Hospitals cut elective surgery in attempt to stay solvent

The NHS may be heading for another winter of discontent. With nearly one third of the financial year yet to run, many hospitals have either run out of money for elective surgery or already fulfilled their block contracts for the year. To remain solvent the hospitals are restricting admissions to emergencies, extra-contractual referrals, patients from fundholding practices, and private patients—some for only December, others until next April. Fundholders, especially, are being courted for business by hard up providers.

In effect, this means that in some districts fundholders' patients will be admitted earlier for elective surgery than non-fundholders' patients with similar clinical indications for treatment. This abandonment of equity would seem to breach the guidelines agreed last year by the Department of Health, the Joint Consultants Committee, and the General Medical Services Committee (*BMJ* 1991;**302**:1486). In this week's journal general practitioner Dr Oliver Samuel writes of the impact of this differential treatment on patients and calls on doctors to refuse to collude with hospital managers "in [this] unethical behaviour and the neglect of their patients" (p 1497).

By favouring the patients of fundholders over patients whose operations won't bring them extra money hospital managers are trying to make ends meet. In many cases "overspending" has resulted from providers completing more work than they were contracted for. Southend Health Care NHS Trust is restricting general surgery to emergency and urgent cases until next April (except for patients who have waited for more than 18 months, whose treatment is being funded by an extra contract) because after the first five months of the year it had treated 800 more cases than it had been contracted for. Announcing a reduction in non-urgent surgery, managers at Basildon and Thurrock General Hospitals NHS Trust cited a 5% increase in activity so far this year (achieved with an increase in costs of only 1%). Continuing at the current level of activity would have taken them £0·5m into the red by March.

This pattern seems to have been repeated elsewhere: at least for the first six months of the year activity has been up on last year, but there is insufficient money to sustain this level until the end of the year. Two main explanations are given for the shortfall: either the money does not exist ("proof," therefore, that the NHS is underfunded) or else overcautious regions, districts, or fundholders are holding money back.

BMA NEWS REVIEW

Come back in April

The internal market was meant to reward efficiency and punish sloth. Ironically, the new year seems set to bring closed wards, idle surgeons, and lengthening waiting lists for the hardest working providers—just the circumstances that provoked the NHS reforms in the first place. This week the Central Consultants and Specialists Committee is scheduled to discuss the issue and decide whether to survey formally the extent of the problem.—TONY DELAMOTHE, *BMJ*

Polish abortion controversy continues

The latest round in Poland's drawn out controversy over abortion is threatening the coalition government of Prime Minister Hanna Suchocka. The draft of a bill promoted by the Christian National Union, one of the main coalition partners, is due for a reading next week. Described as a Christmas gift to the Polish people, the bill seeks to criminalise abortion, with up to two year jail terms for doctors who carry out abortions and for women who terminate their own pregnancies. The bill is a radical change from the act of 1956, which effectively allows abortion on demand and has led to an estimated 800 000 abortions a year. The new law would allow terminations only when the mother's life is threatened.

Although around 90% of the population claims to be Catholic, polls suggest that the Polish people are not as antiabortion as the church would like. In a mid-November poll 69% said that they opposed the criminalisation of abortion as proposed by the new bill, and only 3% said that they would vote for the Christian Nationalists in an election. Following Ireland's example, supporters of abortion have called for a referendum, and this, as much as the bill itself, has divided the country.

The church and President Lech Walesa oppose a referendum. While the prime

Headlines

Nigel Cox returns to job: Dr Nigel Cox, who was given a suspended jail sentence for the attempted murder of a chronically ill patient, has accepted Wessex Regional Health Authority's offer to return to his post as a consultant rheumatologist at the Royal Hallamshire Hospital in Winchester (28 November, p 1311). The authority has stipulated that Dr Cox must attend a course in pain relief and have a mentor.

Brazil's police breach human rights: About 1140 civilians were killed by military police in Sao Paulo in 1991, says a report from the Council for the Defence of the Rights of the Human Person, a human rights organisation. In New York the comparative figure was 27. The report examines the incident in which police killed 111 prisoners after a riot and concludes that the police are trained in summary executions (17 October, p 909).

Report calls for tighter controls on staff in children's homes: More rigorous selection procedures for staff in Britain's children's homes are urgently needed; this is one of 83 recommendations in a government report. The report, based on a survey of all 1300 children's homes in Britain, was commissioned after the scandal of systematic abuse in Leicestershire.

Sentenced to 10 years for having unprotected sex: A US man who is infected with HIV was convicted of attempted murder in Oregon, after having unprotected sex with a 17 year old. She has so far tested negative for HIV. This is the first time that such a judgment has been passed by a US court.

