

## British GPs reject out of hours offer

British family doctors have rejected by 5 to 1 the government's proposals for restructuring out of hours services. They have told their negotiators to make one more attempt to resolve the crisis with an "immediate approach" to the Department of Health. If the talks break down or do not proceed fast enough doctors will be balloted on whether they want to take industrial action.

There was a 77% turnout in the ballot; 83% of general practitioners (20 345) voted against the offer and 17% (4274) voted for. The proposals included £45m in 1995-6 to develop rota systems and more cooperatives and to help rural and isolated doctors—for example, with costs of locum cover; a payment of £2000 for all principals for out of hours work and a consultation fee of £20 for all principals, assistants, associates, and trainees; a commitment to allow general practitioners to transfer their out of hours responsibility to another principal in general practice with the approval of the family health services authority; and a commitment to a campaign to educate patients.

The General Medical Services Committee, which had a long and sometimes angry debate last week, had already rejected an earlier offer, but it did not give any guidance on the latest offer. The vote is a result of the frustration over out of hours work that has built up since the introduction of the new contract in 1990.

In the past three years the number of out of hours calls has doubled. Patients' expectations have increased, fuelled, doctors believe, by the patient's charter. Many people regard night visits—between 10 pm and 8 am on weekdays and on Saturdays and Sundays—as an extension of daytime services instead of for genuine emergencies. An increasing number of younger general practitioners, many of whom are women, do not want this commitment on top of the increasing daytime workload.

In a nationwide survey conducted by the committee in 1992 two thirds of respondents said that they wanted to opt out of their 24 hour commitment, but two years later the annual conference of representatives of local medical committees voted to keep 24 hour responsibility. But since then attitudes have hardened, and the ability to opt out of providing out of hours care has been discussed at all recent meetings of the committee.

Dr George Rae, who practises in Tyne-side, said that the issue was not about money. "A lot of doctors say that even if there was a lot more money they still would not do the work."



Mr Norman Ellis, BMA under secretary, (left) with Dr Ian Bogle after the GMSC meeting

PETER ORME

Recognising that the offer was not ideal, the chairman of the Scottish General Medical Services Committee, Dr John Garner, said that he had voted for the proposal because he did not have the stomach for sanctions.

The chairman, Dr Ian Bogle, called the result "a damning verdict on the way that the government has handled general practitioners in the past five years." The government, Dr Bogle said, "boasts about developing a primary care led NHS. How you can treat people who are leading this change in this way I do not know."

This was the third offer from the government, and although the minister for health, Mr Gerald Malone, said last week that his door was open if the profession wanted further talks, he re-emphasised that there was "no more money." He was disappointed that the offer had been rejected because it was "fair to doctors and good for patients."

If talks do restart the General Medical Services Committee believes that certain

issues will have to be addressed. These include the separate identification and acceptable pricing of the out of hours component of doctors' pay, a realistic option for general practitioners to transfer their responsibility for organising out of hours care if they wish; and financial support for out of hours arrangements to be available to all doctors on an equitable basis. Agreement will also have to be reached on payment of night fees for consultations by any doctors eligible to work in general practice; a proper balance between workload and pay; and a commitment for resources to educate patients.

Next week's conference of local medical committees will be asked to endorse the General Medical Services Committee's decisions and to consider whether, if the government fails to resolve the crisis, the committee should explore options for fundamental change, including the separation of "in hours" and "out of hours" care, and report to a special conference.—LINDA BEECHAM, *BMJ*

**WHO warns of epidemic danger in Bosnia:** The World Health Organisation has expressed concern at the recent increase in war casualties in Sarajevo. It warns of the risk of epidemics, such as diarrhoea, if blockades prevent supplies being brought in. As well as a shortage of food there have been cuts in water, gas, and electricity.

**British CMO's advice about raw milk:** The British government's chief medical officer, Dr Kenneth Calman, has advised that children, pregnant women, elderly people, and those vulnerable to infection should not consume unpasteurised raw milk from cows, sheep, or goats because it has not been heat treated.

**Medicines Control Agency has new database:** The UK Medicines Control Agency, in association with Anderson Consulting, has implemented a new information technology system for licensing medicines for humans. The system holds over 70 000 records, of which 17 000 are current product licences.

**Support for new merit award plan:** The BMA's annual consultants' conference endorsed the draft agreement to replace C merit awards with discretionary points (3 June, p 1430) but insisted that the Central Consultants and Specialists Committee should issue detailed guidance on how schemes should operate locally.

