must be held subordinate to that primary commitment. For-profit companies, on the other hand, have a primary goal of maximising profits; indeed the responsibility of company executives is first and foremost to owners and shareholders. Though improving the public health may be seen as a desirable byproduct of company activities, concerns about health care cannot take precedence over profits: when the two goals conflict profit must win.[2 8]

Similarly, for proprietary companies no healthcare spending, no matter how expensive or inefficacious, is "inappropriate" if it increases profits. It is essentially irrelevant whether a drug unreasonably increases consumer expectations, forces doctors to spend substantial time disabusing patients of misinformation, diminishes the doctor-patient relationship because a doctor refuses to prescribe an advertised drug, or results in poor practice if the doctor capitulates and prescribes an inappropriate agent. Promotions of new and expensive drugs are successful if they increase sales, regardless of these other effects, and even if sales of rival products designed to treat the same diseases are not lessened.[9] Ultimately, of course, consumers pay for these promotions, whether it be the fortune spent on promotions to doctors (estimated to be about as much in the United States as is spent for all medical school and residency training combined[10]) or the potentially even greater spending on direct to consumer advertising.

Direct to consumer advertising of prescription drugs has been described as a "wonder drug" for the drug industry itself, because of its ability to affect patient demands—and in turn doctors' behaviour.[11] If they believe that patients want and expect drugs then doctors will prescribe them even when they know they are not indicated,[12] even when patients don't specifically ask for them, and even when an individual patient never expected the drug but the doctor thinks he or she did.[13] All that is required for direct to consumer advertising to increase product sales dramatically is that some patients ask and that doctors begin to believe that many patients will be dissatisfied without it.

We do not believe that drug companies should be blamed for valuing self interest above the needs of the public. In our society that is how companies are programmed to behave. Nor should doctors expect anyone else to be our ethical watchdogs. It is our responsibility to serve as advocates for our patients and for the public health. Whenever the search for greater profits is allowed to siphon off valuable and scarce resources that would be better used to improve the health of our entire community, we believe it is our obligation to speak out in opposition. We hope readers of the *BMJ* will join us in opposing the introduction of direct to consumer advertising of prescription medicines to the United Kingdom.

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Does the new NHS need personal medical services pilots?

They offer a testbed for primary care trusts

At the time of its publication in late 1996 the *Choice and Opportunity* white paper was seen as heralding revolutionary changes in British general practice.[1] The "listening exercise" by the then health minister, Gerald Malone, had identified once more the inflexibility of existing contractual arrangements as a major barrier to remedying poor quality primary care, particularly in inner cities. The NHS (Primary Care) Act, squeezed through in the final weeks of the last government, allowed health authorities scope for the first time to commission primary care from any local provider within the NHS family, better tailored to meet local needs. Proposals were invited to pilot these new arrangements, though the possibility of experimenting with unified budgets for general medical services and hospital and community services was suspended. Altogether 567 bids of various shapes and sizes were received initially. After a protracted selection process 95 quietly went live in April last year. More white papers and much else have happened since the launch of this policy initiative. So do the personal medical services pilots still have something to offer the new NHS?

Health authorities, community trusts, the NHS Executive, and general practices are exploring uncharted territory. Several factors have added to the challenge. As in the early days of fundholding, all parties

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are "learning by doing." The volume and detail of regulatory guidance has been overwhelming.[2] The new act introduced the term "personal medical services" to refer to those services known as general medical services under the 1977 NHS Act. By agreeing to provide personal medical services under part I rather than part II of the original act general practitioners working in the personal medical services pilots cease to be independent contractors. This was thought to threaten longstanding pension and employment rights, further sapping their enthusiasm. Other issues were unresolved such as the tax status of new primary care organisations and the medicolegal implications of a nurse led service. The profession's leaders were antipathetic to this latest threat to the hegemony of their national contract. Local medical committees were generally unsupportive of local proposals, particularly when community trusts wanted to employ a salaried general practitioner. The so called "return ticket" allowed some protection of general practitioners' previous contracts and rights if they were to leave the pilots, but this only partly reassured those concerned about what would happen at the end of the three year pilots. Finally, participants embarked on these major experiments with little financial support.

Those pilots that remain encompass a wealth of innovative developments. Several large schemes involve constellations of practices forming intermediate primary care organisations in an attempt to rationalise core management functions and improve clinical standards. Thirty three schemes based on community trusts are tackling the needs of particular priority groups in deprived areas. Ten pilots are led by nurses with the support of salaried general practitioners. Many pilot sites have established track records of service development and collaborative working. Schemes cover a range of models based on existing organisations such as general practice cooperatives. Some involve practices becoming absorbed within or taking over parts of community trusts.

The main obstacles to healthy take off have been strategic. Tension remains between the centralising tendencies of recent policy and the local innovation encouraged through the personal medical services pilots. Primary care groups represent an attempt to limit the diversity of organisational form that characterises primary care commissioning, while the NHS (Primary Care) Act is letting one hundred flowers bloom. In practice, many pilots straddled local authority boundaries. They were not easily assimilated within primary care groups. However, in their scale and scope these projects provide an obvious testbed for arrangements obtaining in the primary care trusts proposed in the most recent white paper on the NHS in England.[3] Personal medical services pilots may have early experience of integrating primary and community services and should learn much about how to hold health professionals accountable to intermediate primary care organisations. Finally, the challenge remains of targeting needy populations in urban areas underserved by traditional models of primary care.[4] The range of nurse led initiatives linking out of hours triage systems and NHS Direct is likely to increase.

There are risks inherent in organisations providing both primary and secondary services.[5] The interests of patients must not be overridden by those of health professionals and their employers. In a world of primary care trusts, the meaning of independent contractor status is unclear. The benefits of local contracts are unproved, but the chairman of the General Practitioners Committee has acknowledged that "We will never again see a unitary contract for the vast majority of GPs."[6]

Evaluation of the personal medical services pilots has been generously funded but will come too late to inform the next phase of policy development. There have been over 400 expressions of interest in the second wave of pilots, due to take wing in October this year. They are, however, the sorts of experiment that may help develop cost effective, responsive, and accountable primary care, especially in areas of high health need and poor service provision. They are consistent with the philosophy of encouraging a pluralistic approach to reform. They should—until evidence suggests otherwise—be nurtured rather than obstructed.

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Breast feeding reduces morbidity

The risk of HIV transmission requires risk assessment—not a shift to formula feeds

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It is time that doctors, and everyone else, accepted breast feeding as the biological norm, in terms of both feeding and caring for human infants. Exclusive breast feeding for six months provides the newborn with all the essential nutrients for health and growth and anti-infective properties not present in breastmilk substitutes.[1] The American Academy of Pediatrics recently stated, "The breast fed infant is the reference or normative model against which all alternative feeding methods must be measured."[2] Therefore our vocabulary needs to change,[3] and we should be saying that formula fed babies have more diseases and poorer psychological development than normal babies, rather than that breast fed babies have less disease and higher intelligence. This longstanding view is, however, under threat from the fact that HIV may be transmitted from mother to child through breast milk.

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