increasing rapidly and heterosexual transmission is now the commonest form of spread in Scotland (and in the rest of Europe outside Britain).[2]

Until now HIV disease has generally been treated in hospitals and many patients have been reluctant to consult their general practitioner. The reasons for this have included fear of hostility and rejection, lack of confidentiality, and lack of knowledge. General practitioners have similar fears and anxieties about HIV and AIDS to those of the public and also feel insecure with a disease that is new and ever changing. Indeed, several surveys have shown a "lack of confidence in dealing with the issues surrounding HIV"[3] and a "lack of knowledge" of the topic among general practitioners and trainees.[4] But hospitals will be unable to cope as more people become infected, and more care for HIV disease will have to be provided in the community.

Faced with a disease that is relatively new, with unfamiliar and complex treatment regimens that alter frequently, and with a client group who may be better informed than they are, general practitioners might naturally feel threatened or confused. This is where a facilitator may help. A facilitator who is also a practising general practitioner is ideally placed to understand the specific problems of general practice. General practitioners encountering for the first time an HIV positive patient or one with AIDS may be unaware of the resources available in the community and from where and from whom to obtain help. This is especially important in the community care of terminal disease. Liaison between all groups working with HIV infection, both statutory and non-statutory, is essential,[5] and the facilitator has a role in developing links between these agencies.[6] Another important objective of a facilitator should be to increase awareness of HIV among general practitioners and to promote education, so that as the numbers of affected patients rise general practitioners will be well prepared for their role in caring for them.

Although many general practitioners confidently manage patients with HIV infection, much remains to be done in the community. In places where the number of infected patients is low, HIV is understandably accorded a low priority: none the less, we should "trouble shoot" now rather that "fire fight" later. As Donne concluded in 1627, "the physician who dares scarce come... it is an outlawry, an excommunication upon the patient." Nearly 400 years separates these sentiments and the modern day, but they are still relevant and just as important.

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Fundholding: from solution to problem

Rigorous evaluation should precede any further extension of the scheme

General practice fundholding has become a policy problem for the NHS. Hailed as a success only a few months into its operation,[1] it now seems dogged by limited advantages, high costs, and unintended consequences.

So far the only demonstrable advantage to fundholders has been a reduction in prescribing costs.[2,3] This is an eccentric achievement in a country whose prescribing costs historically have been among the lowest in western Europe.[4] It tells us nothing about either the quality of care, which may decline as costs are cut, or the long term economic costs of short term savings on prescribing, which may be appreciable.[5]

The economic costs of fundholding are considerable and include both open costs (such as management fees, subsidies for computerisation, and the administrative costs of billing and reviewing contracts) and hidden costs (such as costs for staff in family health services authorities, hospitals, and the Audit Commission). The political costs may be equally important given the damage done to equity by "fast tracking," the growing doubts about the value of fundholding, and the government's persistent failure to devolve responsibility for underprovision of health services to purchasers.

Why has fundholding become so problematic? Firstly, fundholders usually cannot act as ruthless purchasers. Not only is there a contradiction between advocacy on behalf of patients and rationing of resources but local providers may not always be influenced by fundholders' interests and the choice of provider may be limited or non-existent.[6] On the contrary, activity by provider units can create overspending for fundholders, a problem that may get worse as fundholders buy more services and as capitation based funding is introduced. Secondly, fundholders are as much a threat as an opportunity for local health policy. Fundholders' decisions about placing resources are primarily budget led because the pressure to avoid overspending is so great. Overspent fundholders may simply lack the money to adhere to wider health policies.

How did this happen? Fundholding has developed as an ideological construct, not a scientific hypothesis. Fundholding is an incentive evolved from Bosanquet and Leese's microeconomic model of development in general practice[7] and has been promoted by "ignorant experts" (in Alan Maynard's words) but never tested in pilot studies despite authoritative advice.[8] Designed as a political solution to kick start the market, fundholding has become an end, not a means to an end.[9]

This idealisation of an untested economic mechanism meets the needs of some general practitioners: it addresses the division in British medicine between generalists and specialists[10] by attempting to invert the power relationship while also touching on the omniscience beneath the surface of generalism. Fundholding also creates a managerial career structure within general practice in parallel with the vocational training structure, the local medical committee career path, and the hierarchy of academic practice. In a profession needing modernisation but locked within the egalitarianism of the independent contractor status, fundholding may represent a new opportunity for personal development.