**£1m will help young people tackle drug misuse:** The British government has announced that 40 projects will receive £1m to help tackle the problem of drug misuse among young people.

**Health managers must show commitment:** The NHS's director of human resources, Mr Ken Jarrold, said that managers must do more to show their commitment to the NHS and their knowledge of patient care to avoid a growing divide between them and their staff.

**Abortion rate falls after new law:** A new law on abortion in Mississippi, requiring parents to consent to abortions for minors has been followed by a fall in the abortion rate by 13%. The law was passed to deter young people from having abortions. Out of state abortions rose by 32%.

## Consultant struck off for fraudulent claims

Malcolm Pearce, a British consultant obstetrician, was last week found guilty by the General Medical Council of serious professional misconduct after fraudulently claiming to have performed a pioneering operation (see also p 1547). The scandal also led to the resignation of his immediate superior, Professor Geoffrey Chamberlain, as president of the Royal College of Obstetricians and Gynaecologists and as editor of the college's journal.

Mr Pearce was sacked from his post as a senior obstetric consultant at St George's Hospital, London, after a hospital investigation showed that he had tampered with computer records in an attempt to create a fictitious patient. He claimed that "patient X," a 29 year old African woman, had given birth to a healthy baby girl after he had successfully relocated a five week old ectopic embryo via the cervix.

Mr Pearce also claimed to have conducted a three year, double blind, randomised trial in which 191 women prone to miscarriage were treated with human chorionic gonadotrophin and placebos. He wrote a paper based on this research, in which he concluded that human chorionic gonadotrophin improved the outcome of pregnancy in women with recurrent miscarriage and the polycystic ovary syndrome.

The paper was published along with a report of the fictitious ectopic operation in the *British Journal of Obstetrics and Gynaecology*. Professor Chamberlain, then editor of the journal and head of Mr Pearce's department at St George's, accepted coauthorship of the paper, which was published in August 1994.

Suspicious were aroused at first by the large number of women prone to miscarriages whom Mr Pearce claimed to have recruited for his study. He was unable to produce notes, consent forms, patients, or any other corroboration. No other doctors had heard of the research while it was supposedly in progress.

His report on the ectopic transfer operation aroused worldwide attention. Colleagues at St George's told the General Medical Council's disciplinary committee of their surprise that such a feat had been achieved in their hospital without their knowledge. Mrs Alison Peattie, a senior lecturer in gynaecology at the medical school, said: "I was completely stunned and extremely embarrassed; I kept thinking, why should I know nothing about this?"

The investigation at St George's quickly turned up the fact that computer records had been tampered with and that in some cases Mr Pearce's password had been used. It emerged that patient X had in fact miscarried. When confronted with this information Mr Pearce admitted that he had lied but said that he had to protect the identity of the real mother, "patient Y," who had not been eligible for NHS treatment.

Professor Chamberlain, who had ordered

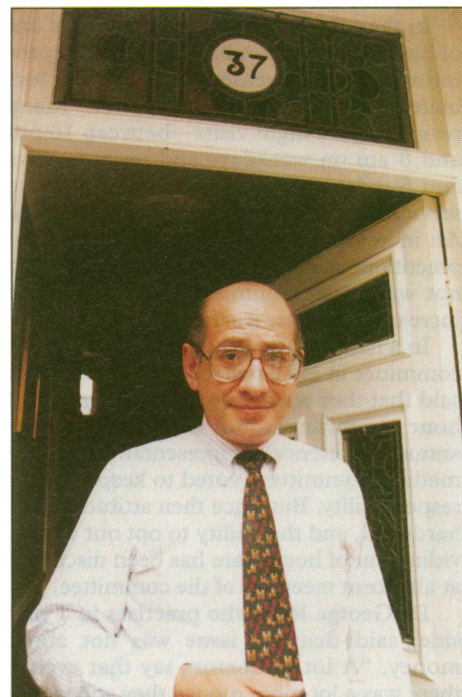
that the records be searched, told the committee that Mr Pearce had also told him that patient Y was fearful of details of a previous abortion coming out. Meanwhile Mr Pearce had further altered records of real patients to manufacture a suitable patient Y. One woman whose details were changed had in fact been born in 1910 and was dead at the time of her supposed pregnancy.

