LETTERS

Proposed academy of medicine

Profession is already more united than ever before

EDITOR,—There is a strange and mistaken view that nothing has been done to bring the medical profession together. Richard Smith refers to the conference on core values in November 1994,[1] which I convened on behalf of a steering committee representing every part of the profession; it was the first medical summit for over 30 years since the Porritt committee. This was not a free standing event but the beginning of a process of combined activity designed to ensure that the profession sings in harmony, if not in unison, in representing the concerns of all doctors and making the profession fit for the future. The steering committee remains in being to guide this programme, which includes forum group discussions to ascertain the views of young doctors and surveys to obtain vital information about the needs and problems of both established and newly qualified practitioners.

As a byproduct of this, leaders of the main professional bodies—the royal colleges, the Joint Consultants Committee, the General Medical Council, the deans, and the BMA itself—meet informally on a frequent and regular basis to discuss policy and to establish an agreed position to pursue in a parallel programme of informal meetings with the secretary of state and his colleagues, including the chief medical officer.

I see these processes as providing a fundamental foundation on which we can together articulate a clear voice for a profession that is already more united than it has ever been.

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1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)

An academy would be inappropriate

EDITOR,—Richard Smith discusses recent proposals to form an academy of medicine in Britain,[1] which are set out in a consultation paper (a leaflet) included in the same issue of the *BMJ*. The matter is both complex and important. I am surprised that the two articles could contemplate such an exercise in the representation of the profession without making any reference to the possible role of the BMA. I do not, however, believe that pique should prevent the BMA from considering the underlying concept. I have long argued that better communication is needed between the main bodies that represent our profession—in particular, the General Medical Council, the Conference of Medical Royal Colleges, and the BMA.[2]

I understand that after publication of an editorial that I wrote about the profession's need to speak with one voice[2] and the subsequent major conference on medicine's core values in 1994 the problem was acknowledged. Since then, regular informal meetings have been held between the leaders of the profession, at which issues of mutual concern are discussed. The latest proposals for a new academy recognise, and reinforce, the need for such an arrangement.

The outline of the proposals in the consultation paper, however, gives rise to concern since almost all of the "needs" identified are already clearly recognised and generally handled competently by the appropriate bodies. The paper contains several proposals, some of which are clear while others are unclear. My view is that those that are unclear should be clarified. Those, however, that are clear are inappropriate (for reasons too numerous to mention in detail but that can be summarised as potential political ineffectiveness, together with damage to existing institutions).

I continue to believe that there is an urgent need for better communication and better relationships within the profession, and I hope that this latest exercise will encourage and stimulate our leaders to develop further (and faster) the arrangements they have already put in place. Finally, and most importantly, I would argue that the creation of bigger and better bodies to represent the profession is no substitute for the exercise (in alphabetical order) of courage, determination, independence of spirit, loyalty, and political skill—qualities that have not always characterised the profession's dealings with the government. If we were to construct a "wet," unrepresentative, or divided academy the last state would undoubtedly be very much worse than the first.

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1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)
2 Grabham AH. Divided we fall (yet again). *BMJ* 1994;309:1100-1.

See p 1587

Physicians clarify their proposal for a National Council for Health Care Priorities

EDITOR,—The main challenge facing the NHS is the need to maintain the expected standards of care while at the same time containing costs. Priorities must therefore be selected, and it will be vital to have the public's support and understanding if this is to be done fairly. The Royal College of Physicians' proposal for a National Council for Health Care Priorities has received much support but also some criticism, on the mistaken grounds that a national council would interfere with local decision making. This confusion may have arisen because of the different ways in which national councils operate in other countries. We would therefore like to clarify the detailed proposals that our working party has formulated.

One of the themes of the college's report was that priorities are often considered on the basis of ill defined concepts of need, appropriateness, effectiveness, and efficiency.[1] There is a need to clarify these concepts and to find ways of dealing with the underlying tension between doing the best for an individual patient and doing the best for the community as a whole, given the available resources. Central decisions on the allocation of funds are usually based on principles of social justice or the need for equity, which are not easy to apply to specific groups of people or to individual cases.

The council that the college proposes would be charged with considering and developing the principles that should guide both national and local health authorities in setting priorities. It would be advisory, not prescriptive, and would have a monitoring role, but it would not provide a forum for considering individual services or specific local decisions. It would also advise on issues concerning quality.

