios.

The first driver is the development of new technologies and ever larger amounts of information. Technology has always been a major driver of change, and the NHS's 50th anniversary coincides with perhaps the most rapid stage in the transition from the industrial to the information age. This the biggest shift in the world since the dawn of the industrial age some two centuries ago, and the middle of such transitions is probably the most difficult point from which to foresee the future.

Predictions on health technology

Year	Predicted development
2000	Artificial blood Full electronic records on smart cards
2005	Personal wearable health monitors Determination of whole human DNA sequence
2010	Artificial heart
2012	Artificial sense Robots extensively used for routine hospital tasks
2015	Genetic links to all diseases identified Individual's genome is part of medical record Artificial lungs
2017	Artificial brain cells
2020	Artificial liver Extension of human life span to 100 years

From the BT Technology Calendar 1997-2045

The world might rapidly become very different. Miniaturisation, automation, robotics, mininimally invasive surgery, imaging, telecommunications, and genomics may come together to pull diagnosis and routine operations into more local settings while centralising expertise still further. In such a world district general hospitals may have no role. Patients will have access to the same information as doctors, and patients with chronic or rare diseases will regularly have more information than their doctors. But who, if anybody, will be controlling and validating this information? New media will become steadily more important, but will ownership be concentrated or scattered? The answers to these questions lead to very different futures.

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The second driver is new power structures in politics, business, and communities. Largescale, producer led organisations (like the NHS) are giving way to smaller, faster moving organisations led by customer needs. The 24 hour society is arriving fast, and old patterns of class, gender, and race are giving way to new ones. Society is becoming much older. More women are working and steadily occupying more powerful positions. The "feminisation" of the NHS workforce will have implications for both the professions and management. National governments may give way to regional governments, but international groupings may become more important. What happens in the Scottish NHS, for instance, will probably be decided much more in Edinburgh and Brussels than in London—and the Scottish NHS may become increasingly different from the English NHS.

The growing importance of our relationship to the living environment is the third driver. Population growth is concentrated where resources are most scarce, and increasing migration may be inevitable. Global inequalities are increasing. Fresh water supplies are diminishing. New diseases are appearing and old ones re-emerging. Could the NHS cope with a pandemic? The NHS will have to recognise increasing concerns about sustainability, but the role of science in this future is unclear. Will it be seen as part of the problem or part of the solution?

The fourth driver is social and cultural change: the ties which bind us in families, schools, and the workplace (the backbone of community life) will be replaced with new, possibly more fragile, relationships. The automatic deference shown towards professionals, experts, and parents has gone for ever. Instead, there will be more consumerism and greater diversity and choice. How will intergenerational conflict be resolved? How will doctors respond to patients who are much less deferential?

Using these drivers the team developing the scenarios imagined two futures in which the NHS would exist. Each world is equally desirable or repellent. One—called "Find my way"—is a world with radically different ways of working and behaving. The other—"Trust their guidance"—is a world in which familiar organisations are revamped. The second box shows the broad characteristics of these two worlds.

"Find my way" is a world of individuals. People have immediate access to global information. Partnerships and networks spring up in business, politics, and peoples' lives but are short lived. There is great concern about global issues but no sustained, long term campaigns. "Trust their guidance" is a world where people get access to information through trusted sources—like the NHS—and where well regulated institutions provide stability. Individualism is weakened, and national political parties are strong. People feel secure but stunted.

In the "Find my way" world the NHS would have to work with other bodies in shifting partnerships. League tables of NHS performance would be readily available, and poor performers would find it difficult to maintain trust. Health policy would have to consider environmental issues, and decisions which limited future options would have to be avoided. Health resources would not be allocated on the basis of scientific evidence.

Characteristics of two future scenarios

Drivers	"Find my way"	"Trust their guidance"
Intuitive associations	Orange, California, kaleidoscope, Virgin, horizontal, adrenaline	British Airways, Sweden, oak tree, Yehudi Menuhin, vertical, endorphin
New technologies and ever larger amounts of information	Individual access to ever more information	More information, but individuals go to trusted organisations who validate information
	Increasingly hard to know the reliability of information	
New power structures	Transient networks and shifting partnerships	Radically modernised but stable organisations National governments strong
	Weakening of national government	
New relationships with the living environment	Environmental policy is decided at global and European levels and implemented locally	Environmental policy is decided nationally and implemented through stable organisations
	Green movement draws on many short term groups	Green movement is focused on scientific evidence and gradual improvement
Social/cultural change	Individual ethics in a world of changing and fragile relationships	New family types develop with child care underpinned by government institutions
	Old people are seen as a resource	Old people are seen as a burden
	Science is one view among many	Science is privileged over other world views

In the "Trust their guidance" world the NHS would have to establish itself as a trusted source of information. Many agencies apart from the NHS would pursue the health agenda, and doing something about inequalities would be important. Professionals would be trusted but only in so far as their organisations have clearly understood and effectively policed protocols. Many of the current institutions of the NHS would survive but only if they could adapt and change.