Mr Pearce did not attend the three day hearing. Sir Robert Kilpatrick, chairman of the disciplinary committee, said: "Mr Pearce not only sought personally to mislead others but to implicate colleagues, including junior doctors, in a web of deceit that has had incalculable consequences for public confidence in the integrity of research. Scientific fraud is dangerous. Medical knowledge worldwide is developed in part on the published results of previous research work."

Professor Chamberlain and Isaac Manyonda, listed as coauthors of the report on the ectopic pregnancy, and Dr Rosoel Hamid, who lent her name to the paper on the trial of human chorionic gonadotrophin, have received letters from the General Medical Council reminding them of their duty to check research before accepting responsibility for it.

In his summing up Sir Robert said: "All individuals named in a research paper must have made an intellectual contribution and been able to verify the raw data. All researchers should be familiar with the declaration of Helsinki."

Professor Chamberlain said later that in hindsight he agreed that gift authorship was a bad idea. "I rubber stamped this paper out of politeness and because he asked me to as head of the department." He argued, however, that even rigorous peer review was not necessarily going to detect outright fraud. "This paper was peer reviewed twice, both medically and statistically. It never occurred to the referees that the whole thing might be a lie."



Mr Malcolm Pearce

Speaking of Mr Pearce, Professor Chamberlain said: "Obviously Malcolm has been extremely silly on this occasion, but in the past he has done a lot of good."—OWEN DYER, freelance journalist, London

## Disabled people take care issues to court

Six disabled people in Britain last week launched a test case in the High Court over the right to community care services, which could have important implications for local authorities nationwide. Five pensioners are challenging decisions by Gloucestershire County Council last year to reduce or cut home help and respite care services because of lack of money. In a second case heard at the same time, Daniel McMillan, aged 53, who has osteoporosis and Parkinson's disease, complained that services provided by Islington council had been regularly interrupted because of shortages of staff.

Richard Gordon QC, counsel for the six, told Lord Justice McGowan and Mr Justice Waller that they had all been wrongly denied the help they were entitled to by law. The Gloucestershire case was brought by the Public Law Project, a charity set up to help individuals challenge decisions of local and central government. The council blamed "inadequate resources" for its decision to withdraw help from Wesley Mahfood, 75, who has spinal injuries and has had a stroke; Christopher Dartnell, 76, a double amputee with prostate cancer and heart disease, and his wife, Violet, 71, who has a heart condition, hypertension, and arthritis; Constance Grinham, 79, who is confined to a wheelchair with rheumatoid arthritis; and Michael Barry, 79, who is partially sighted, has had several heart attacks, and can walk only short distances without a stick. They were told that home help and respite care services were being cut or withdrawn "in order to continue to offer some help to people at greatest risk."

Mr Gordon argued that the wording of the Chronically Sick and Disabled Persons Act means that once a local authority is satisfied that someone needs a service then that service must be provided regardless of resources. Lawyers for the six people say that the duty to provide community care services—unlike the NHS's duty to provide treatment, where the courts have held that resources are relevant—is a personal duty that is owed to individuals.

Before 1993, Mr Gordon said, the government had operated a grant maintained system. In that year local councils' social services departments took over financial control of community care services. There was a dispute between local and central government over who was responsible for cutbacks. But whether they were due to lack of funding by central government or budgetary mismanagement by local councils mattered less than the fact that people were



Taking their case to court

GLoucestershire ECHO

being denied services that they were entitled to by law.

Though not a party to the case, the health secretary, Virginia Bottomley, was allowed to intervene and present arguments. Her counsel, Nigel Fleming QC, contended with counsel for Gloucestershire that resources could be a relevant factor in the provision of community care services. Gloucestershire said that demand for services had increased, while its budget had been cut. Directors of social services hope that the court's judgment, which was expected at the end of this week, will force the government to increase funding for community care.—CLARE DYER, legal correspondent, *BMJ*

## Peers define best and worst of NHS research

The NHS internal market is seriously damaging academic medicine and clinical research, a House of Lords select committee says in a report this week (see also p 1552). While commending some corrective action already taken by the government, the peers identify threats to long term research. These include the closure of teaching hospitals, the decline in tertiary referrals, purchasing contracts, and career blocks to academic medicine.