US Supreme Court denies challenge to abortion law: The Supreme Court has refused to consider arguments to lift the legal restrictions on abortion in Mississippi. The state requires a 24 hour wait before an abortion so that doctors can tell the woman about fetal development and alternatives to abortion.

Risk to drunken pedestrians: Deaths from drink-driving in Britain fell from 1500 to 700 in the past 10 years, but The Transport Research Laboratory reports that 460 pedestrians who were killed last year in Britain had a blood concentration of alcohol above the limit for driving.

minister supports the bill and also opposes a referendum, her own party, the Democratic Union, recently voted to support the call for a referendum. Public committees have been set up to collect signatures around the country, and about 500 000 people have already signed the petition.

The coalition parties have so far managed to avoid discussing the issue in the cabinet, but the heightened tension means that this week's budget debate may be at risk, threatening the government's stability.

Abortions on social grounds have effectively been halted since May, when the Polish General Medical Council's new ethical code came into force (30 May, p 1399). This allows doctors to carry out terminations only when a pregnancy threatens the mother's life or health or is the result of rape. The Polish ombudsman took the case to the Constitutional Tribunal, but its ruling in October was vague and said that resolving the issue required legislation. Many women are having abortions in private clinics or are going across the border to Czechoslovakia.

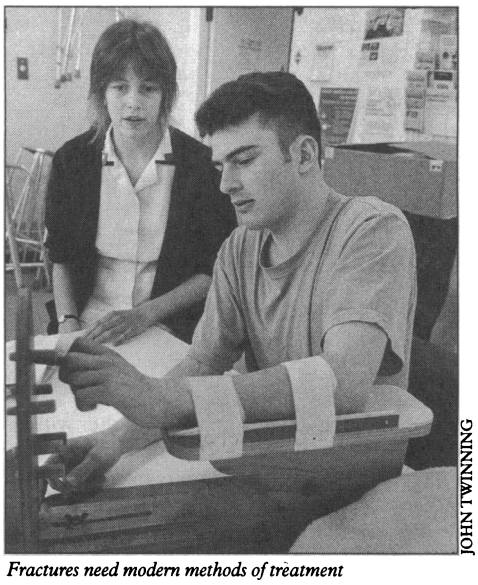
The abortion dispute is part of a wider struggle between the Catholic fundamentalists and liberals who want post-communist Poland to remain a secular state along western European lines. Other points of contention include the teaching of religion and sex education in schools and whether the bill regulating the media should include a reference to incorporating Christian values. The Christian National Union sees a role for Poland as a kind of moral vanguard for the rest of Europe, but whether the majority of Polish Catholics, let alone Poles in general, agree is in doubt.—LUCY KIMBELL, freelance journalist, Warsaw

Trauma care inadequate in Britain

Over 100 000 patients with trauma in Britain each year are left with disabilities that could have been prevented with better treatment, says a report published last week by the British Orthopaedic Association (BOA). The report, which looked primarily at musculoskeletal injuries, argues that trauma services in Britain are fragmented and understaffed, and that some major accident centres are without intensive care units or "the equipment available for the treatment of particular injuries by modern methods." Many injuries are treated by inexperienced doctors, and even when consultants are involved they are unlikely to refer complicated fractures to "superspecialists" who could do a better job.

The BOA surveyed 266 hospitals, asking about their fracture service, staffing levels, and support services. It found an average of one orthopaedic surgeon active in trauma care for every 63 700 patients. This compares with one for every 20 000 in the US and one for every 32 000 in Australia. The report says that in 17% of hospitals consultants work a one in two rota.

In many hospitals there was a shortage of intermediate staff, who were often not in



JOHN TWINNING

Fractures need modern methods of treatment

training posts and poorly supervised. About half of operations on patients with trauma were done after routine lists—in some hospitals this approached 100%.

The report cites evidence from the trauma morbidity audit study, published last year, which asked 30 surgeons to evaluate the result of trauma care for 800 patients. Over one in 10 patients had serious and preventable morbidity, a quarter of these because of missed injuries and 40% because of poor non-operative management.

The British Orthopaedic Association argues that "a restructuring of the entire trauma service is required as a matter of urgency." But while the Royal College of Surgeons recommends the setting up of large trauma centres serving between two and three million people the association asks for additional designated district accident services. Each would be staffed by four consultant orthopaedic surgeons with four intermediate grade staff. There would usually be one accident service per district, serving a population of between 200 000 and 500 000. Other district hospitals would retain their accident and emergency departments, but major injuries "according to agreed protocols" would be referred to the district trauma centre. Use of regional accident centres would be restricted to the care of multiple injuries.—LUISA DILLNER, *BMJ*

The Management of Skeletal Trauma in the United Kingdom is available from the BOA, 35-43 Lincoln's Inn Fields, London WC2A 3PN.

