BMA chairman proposes reforming the reforms

Seven steps are needed to reform the NHS reforms and arrest the mood of alienation and demoralisation in the NHS, the chairman of the BMA's council said this week. Speaking at the start of the BMA's annual meeting in Birmingham, Dr Sandy Macara called for everyone to face the facts. The government had to acknowledge that its "huge national experiment" had failed. The professions had to recognise that they had not always been as imaginative or adaptable to change as they might have been .

Dr Macara said that there was a need to rediscover a consensus of aims and objectives, which were already set out in the *Health of the Nation*. This policy was founded on equity, community participation, priority for disease prevention and health promotion, the appropriate use of technology and expensive therapeutics, and international cooperation. Needs as distinct from demands and outcomes as distinct from outputs also had to be assessed. This required collaboration between public health physicians and clinicians. Society had to determine its priorities in health care, with professional advice and informed lay opinion. Dr Macara also spoke of the need for purchasing to be reformed as an effective mechanism for restoring strategic planning to meet the agreed priority needs. Providing had to be reformed with four elements—the restoration of core services, evaluation of outcome, enhanced medical input to management, and suspension of divisive policies of local pay bargaining and privatisation. Finally, purchasers and providers had to join forces.

The reasons for the sense of despair about the place of doctors and the future of the profession in the health care system were not hard to find, the chairman of council said. Cooperation had been supplanted by commercial competition; business plans overrode clinical priority; there was no longer one national health service; bureaucracy was burgeoning; misleading information was peddled to distract patients' attention from the real needs and real problems; the government proposed to impose the divisive and outdated device of local pay bargaining; and clinical support services were being privatised.

All branches of the profession had their special concerns. General practitioners faced a relentless increase in demand, especially for out of hours care, fuelled by expectations raised in the patient's charter. Senior hospital doctors faced unprecedented insecurity while regressing to the workload and work patterns of permanent senior registrars. Junior hospital doctors were cynical about the likelihood of a major reduction in their working hours and intolerable level of stress. Public health physicians were trapped as agents of the purchasers, separated from their clinical colleagues. Medical academic staff, who were crucial to the future of medical science, were crippled by unreasonable performance norms, which were destroying the balance between research, teaching, and service. Students were rightly questioning whether their country would regard them as anything more than itinerant hired hands.

"We are determined that it shall not go on like this," Dr Macara declared, and he pledged that he would continue to persuade the secretary of state for health to examine the evidence of problems in the NHS. But if the medical profession was to play its full part in the restoration it had to be at the heart of health care. Doctors had the tools to do the job—tools such as audit, outcome measures, clinical guidelines, and accreditation. "We believe that restoring professional values to the NHS, and ensuring the doctors' place at the heart of health care, will put heart back into doctors."

—LINDA BEECHAM, *BMJ*

CHARLES MILLIGAN

Dr Sandy Macara says that the government's "huge national experiment" has failed

Australian insurers accused of overcharging

A report commissioned by the Australian Medical Association has found that private health insurance companies are overcharging their members and contributing to their own decline. It found that recent 20% increases in premiums far outstripped the amount the not for profit companies are paying out in benefits to members. "Unless the health insurance industry can find a way to curb premium increases they will be left with an increasingly unsaleable product," said Roger Kilham, an economic consultant and author of the report.

The findings come at a crucial time for the private health insurance companies, which are struggling to retain members defecting to Medicare—the public health system founded by a compulsory levy on taxpayers. In the past 12 months alone more than 500 000 people have dropped private insurance.

A key joint government and trade union health committee has just rejected the insurance companies' appeals for government assistance. It denies that there is

Headlines

British government bans sale of calves' offal: The British government has banned the sale of calf sweetbreads and intestines as "a policy of extreme caution" after new tests showed that calves could develop bovine spongiform encephalopathy. The chief medical officer said that there was no evidence that eating beef caused Creutzfeldt-Jakob disease.

Call to impose age limit on assisted pregnancies in Italy: The National Committee for Bioethics appointed by the Italian government has said that assisted pregnancies should be limited to adult heterosexual couples of fertile age in a stable relationship. The committee has called for a ban on surrogate motherhood and experiments on embryos and for controls on sperm donors.