The committee, headed by Lord Walton of Detchant, said that there were great opportunities for medical research. "Biomedical science is advancing rapidly. Health service research is also making great strides... towards

a knowledge based service. Research is expanding out of the university hospital to involve new settings in primary care and the community and professional groups not previously much involved. And all these developments are taking place in the context of political commitment to increase the expenditure on research and development."

The report, however, points to aspects of policy that might stand in the way of these opportunities. The main concern is the balance between biomedical research that is driven by science and health services research that is motivated by solving problems.

There was worry over support for clinical trials from NHS services. Regretting the wall of accounting that has replaced the uncoded deals between the NHS and academic medicine, the peers predict that "the cost of separating the scientist from the clinician will be high." They recommend that research driven by curiosity is funded alongside "evidence based" research. The report states: "Clinical researchers are constantly enlarging the frontiers of knowledge and must not be held back rigidly within the boundaries of what is known at a particular time."

With hospitals being rationalised in big cities, medical schools are being forced to find large sums for relocation to avoid being severed from their clinical departments. The failure of the Departments of Health and Education to act together is described as "a depressing story of Whitehall at its worst." The report says that the NHS should foot the bill if necessary.

Radical solutions are suggested to restore the flow of patients for research to the specialist hospitals now that more patients are being treated locally. The peers recommend that specialist centres should advertise their

superior outcomes, or else they should use research funding to lower their prices and maintain the numbers of patients needed for research or teaching.

The report finds that the disincentives to an academic medical career are now so great as to warrant a separate inquiry. One of the obstacles to an academic career is stated to be the new "short, straight path to a consultant's post."—JOHN WARDEN, parliamentary correspondent, *BMJ*

*Medical Research and the NHS Reforms. Report of the Select Committee on Science and Technology, House of Lords is available from HMSO bookshops, price £18.*

## India moves towards equal rights for disabled people

India has drafted a parliamentary bill to safeguard the rights of physically disabled people and those with learning disabilities. The bill is aimed at improving education and employment prospects for people with disabilities and at preventing discrimination. The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Bill 1995, to be introduced in the next session of the Indian parliament, redefines welfare measures for an estimated 90 million disabled Indians.

The bill will make it mandatory for federal and state governments to intensify campaigns to prevent disabilities. It calls for nationwide screening programmes for preschool children at risk of disabilities from poor nutrition, infections, or other causes, and it advocates free education up to the age of 18 for children with disabilities.

Learning aids to help those with poor vision and hearing disabilities, and prosthetic devices for people with physical disabilities, will be provided free. An unemployment allowance will be paid to disabled people registered with employment agencies. The proposals are expected to cost the government at least 8000m rupees (£160m) over the next five years.

Only a tenth of people with disabilities in India receive government sponsored benefits. This year the government will spend only 600m rupees (£12m) on welfare for disabled people. The proposals in the bill require the government to double its spending on welfare for disabled people over the next five years.

Government officials as well as social workers say that scarcity of resources and indifferent attitudes make legislation imperative. "Only legislation will give the disabled in India the legal power to tackle the blatant as well as discreet discrimination against them," said Professor Ali Baquer, a consultant with the Voluntary Health Association of India, a nationwide network of public health workers.

The bill proposes reserving jobs in government institutions for people who are blind, have a hearing impairment, or are

physically disabled. The government will also offer incentives to private sector organisations that recruit disabled people for at least 5% of their workforce.

The bill prescribes fines and imprisonment of up to three months for parents or relatives who "wilfully neglect, reject, discriminate against or deprive a disabled child of food, clothing, and shelter." Schools that discriminate against disabled children are liable to have their grants withdrawn. Educational institutions will be asked to restructure their examination system and modify curriculums to suit the abilities of disabled students.

The government also plans to set up a national coordination committee to identify existing discriminatory laws against disabled people and amend them. It will also monitor development projects for disabled people run by non-government organisations and international agencies operating in India.

The bill proposed by the Indian government is "far more comprehensive and enforceable than the legislation being proposed by the British government and will be a model law for many other countries in the future," said Rachel Hurst, project director of Disability Awareness in Action, a non-government organisation in London.