Sex survey gives information on HIV risk

People continue to put themselves at risk of HIV infection, according to the preliminary findings of the national survey of sexual attitudes and lifestyles published in last week's issue of *Nature* (3 December). Single people, young people, and men from the professional and managerial classes are

the most likely to have had multiple partners in the past year.

The study, of a random sample of almost 19 000 men and women aged 16 to 59 in England, Wales, and Scotland, found that heterosexual behaviour varied widely with age and gender. About a quarter of 16-24 year old men had had at least two sexual partners in the past year but only 1·8% of women aged 44 to 59. Over half the respondents had been monogamous in the past five years, but over a lifetime this proportion fell to one fifth of men and two fifths of women.

Kaye Wellings, a sociologist from St Mary's Hospital Medical School and co-author of the study, said that men in professional and managerial jobs were more likely to have had multiple partners in the past year because "they have the highest incomes, are more mobile, have higher education and more opportunities to meet partners, and marry later."

One in 16 men reported having had a homosexual experience, although only 1·4% said that they had had a homosexual partner within the past five years. For men living in London the likelihood of homosexual contact more than doubled.

The interviews were conducted face to face in people's homes by trained interviewers. "Showcards" were used for sensitive topics, with respondents choosing numbered answers shown to them on a card. Other sensitive topics were asked about in self completion questionnaires. The response rate was 65%, and answers showed a high degree of internal consistency. The researchers look on this as evidence of the respondents' honesty, although they warn that "estimates of socially censured behaviours have to be regarded as minima."

Fewer than 1% of respondents, and about twice as many men as women, admitted having injected drugs. Extrapolating from the sample suggests that 175 000 people in Britain have injected drugs and over half of them have shared needles. This figure is similar to estimates by the Office of Population Censuses and Surveys.

People who had had at least five heterosexual partners in the past five years, homosexuals, and women who had injected drugs were more likely to have attended clinics for sexually transmitted diseases. Overall, about one in seven people had had an HIV test, rising to three fifths of high risk groups. The researchers emphasised the importance of sexually transmitted disease clinics in promoting sexual health and of offering counselling in association with HIV testing.

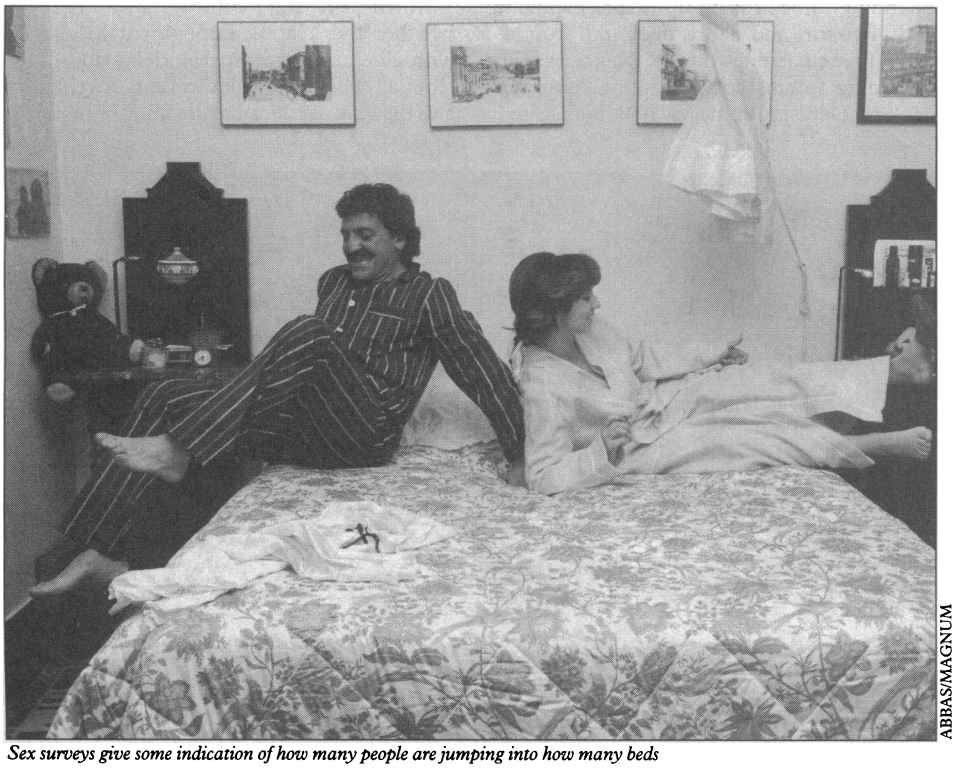
The British study was funded by the Wellcome Trust after the Thatcher government withdrew its support in 1989, claiming that the study was intrusive and would undermine family values.