Finally, no school of general practice sees itself as simply having a gatekeeper function, but fundholding as currently

pursued emphasises the role of the prudent gatekeeper. The costs of specialist care may be reduced by better management of chronic diseases and through primary and secondary prevention in general practice, but we cannot be sure of that. A mechanism that encourages fewer referrals or less prescribing on the assumption that other forms of treatment will be developed to make this reduction possible is running far ahead of the evidence.

How can fundholders escape from their current dilemma? A moratorium on recruitment to fundholding is needed so that the cost effectiveness of the project can be evaluated. The lack of evaluation[11] reflects badly on the Department of Health, which ostensibly seeks policies based on evidence and care based on knowledge, but evaluation is still possible. A realistic time scale for such evaluation is needed, probably of about three to five years.[12] Pilot projects in advanced fundholding practices will show whether purchasing all services, including social care, can make a difference to public health and the quality of specialist services. Complex questions need to be asked about outcomes for patients rather than just about cash flows, and fundholding needs to be measured against its alternatives to gauge its real value.[13]

This is a test for the government, which can either adopt a more scientific attitude or press on with an unplanned and unevaluated experiment with possible damaging effects on the health service and on public health.[11] If fundholding can be shown to provide better medical care then its extension to include general practitioners who are not natural innovators can be planned rationally. If fundholding fails to deliver the goods its pioneers can bring their experience back into alternative purchasing mechanisms, hopefully to everyone's benefit.

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Conflict of interest and the *BMJ*

Time to take it more seriously

Last year we had to reject a review article submitted to us because of conflict of interest. What seemed to us an ad hoc group reviewed the treatments of a particular condition. The referee was initially impressed by the clarity of the review but was perplexed that one particular treatment was given much greater prominence than it deserved. Eventually he realised—from his own knowledge rather than anything stated in the paper—that the group had been brought together and funded by a particular drug company. The company manufactured the treatment that was given extra attention.

Years ago, when our editorials were unsigned, we came to learn that one researcher who regularly wrote for us had substantial financial interests in pharmaceutical companies which might have benefited or otherwise from what was written in the editorials. Conflict of interest may also arise with letters, and many letters that seem to come from individuals who simply have an interest in the subject are in fact prompted by organisations with an interest, financial or otherwise, in the outcome of the correspondence. This is particularly true with tobacco companies. Or conflict of interest may arise with referees. John Maddox, the editor of *Nature*, has described several examples from his personal experience.[1] In one case, a referee sent back his opinion that a paper be rejected together with a paper of his own that he thought *Nature* might prefer to publish.

These are anecdotes, but they give readers some idea of why editors need to think about conflict of interest. Recognising the growing concern, the International Committee of Medical Journal Editors (the Vancouver group) last year produced a statement on conflict of interest.[2] Dennis Thompson from Harvard recently defined just what is meant by conflict of interest—"a set of conditions in which professional judgment concerning a primary interest (such as patients' welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)."[3] He emphasises that conflict of interest is a condition not a behaviour. We should pay attention to conflict of interest not only when it is clear that a judgment has been influenced by conflict of interest but simply when it might have been. Bias works subtly—which is why the double blind randomised controlled trial is such a crucial development—and most of us have limited insight into our own motives, let alone the motives of others. Suggesting that somebody has a conflict of interest is thus far removed from accusing them of dishonest behaviour. But conflict can have important effects: several studies have shown that doctors are more likely to refer patients for tests, operations, or hospital admission when they will benefit financially than when they will not.[4-6]

It is financial conflicts of interest that cause the most concern. The *New England Journal of Medicine*, which has led the way with its policies on conflict of interest,[7] concentrates on financial conflicts of interest on the grounds that they are widespread, optional, and seductive.[8] Thompson says that policies concentrate on financial gain because it is more objective and easier to regulate by impartial rules.[3] These arguments have much to recommend them, but we want to try to have a policy that covers all conflicts of interest. Other sources of conflict are personal, political, academic, and religious, and we believe that these may be just as potent as financial conflicts.

Editors need to deal with conflict of interest in order to make sure that the quality of research, judgments, and information in their journals is not reduced by secondary interests. They must also pay attention to the issue in order to