Spain may have abortion on demand: The Spanish government has submitted a bill for judicial review that would eliminate practically all the restrictions on abortions during the first 12 weeks of pregnancy.

Global AIDS figures rise: The estimated number of people with AIDS in the world has risen by 60% in the past year, according to figures released by the World Health Organisation. The rise from an estimated 2·5 million last year to 4 million has occurred mainly in Africa, but there has also been an eightfold increase in cases in South East Asia.

Law planned to widen disciplinary powers: Legislation to widen the General Medical Council's statutory powers to deal with doctors whose performance is "seriously deficient" is to be included in the government's next legislative programme. New performance procedures will be part of a single health services bill, which will enact structural changes, including the formal abolition of the NHS regional tier.

New head of communications for NHS Executive: Ms Helen McCallum has been appointed head of communications for the NHS Executive. She is at present acting head of communications for Anglia and Oxford Regional Health Authority.

any crisis in the industry and says that the health system could accommodate a fall in insurance numbers to just 20% of the population.

In addition federal health minister Dr Carmen Lawrence has unveiled plans for radical changes to the insurance companies aimed at making their premiums more attractive.

She said that she wants to introduce a "free and open industry subject to competition" and that the companies should be able to get value for their dollar from both hospitals and doctors. "It would be in my view freeing up the market and getting a better result for everybody," she said.

The AMA sponsored report said that members had been overcharged to help the funds build up record operating surpluses after the recent recession. But it said that the strategy had caused a decline in members as many families could not afford more than A$2000 (£950) a year for top cover.

"Without doubt the funds have exacerbated the problems in the industry and thereby exacerbated the problems facing private health care in the broader sense," the report says.

Mr Kilham, the author of the report, was also critical of the insurance companies' failure to reduce their administrative overheads, which account for an average 13% of premiums compared with Medicare's 3·8%.

The industry rejected the report, claiming that it was designed to frustrate insurers' plans to negotiate cheaper doctors' fees direct with hospitals.

Mr Russell Schneider, of the Australian Health Insurance Association, said that the report was a distraction from the real issue of doctors charging more than the scheduled fees. He said that the Australian Medical Association should commission Mr Kilham to find out how many doctors are charging above the scheduled fee.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