The same issue of *Nature* contains a report of a French study on sexual behaviour that was both commissioned and funded by the French government. The *analyse des comportements sexuels en France* was conducted by telephone on a random sample of 20 000 people.

The mean number of sexual partners over a lifetime is similar to that in the British study: 11 for men and 3·3 for women. Homosexual intercourse was reported by 4·1% of men overall but was twice as common in Paris.

The French study also reports the use of condoms. Young people were most likely to use them, particularly with new partners. When asked about the last time they had had sex 18% of men and 11% of women said that they had used a condom. Despite the findings the French researchers conclude that "the level of protection currently used is insufficient to halt the spread of the HIV epidemic."

—STUART HANDYSIDES, *BMJ*



ABBAS/MAGNUM

Sex surveys give some indication of how many people are jumping into how many beds

Call for campaign on juniors' hours

Junior doctors are so angry at the lack of progress on implementing the new deal on hours of work that they have called for a public campaign. They want to draw attention to the fact that many juniors are still working over 83 hours a week. "Tired doctors are still killing patients one and a half years after the new deal," Dr Paul McLaren, a psychiatric senior registrar at Guy's Hospital, told the Junior Doctors Committee last weekend. There was a suggestion that there should be a Christmas campaign to emphasise the poor accommodation and mess facilities that many junior doctors working long hours had to endure. The committee decided, however, that with so many people homeless and unemployed this would be inappropriate.

The new deal set a target date of 1 April next year for contracted hours to be brought down to 83 for those on on call rotas, 72 for those on partial shifts, and 60 for those on full shifts. The next stage is to bring down the hours of those in hard pressed posts to 72 a week and of all doctors on partial and full shifts to 64 and 56 respectively by 31 December 1994. The intention is also to reduce working as opposed to contracted hours to a maximum average of 56 a week by 31 December 1994.

The JDC doubts that these targets will be achieved, and some speakers accused the signatories to the deal of renegueing on it; they called on the secretary of state for health to give a commitment that the new deal was back on course.

Although the hours have come down in many places, the intensity of the work has increased, and the committee wanted the working pattern to be determined by the intensity of work from 1 April next year. Several speakers at last week's meeting complained about the lack of a definition of partial shifts, which was one reason why they had not been taken up with alacrity. Many juniors, however, were still reluctant to change the way they work, preferring to remain on rotas. It was often consultants and managers who opposed the introduction of new working patterns. Dr Kym Hildyard said that she had taken a lot of trouble to try to introduce shifts, only to have the proposals turned down because of the expense. But shifts worked where they were properly constructed, Dr Paul McLaren told the committee, and where the deal had been funded properly with support from senior managers the targets were being achieved. In Guy's and Lewisham NHS Trust the 1994 targets would be achieved in 1993.

One of the JDC's deputy chairmen, Mr David Wrede, called for examples of where partial shifts were working well and of where junior doctors were doing inappropriate jobs. He warned that it would not succeed unless the whole committee was committed to it.

The JDC believes that the first solution to reducing hours is to create more consultants. So it was annoyed to learn that the NHS Management Executive had created an additional 225 senior house officer posts "in

anticipation of future service changes in London" to help with new working arrangements such as partial shifts. The committee resolved not to accept an increase in the total ceiling on senior house officers.—LINDA BEECHAM, *BMJ*

High Court will rule on hunger striker

The home secretary, Mr Kenneth Clarke, last week went to the High Court in a bid to clarify the law on whether prison authorities could lawfully stand by without intervening while a prisoner on hunger strike starved himself to death. Mr Clarke launched an application for declarations that doctors and medical staff at Belmarsh prison, south west London, need not feed Mr Jesus Marquez-Neira, a convicted Colombian drug smuggler, or give him medical treatment if his condition deteriorates, unless he decided to accept treatment.

Mr Neira, aged 37, has been on hunger strike since mid-May in protest at an 11 year sentence imposed last February at Croydon crown court for smuggling £250 000 worth of cocaine into Britain. The Home Office sought the declarations on the basis of evidence that Mr Neira had the mental capacity to decide whether or not to eat, fully comprehending that the fast could lead to death. But the case was adjourned last Friday after Miss Nicola Davies, QC for the Home Office, told Mr Justice Macpherson that a report from a psychiatrist appointed by the official solicitor, Mr David Venables, raised doubts about his capacity.

Two other psychiatrists, instructed by the Home Office and by Mr Neira's legal advisers, were to examine him as the *BMJ* went to press. If two of the three agree that he could be forcibly admitted under the terms of the Mental Health Act, and the Home Office gives permission, he could be admitted to a secure hospital and treated.