All of these issues are ethical and involve human values and judgments. It is therefore necessary to be more open and explicit. When principles are being formulated it is important to involve non-medical people, since the purpose is to make these principles acceptable and applicable generally. We propose that the problems should first be analysed by an expert council considering solid, practical, state of the art information; this should be followed by the deliberate generation of public awareness and debate, a way of recommending improvements in policy, and a mechanism for monitoring how the principles are being applied at national and local levels.

The national council would therefore need to:

- advise on the framework for use in making decisions on health care priorities and the protection of quality
- develop methods of consultation involving appropriate groups
- develop educational strategies and methods of making its findings public
- define what information is needed to monitor the application of these principles
- decide how to report the results of monitoring and how to improve the principles for decision making in the light of experience.

If there is to be a balanced public debate on these issues it will need to be informed by knowledge of

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When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

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Letters will be edited and may be shortened.

the ways in which health authorities and general practice purchasers now make their decisions, so that recommendations that are made can be translated into practice. A National Council for Health Care Priorities should draw on this information and experience from other countries in developing methods for determining priorities and monitoring how they are set while protecting training, research, and development.

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1 Royal College of Physicians. *Setting priorities in the NHS: a framework for decision making.* London: RCP, 1995.

Rationing in the NHS

Public does not always favour lifesaving, acute interventions

EDITOR,—I recently ran a series of seven focus groups on rationing and prioritising in the NHS, which were attended by members of the general public in the Cambridge and Huntingdon area. The results provide an interesting contrast to those of previous studies, including that by Ann Bowling,[1] which have consistently indicated that the highest priority is attached to lifesaving, acute interventions. I found that more investment in services for mentally ill and elderly people was considered to be essential and was accorded higher priority than cancer services and high technology surgery. A shorter life of higher quality was thought preferable to painful longevity, with patients' informed choice and control over treatment being seen as essential components of "quality of life."

Participants said that they would advise the health authority to base purchasing decisions on ensuring "the greatest good for the greater number." This meant trying low technology, alternative approaches before the more costly invasive treatments, even in life threatening circumstances.

One reason for these and other differences from Ann Bowling's findings may be the methods used. The focus groups lasted two or more hours, which allowed participants to undertake several discussion exercises. This enabled them to engage with complex issues and to encounter the diversity of opinion within the group before attempting to reach a consensus on purchasing options; this is not dissimilar to what happens in real purchasing by paid professionals. Although participants recognised their lack of technical information, most thought that, given more time and information, lay people could make a positive and unique contribution to debates about the allocation of resources in the health service.

The health authority's purpose in conducting the focus groups was to begin a long, continuous process of public involvement in and education about priority setting in the health service. The exercise was not intended to serve as the basis for immediate changes to purchasing. While we are interested in people's basic instincts, we are equally interested in developing their capacity as partners in the decision making process. The challenge presented by the public's involvement is to ensure that its views are heard, valued, and acted on appropriately.

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1 Bowling A. Health care rationing: the public's debate. *BMJ* 1996;312:670-4. (16 March.)

Social decisions associated with rationing are not yet acceptable

EDITOR,—The *BMJ* is a scientific journal, testing practice against theory and theory against practice and thus changing both in a verifiable progress towards the solution of human problems. These problems include two questions: how much should we spend on health care and what should we spend it on?

The usual scientific approach to any question is first to observe and measure reality, in dimensions that seem most likely from past experience to provide a basis for disprovable hypotheses. Endorsed enthusiastically by Richard Smith,[1] Professor Ronald Dworkin offers his "prudent insurance principle" as an innovative theory to clarify these two questions, based, he says, on five assumptions. These assumptions are not derived from any study of the real world and contradict all human experience.

He asks us to imagine a world in which wealth is justly distributed (the richest fifth of the population now gets 150 times the income of the poorest fifth, a difference that has doubled over the past 30 years); in which information is available to all on all aspects of medicine and its effectiveness (when doctors are now said to need to read 19 articles a day for 365 days a year just to keep up with internal medicine); and in which everyone makes decisions rationally, parents put their children's interests on the same level as their own, and nobody knows anything about genetic, cultural, or social predispositions to disease. Interestingly, he asks us to make two further assumptions, which are at least credible: that governments abstain from providing health care and that people would be left to make their own decisions on which insurance policies to buy, what health problems to insure against, and what intensity of treatment they should be covered for.