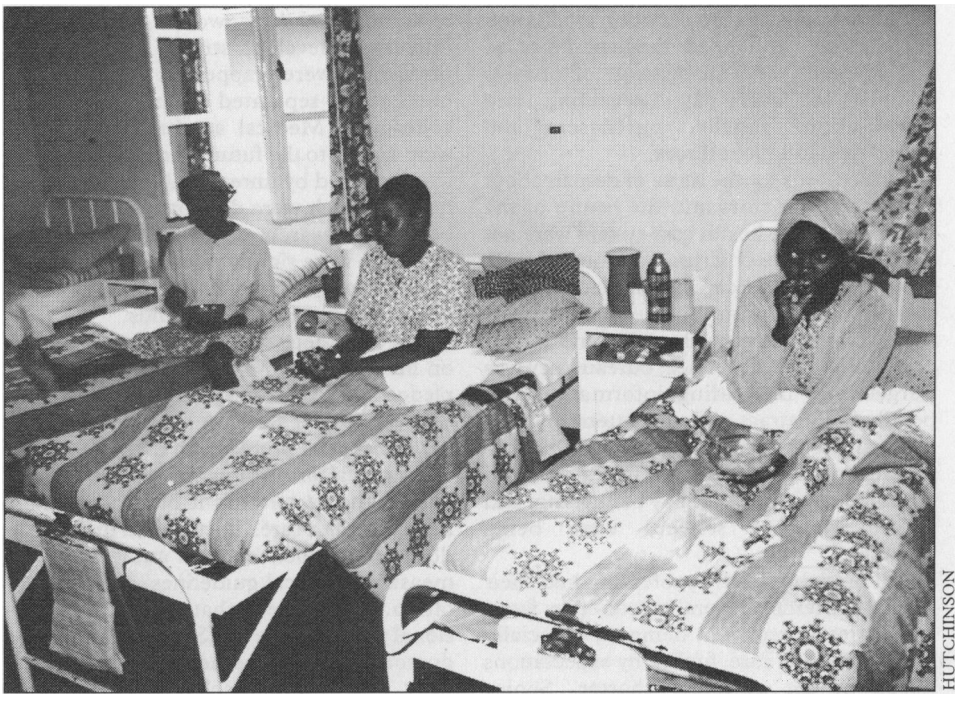
Kenyan doctors meet political deadlock

D ctors working in the public sector in Kenya are now in the third week of a strike in protest at the government's refusal to register their trade union. They are also demanding better conditions of service, particularly with regard to salaries and housing. The 3000 striking doctors want to be able to bargain for their rights in the future and have asked the government to register the Kenya Medical Practitioners and Dentists Union. But the conservativ government of President Daniel arap Moi has rejected the request, saying that such bodies are for unskilled workers and not for professionals.

Doctors working in Kenya's public sector are said to be among the poorest paid doctors in Africa. Reflecting the determined mood among the striking doctors, their leader , Dr Givan Ateka, said: "We have no intention of ending the strike until there is commitment on the part of the government to meet our demands. Doctors are not worried about losing their jobs. The pay is so ridiculously low that it does not matter." According to Dr Ateka, public sector doctors in Kenya were paid between £59 and £105 a month, and most had to pay for their housing out of that amount. He said that their colleagues in private service received more than £2000 a month.

Daniel arap Moi has threatened to recruit foreign doctors unless the strikers return to work, but analysts say that such a move would prove too costly for a government that relies on Western aid to keep its economy running.

Health minister Joshua Angathia said that he would talk to the doctors but only on the



HUTCHINSON

Patients in a Kenyan hospital: doctors are currently on strike

government's terms: "The government is willing to enter into dialogue with the striking doctors only if they resume duty and abandon their call for registration of a union. It is selfish and unrealistic for doctors to ask for better conditions of service without considering other civil servants." —BUCHIZYA MSETEKA, freelance journalist, Nairobi

Psychiatric services are dangerous, warn doctors

Potentially violent psychiatric patients in parts of London are waiting up to two months for beds in private medium secure units. Some patients are being placed as far away as Yorkshire. "We have a five bedded locked ward for patients who need intensive treatment, but this is for a population of nearly 200 000—we used to have 15 beds five years ago," said Dr Zerrin Atakan, a senior lecturer in psychiatry at South Western Hospital in West Lambeth. "The unit is at times completely blocked with forensic patients, and when we admit a new patient who is acutely disturbed we have to move someone from the unit on to an open ward because these patients are waiting to be placed in private secure units. We believe that some of these patients are a risk to themselves and to others.

"I have not been able to refer anyone to a medium secure unit within the NHS for 18 months. In the past six months we have had waiting lists to get patients into private medium secure units. The health authority has the funds to pay for places, but there aren't any available." Tooting Bec Hospital in south London is due to be closed early next spring.

Dr Atakan has written to Virginia Bottomley, the secretary of state for health, warning that the presence of "highly disturbed" patients on open wards presents a danger to staff and to the public. "Last month we had to admit a patient who had attempted to attack me twice before," said Dr Atakan. "He was brought to us by the police. The senior registrar phoned about 23 hospitals, trying to find a bed for him, and there was none." Schemes to divert mentally disordered offenders from prisons to psychiatric care have increased the pressure on acute psychiatric beds.

The Reed report into services for mentally disordered offenders recommended that at least 1500 medium secure places were needed. There are currently about 600. Dr John Taylor, medical director of Kneesworth House Hospital, a private psychiatric hospital, said that it had developed a waiting list for medium secure beds during the past year. "In the past we could offer a bed the same day," he said. "It is difficult to find a bed today. We can't say how many referrals we don't accept because we don't keep track of them.There is a constant demand." According to Dr David Roy, director of services at South Western Hospital, many psychiatric consultants in London say that they are running a service purely for psychotic patients. "Bed occupancy is 108% whereas six years ago it used to be 96%," he said. "The number of patients detained under sections of the mental health act has never been so high. In 1991 in West Lambeth it was 46% of acute admissions; in 1993-4 it is 71%. We have people in acute beds for three years before we can move them on."