The only legal precedent is the case of a suffragette more than 80 years ago, in which the court held that prison authorities were under a duty to feed a hunger striker. But lawyers for the Home Office argued that the position was different today because suicide was no longer a crime. In 1974 the then home secretary, Roy Jenkins, issued administrative guidance to prison authorities instructing them that they were not obliged to force feed prisoners on hunger strike.

A Home Office spokeswoman said that previous hunger strikers in English prisons had either abandoned their strike or been admitted under the Mental Health Act, allowing treatment and feeding without consent. A spokesman for the Northern Ireland Office said that the issue had never been taken to court in Ulster. Prisoners would not be force fed and could refuse medical intervention by signing a form. Ten convicted IRA men committed suicide by hunger strike at the Maze prison outside Belfast in 1981.

The court heard that Mr Neira had accepted some food during the hearing but insisted that it was only to "alleviate stomach pain" and he would continue to starve himself if kept in prison. He was still taking fluids—apple juice and Guinness—in decreasing amounts and was receiving 24 hour nursing care in a ward at the prison.

Miss Davies said that Mr Neira's health would steadily deteriorate, with impairment of vision, swelling of his legs from fluid retention, and cardiac problems, if he continued to refuse food. One expert's prognosis was that he had about two to three months to live. Lawyers said that treatment under the Mental Health Act would not entail force feeding but would include psychological techniques such as those used to persuade people with anorexia to accept food.—CLARE DYER, legal correspondent, *BMJ*

Red Cross campaigns for new convention on mines

Over 500 civilians, many of them children, are killed or maimed each month by anti-personnel mines left at the scenes of military conflicts. Speaking at the British Institute of International Law, Ms Louise Doswald-Beck, a legal adviser to the International Committee of the Red Cross (ICRC), said that the committee was launching a new campaign to stop the indiscriminate use of mines. The existing UN Weapons Convention, which prohibits the indiscriminate use of mines, dates from 1980 and has been ratified by only 23 countries, with limited effect. Britain, the US, and France have not ratified the convention.

Mines that are triggered by foot pressure can blow off a person's lower leg, while bounding mines spring up before exploding and drive dirt and debris deep into wounds. At £4 each, mines are a cheap way of defending an area and disrupting communications. Defusing mines is now increasingly hazardous as many are resistant to methods of mine clearing and contain booby traps.

The ICRC estimates that in Angola alone 20 000 civilians have had limbs amputated from mines. In Kuwait, defusing some of the estimated one million mines has so far killed 84 mine clearers. Governments can afford to clear only valuable land. In Afghanistan—where the ICRC estimates that 10 million mines have been scattered—the UN has provided 27 mine clearing teams. Working at a rate of 30 km^2 a year, they would take 4300 years to clear the mines.

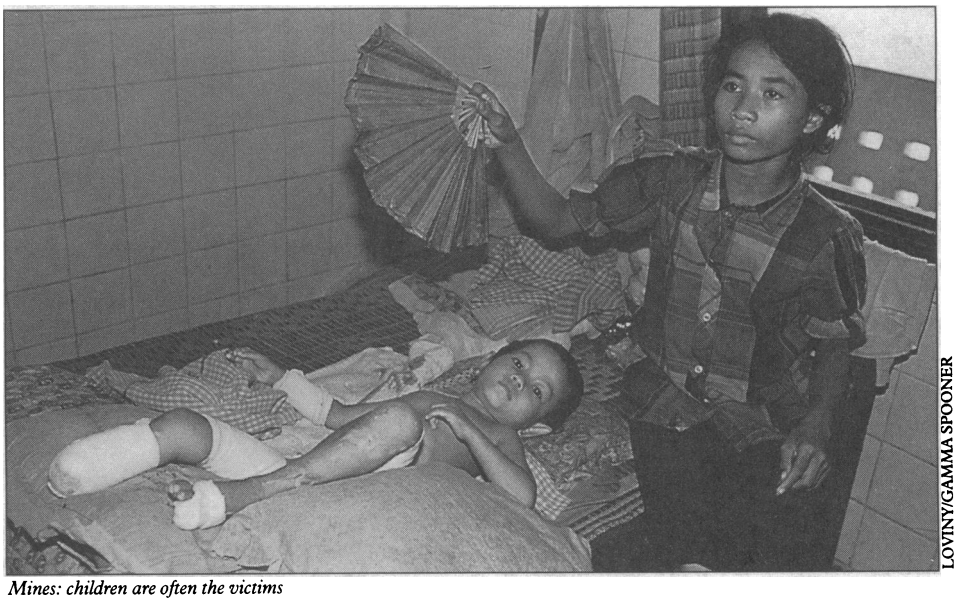
The 1980 convention requires military authorities to record the location of mines accurately and to defuse them at the end of hostilities. The ICRC recommends a convention demanding that mines should be detectable and programmed to self destruct.