In both scenarios, the team agreed, it will be important for the NHS to secure the trust and collaboration of the communities it serves. It will have to do more than deliver a high quality service: it will have to become embedded in communities that will themselves be changing fast. This is not easy—so another 50 years cannot be guaranteed. Indeed, for an institution born in the industrial age to survive in the information age would be a remarkable achievement.

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*A booklet describing the scenarios and how they were created can be bought from Madingley Scenarios, NHS Confederation, 26 Chapter Street, London SW1P 4ND. Tom Ling will also advise on how the scenarios might be used in your organisation.

On the way to Calvary

Ministers should realise the command and control model the white paper entails

What is surprising about the government's plans for the reform of the NHS in England is not what is in the white paper[1] but what is omitted. The white paper was a triumph of style over content, which temporarily convinced a sympathetic profession and the wider public that all would be well for the NHS under Labour. Now the presentational triumph is over, come the pains of implementation, and ministers may find that they have unintentionally nailed themselves to a cross. For what is implicit in the white paper, but not spelt out, is that if the policies outlined in it are to succeed central government will have to play a more active role, managing and directing change.

The Conservative reforms of 1991 were intended to diffuse blame to the market. In practice, politics dragged ministers back, as the market was never allowed free play. The new Labour plans will, in contrast, focus on ministers. For implicit in the white paper is a command and control model of central management which will not only test the capacity of ministers but ensure that the spotlight remains firmly fixed on them as they are seen to carry direct responsibility for every weakness and every failure in the NHS.

Only consider the centrepiece of the new NHS in England: primary care groups. Not only will setting up the groups represent a formidable managerial challenge, as the experiment with total purchasing has already shown[2]; so, too, will fixing their budgets.[3] There is a 6% national difference between the census population and the population on general practitioners' lists, with considerably greater local variations. Some crude mix of the two will inevitably have to be used to determine local budgets, with harsh implications for some. The tasks of estimating population needs, providing patient care, and staying within budget will have to be undertaken within a tight managerial budget of £3 per head (£300 000 per average group). And all this will have to be supervised by health authorities, who will be preoccupied with cutting their own management costs, "reconfiguring" hospitals, and meeting a variety of health improvement targets.[4]

More profound still, in the long term, may be the consequences of imposing cash limits on primary care group budgets. If, for instance, cash limited drug budgets are overspent general practitioners will have to exert pressure on fellow group members who are overgenerous in their prescribing habits and manage responsibility for the waiting list as elective procedures are cut back. The attractions for government of creating a situation in which general practitioners improve resource use by controlling their colleagues are self evident. The attractions for independent contractor general practitioners are less apparent, and they may not comply. Indeed, the long term implication may be that ministers expect general practitioners increasingly to become salaried employees. This would, however, be horrendously expensive: buying practice facilities could cost well over £1 billion.

The managerial capacity of the centre will be further tested by the commitment to "renew the NHS as a genuinely national service" by ensuring that "patients will get greater consistency in the availability and quality of services." The reduction of variation in medical practice is an entirely laudable aim. But, again, it presumes that the centre will have the managerial capacity to ensure the implementation of the proposed national service frameworks for major care areas and disease groups. The proposed Commission for Health Improvement is clearly intended to give central government a new tool for monitoring and controlling what happens at the periphery. However, there is a tension between giving the commission powers to impose sanctions and making it acceptable to the profession. Promoting good practice through education and persuasion, the role of the new National Institute for Clinical Excellence, may be at odds with imposing it through sanctions, via the commission. And the more ministers accept direct responsibility for the quality of clinical services, the more difficult it becomes for them to shelter behind the doctrine of clinical autonomy if things go wrong or questions are raised about how resources are rationed. Expunging the word "rationing" from ministerial vocabularies will not change the reality of resource constraints.

The eradication of the limited incentives to use resources better offered by the "internal market" will, on the contrary, impose even greater responsibilities on ministers and managers. It is difficult to be optimistic about the capacity of the centre to carry out this task successfully, given its ability to misjudge policies. For instance, the government has chosen to ignore evidence that investment in services other than elective procedures—for example, mental health—may produce more health gains than spending money on waiting lists and waiting times. This political priority is nonsense but reflects the logic of the political market place and pre-election pledges. Nevertheless, the price of achieving this priority may be higher than the government expects: managing waiting lists rationally would imply managing demand more effectively—for example, by reducing variation in general practitioner referral criteria and consultant treatment thresholds, so bringing ministers into collision with practitioners. Command and control concentrate blame and conflict, which is why the white paper may lead ministers to a political Calvary.

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1 Secretary of State for Health. *The new NHS.* London: Stationery Office, 1998.
2 Mays N,Goodin N,Malbon G, Leese B, Mahon A, Wyke S. *What were the achievements of Total Purchasing Pilots in their first year and how can they be explained?* London: King's Fund, 1998.
3 Bevan G. Taking equity seriously: a dilemma for government from allocating resources to primary care groups. *BMJ* 1998;316;39-42.
4 Secretary of State for Health. *Our healthier nation: a contract for health.* London: Stationery Office, 1998.