Dworkin is a professor of law in Oxford and New York. We are used to extraterrestrial flights of this sort from lawyers, concerned with adversarial justice rather than material truth, but his enthusiastic endorsement by Smith is serious. No refutable hypotheses can be derived from fantasies of this kind, but they lead directly to a list of social decisions that most of us have not yet learnt to accept.

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1 Smith R. Being creative about rationing. *BMJ* 1996;312:391-2. (17 February.)

Debate over NHS-wide network is centred on wrong issue

EDITOR,—For some time the NHS and the BMA have been exchanging shots at each other about the NHS-wide network. The dispute about these technologies culminated in a heated argument after the presentation of a paper by Dr R J Anderson,[1] who seems to be the BMA's advocate against these technologies. Not being a partisan of either the NHS or the BMA, I wish to raise the issue that now seems to be almost forgotten—the real case for or against these technologies. Fortunately, there seems to be little dispute over the two most important points about the technologies: they entail risks with regard to security and privacy, and they could benefit patients' care substantially.

Debate might better centre on three questions. Do possible benefits to patients from the disputed technologies outweigh their possible risks? If the technologies are beneficial, are they cost effective? If the technologies are beneficial and cost effective, how can a reasonable level of risk be maintained and what is the quickest reasonable way to implementation?

My opinion is that the likely benefits to patients from these technologies outweigh their known or potential risks. Even Anderson has recognised that the NHS-wide network "might occasionally save life,"[2] which seems to finish the argument conclusively in favour of the proposed technologies, given the weak risks presented.

Concerns about security and privacy are legitimate, especially with the powerful combination of the two technologies of computers and networking. The NHS has, however, considered network security carefully, and its policy[3] seems at least on a par with good commercial practice. The Data Protection and Computer Misuse Acts offer effective legal recourse if security is unlawfully breached; a new European directive reinforces these acts and establishes a right to privacy.[4] Unfortunately, the issue of cost effectiveness is unlikely to be resolved in the present climate. The NHS seems to be determined to proceed with implementation without inviting contributions from the public. Perhaps this is just as well, given the delays already encountered.

Raising anecdotal tales of alleged abuses of security or privacy[1 2] or sensationalising in the press the serious issues concerning these technologies seems hardly responsible. If the argument is really over disclosure[5] then why not debate that subject explicitly? The pity of this public and possibly misdirected squabble is that neither the NHS nor the BMA has been able to conduct a constructive or informed debate over technologies that could benefit patients so substantially.

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1 Anderson RJ. Patient confidentiality—at risk from NHS-wide networking. In: Richards B, de Glanville H, eds. *Current perspectives in healthcare computing.* Weybridge: BJHC Books, 1996:687-92.
2 Anderson RJ. NHS-wide networking and patient confidentiality. *BMJ* 1995;311:5-6.
3 NHS Executive. *NHS-wide networking—security project: security guide for IM&T specialists.* London: Department of Health, 1995.
4 Smith MF. Data protection, health care, and the new European directive. *BMJ* 1996;312:197-8. (27 January.)
5 Anderson RJ. Clinical system security: interim guidelines. *BMJ* 1996;312:109-11. (13 January.)

Air pollution related to transport

Diesel is the main problem

EDITOR,—David V Bates's call for new clean air legislation in Britain[1] is made more urgent by the results of the two London based studies published in the same issue that show the relation between air pollution, daily mortality, and childhood wheezing.[2 3] Ozone and particulates are most strongly related to daily mortality,[2] while ozone and sulphur dioxide are most strongly related to childhood wheezing, though the study by Roger Buchdahl and colleagues did not measure particulate levels.[3] Unfortunately, particulates are also carcinogenic and are the most likely explanation for the relation between air pollution and annual mortality from lung cancer.[4]

The main problem is diesel. Historically diesel has been perceived as an environmentally benign fuel since it is 25-30% more efficient than petrol, contains no added lead, and produces virtually no carbon monoxide. In urban areas, however, it is the main source of particulate emissions, and in London 96% of black smoke comes from