Paul Jefferson, who trained as a mine clearer in the British army, had his leg blown off and was blinded while clearing mines in Kuwait. He believes that the ICRC's requests will go unheeded. "The military advantage of undetectable mines, and of plastic mines—being both cheaper to make and lighter to carry—influences the specifications that munitions manufacturers are given by their clients," he said. "Self destructing mines are more expensive. The most unpredictable and therefore the most dangerous are the mines made by soldiers in the field."—PETER HALL, Physicians for Human Rights

Less surgery for glue ear, says bulletin

Glue ear is the commonest reason for children to have elective surgery, but there is controversy about almost every aspect of the condition. This month's issue of *Effective Health Care* tries to sort out the facts.

Much of the controversy surrounds whether the hearing impairment associated with glue ear causes speech delay and problems at school. The indications for surgery and the type of operation are also contentious.



LOVINY/GAMMA SPOONER

Mines: children are often the victims

Most episodes of glue ear are brief; nearly half of all 3 year old children may begin an episode in the course of a year but only 5% will have bilateral hearing impairment lasting for at least three months. The bulletin's authors believe that there is insufficient evidence that glue ear causes clinically important disability.

If surgery is performed insertion of grommets and adenoidectomy (alone or in combination) are about equally effective and improve hearing only moderately and temporarily. Tonsillectomy and myringotomy do not help.

Because most children will recover spontaneously from glue ear a period of "watchful waiting" with a range of high quality hearing tests at the beginning and end is recommended. Meanwhile the child should go on a provisional waiting list, so that if surgery is eventually required it will not be further delayed.

These recommendations could both save and spend resources. They would lead to an overall reduction in rates of surgery—which at present vary a lot between regions. However, there would be increased demand for good quality audiology services for children, during the period of watchful waiting. Currently, grommet insertion costs an average £307, and a full paediatric audiological assessment £40 to £70.—ROGER ROBINSON, associate editor, *BMJ*

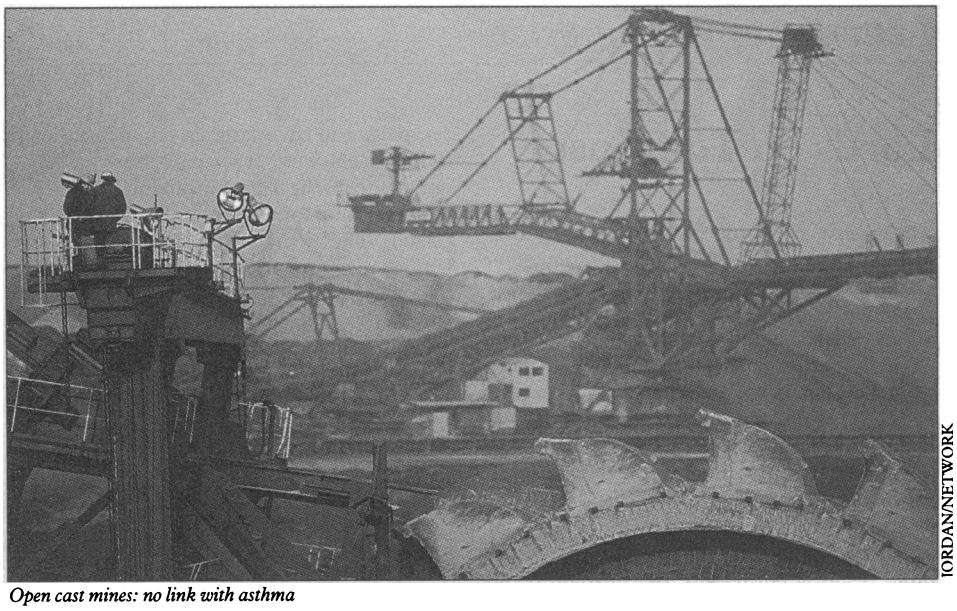
• *Effective Health Care* calls itself a "bulletin on the effectiveness of health service interventions for decision makers." It is funded by the Department of Health and produced by a research team from the University of Leeds School of Public Health, University of York Centre for Health Economics, and the Royal College of Physicians' Research Unit. They use checklists and advice from consultants to review the literature systematically. Topics are chosen because they have an important impact on health and have resource implications (particularly for purchasers and providers), and because there are uncertainties about treatment.

Effective Health Care No 4 (November 1992) is available from Christine Wilson, School of Public Health, University of Leeds, 30 Hyde Terrace, Leeds LS2 9LN and costs £3, or £25 for a series of nine bulletins.