Doctors have asked the Indian ministry of welfare, which is now finalising the bill, to ensure that welfare programmes of vocational training for disabled people are integrated with rehabilitation. A non-government medical team found that some schools for blind students were not interested in rehabilitating even those students whose sight could be restored.—MEENAL MUDUR, freelance writer, New Delhi

## Abortion laws cause problems in Poland

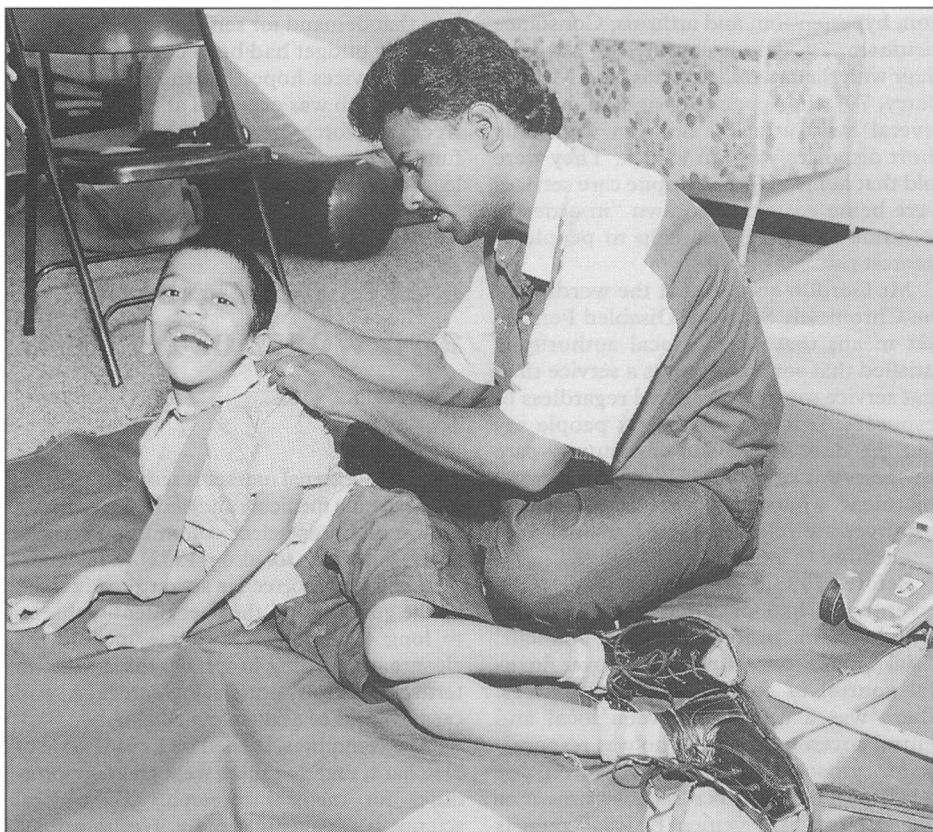
A doctor in Poland has been put on trial for contravening tough new laws by carrying out an abortion. The doctor faces two years in prison and the removal of his medical licence for up to 10 years if he is found guilty.

The case, which has attracted enormous media and public attention, follows the introduction in 1993 of strict new laws governing abortion, brought in as the result of a lengthy campaign by the Catholic church together with the Christian Democratic Union party. The new law permits abortion only in cases in which pregnancy threatens the life or seriously threatens the health of the mother or results from rape or incest, or if there is serious and irreversible malformation of the fetus.

The case in question concerns a woman who had been jilted by her lover and apparently pleaded with the doctor that she would not be able to support the child on her own. Her former lover also faces two years in prison if he is convicted of having paid for the operation.

The country's new policy follows 40 years of extremely liberal abortion laws during the Communist regime. During those years abortion was seen by many as a form of contraception, with an estimated 100 000 abortions being carried out each year during the 1980s. Since the new law was passed, figures show a dramatic decrease in the number of abortions: just 777 were recorded in 1993, of which only nine were in contravention of the law.

A spokesman for the Polish Ministry of Justice, Andrzej Cubala, said: "One presumes



*Disabled and discriminated against*

NEIL COOPER/FANOS

that now there is a large underground incidence of abortion. Illegal abortion resembles a bribe: both parties want to hide it. Both surface only by denouncement." Certainly in this latest case a third party seems to have been the problem. Reports claim that the woman's lover reported her in an act of vengeance.

As with so many illegal activities, abortion in Poland now costs a great deal. Doctors can charge the equivalent of two months' salary for performing the operation. The high cost is forcing many Polish women to go elsewhere—for instance, to Russia, Belarus, or the Ukraine, where abortion remains cheaper.