The problem is not confined to London. Dr Susan O'Connor, a consultant psychiatrist at Barrow Hospital in Bristol, said that in the past six months patients had been admitted to psychiatric hospitals in Bath. "We are completely full today," she said. "Our patient profile has changed—we have more disturbed patients." Dr O'Connor believes that the government's introduction of supervision registers—whereby consultants must document patients who are at risk of harming themselves or others and ensure that a key worker is assigned to them—is contributing to the blocking of acute beds.

Dr Fiona Caldicott, president of the Royal College of Psychiatrists, has written to Virginia Bottomley stating that the criteria for inclusion on the register remain too broad and that estimates in the Nottingham district alone suggest that 2000 people should be placed on the register. Across Britain the cost of setting up and servicing the registers is put at £77m.

"There's a tendency for people to believe that the medical profession are trying to cover their personal position in fighting for more resources, but if we don't sort these problems out then it is patients and their families who will suffer," she said. "There are no free medium secure unit beds in the whole of London, and we find that alarming."

The Mental Health Task Force, set up by the NHS Executive, is currently looking at service issues in London. —LUISA DILLNER, *BMJ*

TOOTING BEC HOSPITAL

Tooting Bec Hospital is due to be closed next spring

French orthopaedic surgeons charged with fraud

Public prosecutors in several French cities have charged a dozen orthopaedic surgeons with overpricing knee prostheses and receiving kickbacks from producers or importers of the devices. More than 100 surgeons may have been involved in an alleged swindle that may have cost the social security's health insurance branch about Fr100m (£12m) over three years.

About 22 000 knee prostheses are used in France every year. The Caisse Nationale d'Assurance Maladie (CNAM), the health insurance branch of the Sécurité Sociale system, has not fixed a price range for them as it has for pharmaceuticals and for most other products or activities related to health. The CNAM has therefore paid clinics and hospitals whatever they have charged. Identical prostheses have apparently been charged for at prices ranging from Fr18 000 to Fr50 000 (£2000 to £5800).

The overpricing and kickback system has apparently been going on for several years and was highlighted only when a few surgeons reported the activities of one of their colleagues. The usually well informed satirical weekly *Le Canard Enchainé* disclosed the swindle to the public at the same time as several public prosecutors levelled charges against a few doctors. Police searched through the records of manufacturers and distributors of knee prostheses, reportedly establishing a list of more than 100 doctors who might be implicated. (There are some 1200 practising orthopaedic surgeons in France.)

Dr Bernard Glorion, president of the French medical association (who is also an orthopaedic surgeon), deplored the fact that no price scales had been established for knee prostheses. "A free market creates

temptations," he said, pointing out that culprits may be disciplined by the association. He said that he had appealed to the Ministry of Social Affairs and Health to include knee prostheses on a list of health tariffs. The government agreed, and the CNAM has now approved a plan to put a ceiling on the price of prostheses. —ALEXANDER DOROZYNSKI, medical journalist, Paris

Anaesthetist loses final appeal

An anaesthetist found guilty of manslaughter four years ago for causing the death of a patient had his appeal unanimously rejected by the House of Lords last week. Five law lords, including the Lord Chancellor, Lord Mackay, held that the trial judge had correctly summed up the law to the jury that convicted Dr John Adomako in 1990.

The prosecution arose from the death of Alan Loveland, 33, during an operation for a detached retina at the Mayday Hospital, Croydon, in January 1987. Forty five minutes after the start of the operation Dr Adomako, a locum anaesthetist who trained in the Soviet Union, was called in to take over from another anaesthetist.The patient's endotracheal tube became disconnected, leading to a cardiac arrest. Dr Adomako took various measures, including administering atropine, after an alarm sounded on the machine monitoring the patient's blood pressure, but he failed to notice that the tube was disconnected.

At the trial an expert witness for the prosecution, Professor James Payne, described the standard of care as "abysmal." Another, Professor Anthony Adams, said that a competent anaesthetist should have recognised the signs of disconnection within 15 seconds and described Dr Adomako's conduct as "a gross dereliction of care." The jury found him guilty of manslaughter by a majority of 11 to 1. Giving him a suspended prison sentence, Mr Justice Alliott said: "I have come to the conclusion that you and you alone are not the only person responsible for (the patient's) death. . . . The view I take in sentencing you . . . is that the responsibility lies wider."