Study finds no link between open cast mining and asthma

A study of open cast miners published last week has found no increased risk of asthma or chronic bronchitis. The findings conflict with data from Glynneath, West Glamorgan, recently published in the *BMJ* (15 August, pp 396-7), which suggested that the introduction of open cast mining in the area had caused an increase in asthma in workers and local people.

The study, undertaken by the Institute of Occupational Medicine in Edinburgh on behalf of British Coal, looked at the respiratory health of 1249 employees at nine open cast mines in England, Scotland, and Wales over one year. Symptoms of asthma were found in 5% of the workforce—2% less than in the general population. The authors point out, however, that employees suffering from asthma are more likely to seek work in dust free environments.



IORDAN/NETWORK

Open cast mines: no link with asthma

There was a small increased risk of silicosis, which is caused by inhalation of quartz dust. Silicosis was diagnosed in five of the workers studied, most of whom were employed in the dustiest job—removing layers of stone from around coal seams. The risk was related to the time worked in these jobs.

According to Dr Siyami Afacan, British Coal's director of medical services, the findings should reassure people living near open cast mines. "This report completely supports our long held view that there is no link between asthma and dust generated on open cast mines," he said. "It follows that if a large sample of our workers are not affected then the general population around our sites are not likely to be affected either."

Overall, the levels of airborne dust found by the researchers were low. But the authors suggest several moves to improve the health of open cast miners, including a review of dust control measures, regular monitoring of dust levels, and regular health checks for workers most at risk—those working in the dustiest areas.

"There is no doubt that those demonstrated to be at risk are those where the dust levels are highest," said Dr Richard Love, one of the authors of the report, "but for those people living outside the site boundary there is unlikely to be a risk to health."

The study has been welcomed by miners' leaders. George Henderson, national secretary of the Transport and General Workers Union, the union mainly responsible for open cast miners, was "very impressed" with the study. "Clearing the air like this is very good. It should put to rest the scare stories," which, he said, could otherwise threaten miners' jobs.—FIONA GODLEE, *BMJ*

A Cross Sectional Epidemiological Study of the Respiratory Health and Exposure to Airborne Dust and Quartz of Current Workers in Opencast Coalmines" is available from British Coal Opencast, 200 Litchfield Lane, Nottinghamshire NG18 4RG

Charter moves into the surgery

Last week the citizen's charter movement reached the part of the health service that most patients deal with: general practitioners' surgeries. The Department of Health's guidelines for the patient's charter in primary care cover individual general practices and the work of family health services authorities. Both groups are to develop their own charters by 1 April next year.

The guidelines, devised after discussions with the professions, allow practices much more flexibility to devise their own standards than either hospitals or family health services authorities are given.

All charters must, however, incorporate the 12 rights of patients to general medical services—covering such rights as to be registered with a GP, to receive emergency care through a GP, to be referred to a consultant, and to receive a copy of the practice leaflet. They must also incorporate the users' guide to primary care. This tells patients that they can expect to be treated with courtesy and to have their treatment explained. In return it asks patients to ask questions if they are unsure, to ask for night visits only when they are truly necessary, and to try to keep appointments.

Individual charters should then tell patients how long it should take to get an appointment or repeat prescription and how quickly they can reach a doctor in an emergency. The guidelines suggest that charters drawn up collectively by all the members of a primary care team are preferable to doctors and other providers each drawing up their own charters.

The charter also lays down standards for FHSA's administration and complaints. Authorities should acknowledge complaints and inform the practitioner within two working days. Complaints dealt with through informal conciliation must be cleared within a month and those that go to service committees within six months.—JANE SMITH, *BMJ*

Lords on Tomlinson

The House of Lords last week had parliament's first crack at the Tomlinson report on London's health service. There was no vote in the five hour debate, but the balance of the 40 speeches was tipped against Tomlinson's formula. Their lordships did not dispute what Tomlinson wanted to do but rather how he proposed doing it.

This was largely because the shadow of St Bartholomew's Hospital cast itself over the proceedings. As a venerable institution under frequent threat of extinction, the House of Lords knows how it feels to live on borrowed time. It can identify with the hospital's 900 year history and with St Thomas's, which has stood on the bank of the Thames for longer than the Houses of Parliament.

Under Sir Bernard Tomlinson's plan St Bartholomew's would close and merge with the Royal London Hospital. St Thomas's and Guy's Hospitals would merge on one site. The Royal Brompton and Royal Marsden Hospitals would be absorbed into Charing Cross Hospital. The Middlesex Hospital would be closed. Savings thus made would be ploughed back into general practice and community health.

The Lords were unanimous about the need to develop general practice in London, doubting only whether Tomlinson's estimate of £140m would be anywhere near adequate. Lord Annan, who initiated the debate, saw a weakness in amalgamating hospitals to finance primary care. "Whoever heard of the Treasury agreeing to a swap of that kind?" he asked, adding that rationalisation nearly always required more expenditure today to bring about real savings tomorrow.