The high cost of abortion in Poland also means that women with little or no money to spare are forced to give birth or to take matters into their own hands. The Polish press recently reported the case of a mother who killed her baby, saying that she would not have done so if abortion had been available.—MAREK GAJEWSKI, freelance journalist, Warsaw

## Academics call for review of National Lottery's funding

Medical academic doctors want the National Lottery's charities board to widen its remit so that medical research charities can benefit. Representatives at last week's meeting of the conference of medical academic representatives said that the board should be better informed about medical research and called for national consultation about whether medical research should continue to be excluded.

Representatives said that the home secretary should be asked to bring influence to bear on the board and that the BMA should publicise the fact that at present none of the money from each lottery ticket sold goes to fund research into cancer and other diseases. The meeting also called on the government to consider compensating charities that had been affected.

Proceeds from the lottery are distributed by five boards, one of which is the charities board, which should have between £160m and £190m to distribute each year. The charities board is concentrating on charities aimed at relieving poverty and at people who are disadvantaged.

The meeting heard from Ms Diana Garnham, general secretary of the Association of Medical Research Charities, that donations to all charities could fall by about £200m a year and donations to medical research charities could fall by £10m to £14m a year as a result of the lottery. She told the conference that medical research charities funded a third of all medical research in Britain. Last year the 86 members of her association spent £360m on medical research. Ms Garnham said that the board's narrow interpretation of its remit was at odds with what parliament intended and with the public's concept of giving to charity.

After the meeting the chairman of the



*Medical research is a lottery loser*

BMA's Medical Academic Staff Committee, Dr Colin Smith, said that the BMA should look at a legal challenge to the lottery's current criteria for handing out money if all the other steps failed.

When the issue was raised in the House of Lords the parliamentary under secretary for the Department of National Heritage, Viscount Astor, said that in the first applications the charities board's primary aim was to improve the quality of life for people disadvantaged by low income, but the board would "certainly address applications from medical charities for the second and further rounds."—LINDA BEECHAM, *BMJ*

## Health ministers to help orphan drugs

The European Union is to try to increase research into, and the development of, medicines to treat rare diseases. Health ministers will look for a union-wide strategy to reduce the financial and administrative hurdles of producing these so called orphan drugs. The decision was taken after forceful prodding by the French government.

In a nine page memorandum to EU governments, the French, who hold the rotating presidency until the end of June, argued that European manufacturers were at a competitive disadvantage compared with firms in the US and Japan, where incentives to develop these drugs have been in place since 1983 and 1993 respectively.

The World Health Organisation has

identified almost 5000 rare illnesses affecting 650-1000 people in every million. Of these, four fifths are genetic in origin. The health ministers shared France's view that a framework that allowed companies to plan on a European scale of 370 million people rather than nationally would stimulate research.

Attention will now focus on certain specific issues: gaining a better understanding of rare illnesses; providing research and development aid for orphan drugs; considering how to introduce a fast track into the registration processes; and ironing out conflicting national legal and administrative rules. The European Commission now intends to canvass union governments on specific ideas and will be looking for an input from health authorities, industry, and non-government associations.

There was also political support for the union's goal of achieving self sufficiency in blood products. The main concern of ministers is to strengthen public confidence in the collection, distribution, and use of donated blood. EU governments intend to work out joint procedures for screening donors and have ruled out paying for donations.

At the same ministerial meeting in Luxembourg earlier this month ministers informally discussed the European Commission's controversial proposal to ban tobacco advertising in newspapers and periodicals. The scheme has been on the table since 1989 but has been consistently opposed by countries with major tobacco interests—Britain, Germany, and the Netherlands—and on more libertarian grounds by Denmark.

Germany is the largest manufacturer of cigarettes in the union and the biggest supplier to eastern Europe. The Dutch lead

the way in exporting cigars and cigarettes, and the United Kingdom is home to three of the top tobacco multinationals. Supporters of a ban who were involved in the discussion said that the three new member states—Austria, Sweden, and Finland—seemed well disposed to the idea, while the Dutch hinted that they might reassess their hostility.