Dr Adomako's appeal was heard in the Court of Appeal last year with those of Dr Barry Sullman and Dr Michael Prentice, two junior doctors convicted of manslaughter for having injected vincristine into the spine of a patient with leukaemia. Their convictions were overturned, but Dr Adomako's was upheld. He took his case to the House of Lords, arguing that the trial judge had been wrong in telling the jury that it could convict him of manslaughter if it found him guilty of gross negligence. His lawyers submitted that the test should be based on recklessness, as for a conviction for manslaughter in motoring cases. But the law lords held that gross negligence was the right test.

Robin Lewis, Dr Adomako's solicitor, said: " This judgment may encourage juries to convict doctors if they react to a particular event by feeling simply 'This must be criminal.' "—CLARE DYER, legal correspondent, *BMJ*

Focus: Birmingham

The bottom line is a moral one

With some help from the Bishop of Birmingham Britain's doctors looked this week as if they had found just the right tone to strike in their continuing debate with the government over the reformed National Health Service.

In his sermon on Sunday to doctors gathering in Birmingham for the BMA's annual representative meeting the bishop, the Right Reverend Mark Santer, talked about the moral values embodied in institutions. He spoke of the achievements of the NHS in its first 46 years—and the fact that they were related to avowedly moral ideals: health care for all and equality of access. The NHS, he said, "has promoted and embodied a culture of generous service and unstinting care which continues to astonish those who receive it."

He contrasted this with the current business model of the internal market and how it replaced cooperation with competition and excluded from its reckoning "precious elements which in fact help to give the service its distinctive quality." Patients now were reduced to the status of a unit of consumption and exchange; in the Christian view that was wrong because it treated people as means and instruments instead of ends. Important facts about human behaviour had been ignored—"such as that people do not function well if they sense that their professional expertise is being denigrated."

He spoke too of the need to re-establish a publicly shared consensus with a moral basis—including equality of access, dignity of treatment, and a particular care for the weak. "What we are talking about . . . is the institutional expression of the virtues of justice and compassion." The bottom line was to be found "not in the published accounts but in the human consequences." Politicians' duties included listening to what their professionals were telling them, while doctors' duties included taking responsibility for naming the human needs they saw. Doctors also had a duty, Dr Santer said, not to confuse professional integrity with sectional interest.

The problem for the medical profession is that market economists (following Adam Smith) tend to think that professional integrity is just another name for sectional interest. The force of the bishop's message lay in his assertion that the two are different.

It was, of course, a message the BMA was happy to hear. The following day, Dr Sandy Macara, chairman of council, received a spontaneous and warm standing ovation for a speech that was very much in tune with the bishop's (see p 75). The bishop spoke about "a system in distress"; Dr Macara spoke of a feeling of alienation and despair. Like the bishop, Dr Macara also wanted to move on from that despair and look to the future. He too looked for a consensus over aims and objectives. If politicians ought to acknowledge that the huge national experiment of the reforms had failed, then doctors also ought to recognise that "we have not always been as imaginative or adaptable to the challenges of change as we might have been."

One of the main debates during the meeting (held after we go to press) is likely to be on the profession's united opposition to performance related pay. The secretary of state is no doubt already dismissing this opposition as sectional interest. But she should recognise it as a symbol of something deeper. The proposal for local bargaining over performance related pay strikes at the ideal of equity that runs very deep within Britain's health service. It may be that the ideal has as often been breached as honoured: private practice income and merit awards have always been ill distributed between specialties and hospitals. But the structure of national pay bargaining was intended to be equitable. If, as the Bishop of Birmingham argued, structures and institutions embody moral values, then the proposals for performance related pay repudiate that intent. (Similarly the anger about a two tier service due to fundholding arises because of the explicitness of the two tiers—not because there were never inequalities of treatment in the old NHS.) Ministers too should heed the bishop's warning not to confuse professional integrity with sectional interests.—JANE SMITH