Because so many peers wanted to speak they were limited to six minutes each, allowing time for only the baldest of arguments. The mini-speeches were like a penalty shoot out: Barts 10, Tomlinson 9.

Barts' royal patron, the Duke of Gloucester, questioned the basis on which Tomlinson had condemned the hospital, which, he said, was prepared for change but not for extinction. The duke pleaded for a stay of execution. Lord Smith, a medical peer though not a Barts man, thought the government would want to avoid the stigma of having abolished Barts, which Lady Masham said had survived both the great fire of London and Hitler's bombs.

Despite several references to the "disaster" of closing Barts, the junior health minister, Lady Cumberlege, was unmoved. For all its symbolic glory, she could hold out no distinction between Barts and other hospitals when the government finally came to decide a health strategy for London.

Other peers spoke in defence of the Brompton and Mardsen Hospitals as centres of excellence to be retained, and on behalf of St Thomas's as the casualty station for the elite of Westminster and Whitehall. Fierce loyalty to particular hospitals was compared to the campaigns to save famous regiments except that officers were trained to obey orders—unlike the medical establishment.

Some alternatives to closure were suggested. The former health secretary, Lord Jenkin, recommended integrated trusts combining community care and acute services. Another was for hospital accident and emergency units to form a new primary care service staffed by general practitioners. Two former health ministers, Lord Joseph and Lord Hayhoe, strongly supported the Tomlinson changes, but Lord Rea, from the opposition front bench, said that closing hospitals and selling off sites was wrong. For the government, Lady Cumberlege gave an assurance that it would keep an open mind until it responded to Tomlinson in the new year.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Week

Thoughts crystallise on Tomlinson

There are probably four broad responses to the Tomlinson report on London: Barts', the optimists', the realists', and the despairing. Barts' reaction—to fight—is old style campaigning (this week it is delivering petitions to Downing Street), and what is interesting is how few of the institutions threatened by Tomlinson are indulging in it.

The optimists' view is that Tomlinson provides an opportunity to create primary and community—and even hospital—services that match those anywhere in England. Let's grab it, run, and make it happen, they say. This view was expressed at this week's conference on London health care, organised by NAHAT and the King's Fund, by the managers of Lambeth Southwark and Lewisham Family Health Services Authority. They criticised the obsession with hospitals and argued that Londoners didn't realise how poor some of their primary care was. They reckoned that £35m in capital over five years and a 15% uplift in revenue could immensely improve primary care in their patch.

Peter Griffiths too, the chief executive of Guy's, took the visionary line. He hadn't heard a coherent alternative to Tomlinson, and he saw it as an opportunity to rethink hospital services—and make them contribute more to the management of Londoners' real problems: violence, drugs, AIDS, unemployment, and homelessness.

The realists accept the Tomlinson recipe but are gloomy about the money and the difficulties; they insist that there must be investment to improve community and primary care services before hospitals are rationalised. The realists probably include large numbers of people and institutions, quietly working out what the changes mean and how to cope with the difficulties: Sir Colin Dollery spoke at the conference of the University of London's plans and argued for its role in restructuring London's health; this week too Guy's and St Thomas's have started to consult on a merger.

Tomlinson himself probably holds the realists' view. To various audiences recently, including ministers and again at this week's conference, Sir Bernard has said how important investing money in primary care is and how the timescale for change needs to be long. Make decisions quickly, is his prescription, but then take time to plan the changes properly.

The fourth response is the despairing one, and it is shared by an alarmingly large number of people. An outsider reading the Tomlinson report might expect GPs to see the opportunities in the proposals. And some do: Dr David Tod, a fundholder in Tooting, had an upbeat approach to the problems at the King's Fund meeting, but it contrasted sharply with the mood of 100 or so GPs (many of them young) who met last Sunday at a forum organised by the inner London local medical committees (p 1507). They were angry and sceptical about the government's willingness to fund primary care in London while piling more work on to GPs. They spoke of how long it takes to improve premises, of the impossibility of getting and retaining staff, of the difficulty of getting patients into hospital.

Much the same scepticism on behalf of Londoners was expressed at the King's Fund conference. Londoners were cynical about government promises: psychiatric patients had been shifted out of asylums without the promised community support and they had been fobbed off with temporary bed closures that had become permanent. Londoners saw Tomlinson as a loss; they needed to be convinced that what will come will be better.

The despairing view is depressing because it clings to an impoverished status quo for fear that anything will be worse. It is the realists that Mrs Bottomley needs to convince—and to do that she must produce both money and an imaginative mechanism for managing the changes.

HART