Getting evidence into practice

Needs the right resources and the right organisation

The person who did perhaps more than anyone to bring the rigours of systematic review into clinical research, Tom Chalmers, once asked: Why do doctors kill more people than airline pilots do? He suggested 10 reasons. These included the fact that pilots are required to have time off to sleep, that they do everything in duplicate, and that they follow protocols. But his final reason was that if doctors died with their patients they would take a great deal more care.

Taking more care means, among other things, practising evidence based health care, and, even to enthusiasts, death for failing to do so seems harsh. After all, as Gina Radford, director of Britain's new National Institute for Clinical Excellence, said at a recent meeting on evidence based medicine in York, no one goes to work to do a bad job. If they are to improve how they care for patients, clinicians need to know what they are doing wrong, or badly, and how to put it right. At the moment this is difficult.

Firstly, the medical literature is unwieldy, disorganised, and biased. In a recent survey, over 95% of articles in medical journals failed to reach minimum standards of quality and clinical relevance.[1] Good research on important questions is often analysed and presented in ways that make it hard to apply in clinical practice. In answer to a question about the risks associated with the oral contraceptive pill, only five of 74 articles identified by a systematic review contained information in a useful form.[2]

Secondly, many of the questions that arise daily in clinical practice remain unaddressed by well designed research. Studies have suggested that up to 80% of clinical decisions are based on good evidence,[3 4] but these studies looked mainly at prescribing decisions. Evidence on many other types of decisions—such as when to investigate, which test to use, and when to refer, not to mention the complex mix of sociology, mythology, and pastoral care that make up general practice—is sparse and its quality poorly defined.

Nor are clinical practice guidelines the long term solution they once appeared to be. They are slow and expensive to produce, mostly of poor quality, and hard to update. Although they can change practice in some circumstances—when they are locally developed, involve a specific education strategy, and have patient specific reminders at the time of consultation[5]—anecdotal evidence suggests that they are not widely used.

Finally, there is the problem that medicine is traditionally a solitary profession—one clinician dealing with one patient. Finding out how well you are doing and how you could do better can be difficult without the help of well designed and administered systems for audit and feedback.

But help is at hand, as described in a series starting this week on getting research evidence into practice (p 72).[6] Thanks to the Cochrane Collaboration and others, good systematic reviews are now available in many areas of health care, overcoming the biases inherent in the biomedical literature and providing a firmer base for clinical decisions. These are available on the Cochrane Library CD Rom. Abstracting journals such as *Evidence Based Medicine*, *Evidence Based Mental Health*, and *Evidence Based Nursing* identify the best and most relevant clinical research in their areas; the *Best Evidence* CD Rom presents a cummulative record. The major electronic databases are making searching easier by incorporating quality filters for different types of search question. Training courses and books on critical appraisal are helping clinicians to become educated consumers of these new resources. And because the information may still seem hard to access and understand, a new tool for clinicians, *Clinical Evidence*, will soon bring this concentrated wisdom a few steps closer to patient care (see box).

"Taking more care" involves more, of course, than getting research evidence into practice. At the York meeting, Liam Donaldson, director of the NHS Executive's Northern and Yorkshire region, listed his three ingredients for success in health care organisations—culture, culture, and culture. He warned that the design of the organisation (in Britain's case, the NHS) must be right for evidence based medicine to flourish. The new framework for organisational change in England is clinical governance, and on p 61 Scally and Donaldson explain what this means and what we can expect if it succeeds.[7]

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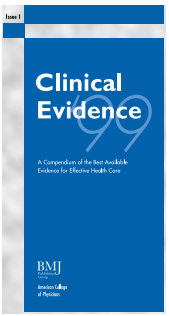
Clinical Evidence

Clinical Evidence is a compendium of summaries of the best available evidence on a range of important clinical questions. Produced jointly by the *BMJ* Publishing Group and the American College of Physicians, it will be updated and expanded twice a year, both as a book and on the web. It does not make recommendations, and where there is no good evidence it says so. Contributions are written by practising clinicians with expertise in evidence based medicine. The first issue will be available in January 1999. For more information, contact mnasser@bmjgroup.com.



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See also advertisement for clinical editors in Classified Supplement (special appointments)

1 Haynes RB. Where's the meat in clinical journals? *ACP Journal Club* 1993;119:A22-3.
2 Hannaford PC, Owen-Smith V. Using epidemiological data to guide clinical practice: review of studies on cardiovascular disease and use of combined oral contraceptives. *BMJ* 1998;316:984-7.
3 Ellis J, Mulligan I, Rowe J, Sackett DL. Inpatient general medicine is evidence based. *Lancet* 1995;346:407-10.
4 Gill P, Dowell AC, Neal RD, Smith N, Heywood P, Wilson AE. Evidence based general practice: a retrospective study of interventions in one training practice. *BMJ* 1996;312:819-21.
5 Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice. A systematic review of rigorous evaluations. *Lancet* 1993;342:1317-22.
6 Haines A, Donald A. Making better use of research findings. *BMJ* 1998;317:72-5.
7 Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61-5.

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