If confirmed, the shift would provide the majority necessary for the legislation to be adopted when health ministers next meet on 30 November under the chairmanship of Spain, which has already expressed support for the ban.—RORY WATSON, Brussels correspondent, the *European*

## Nurses claim breakthrough in pay

The health secretary in Britain has promised several concessions on local pay bargaining, which the Royal College of Nursing claims are a breakthrough in the five month old pay dispute. The NHS Executive will tell NHS trusts that they cannot change nurses' working conditions as part of any pay agreement

this year and that they should offer nationally a 3% increase in the cash element of London allowances. Other allowances relating to basic pay will be increased automatically. Bursaries for students on Project 2000 will also be increased by 3% for the academic year 1995-6. In a letter to the general secretary of the college the health secretary says that the government will provide £1.3bn to the NHS "to permit fair pay settlements this year for nursing staff."

Earlier this year all the unions representing nurses decided to take action in protest at the 1% pay award recommended by the nurses' pay review body. The review body recommended that an additional increase of between 0.5% and 2% could be negotiated locally. Where trusts did award a further 2% many nurses had to accept changes to their conditions of service, such as entitlement to holiday or sick leave, as part of the pay deal.

According to the college, 346 trusts have made offers so far this year, 85% of which are of 3% or more. Once a significant majority of trusts has made such offers the college says that it will start to make local settlements while continuing to campaign to achieve 3% for every nurse.

The college believes that it has side-

stepped the review body's initial drive towards local bargaining and in next year's evidence will argue that the proposal was ill conceived and inappropriate. The college will go ahead and ballot its members on whether the ban on industrial action should be abolished.

Other unions say that they will continue the battle against local pay bargaining and have criticised the Royal College of Nursing for making secret deals with the government. But Mr Bob Abberley, the head of health at the union Unison, which is pursuing separate negotiations this week, said that ministers had been "rattled" by protests. "The government has clearly backed down on local pay. It is a small step, but it is in the right direction," he said. Representatives of his and other health unions were due to meet the NHS Executive for exploratory talks, which will include the National Association of Health Authorities and Trusts and the NHS Trust Federation.

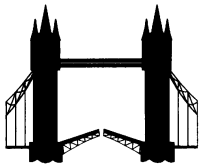
To reassure managers that the government was not abandoning local pay bargaining the NHS's director of human resources, Mr Ken Jarrold, has written to chief executives of NHS trusts restating ministers' commitment.—LINDA BEECHAM, *BMJ*

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## Focus: London

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### How we live now



"When I grew up in Glasgow health care was a right; carrying a machine gun was a privilege. In the USA it's the other way round." This comment

from Ian Morrison (Glaswegian, now president of the Institute for the Future, Menlo Park, California) during his *BMJ* lecture at BMA House a couple of weeks ago was to show that health care systems are determined by the culture of their country. In other words, despite the defects of the US health care system—which Ian Morrison ably and amusingly set out—Americans are not likely to change to a system like Canada's or, God forbid, the British NHS.

If Morrison is right then Arthur Seldon may have got it wrong. Seldon is a free market economist and founder of the Institute of Economic Affairs, a British think tank which last week published an assessment of the NHS reforms. *Patients or Customers: Are the NHS Reforms Working?* is a slightly unusual report. Firstly, thanks to its editor, Sir Reginald Murley, former president of the Royal College of Surgeons, it's largely written by practising doctors about their daily experiences of operating in the internal market. Secondly, it's notable for the division of thinking between the doctor-essayists and the more removed

commentators: Seldon, a trust chairman, and a sociologist.

Seldon himself argues that the health reforms have not gone far enough: the entire system should be privatised, allowing individuals to buy their own health care while providers gradually become private. His view is that consumers are the best judges of how they want to spend their money—not politicians: "For the mass of people shopping is more important than voting." One of the other commentators, Peter Collison, professor of social studies at Newcastle University, rather undermines this view by bringing readers back to Morrison's point about how culturally determined health systems are. As an illustration of the unique place the NHS holds in the national consciousness he cites the passion surrounding any attempt to close a hospital. His solution (surprising in this company) is for directly elected health authorities.

Probably neither Seldon's nor Collison's solutions would appeal to the doctors writing in the book. The three general practitioners (one a fundholder), former clinical director, medical director, senior registrar, and consultant orthopaedic surgeon concede some good things about the reforms. But their really telling examples are about the failures.

There are the usual sideswipes at poorly trained managers and waiting list targets from the patient's charter and the universal

agreement that patients follow money, not vice versa.

Hamish Laing's account of patients falling off a waiting list when a purchaser moves a contract and having to rejoin at the bottom of another with another provider—and of this happening more than once—is particularly damning. But it doesn't take wholesale reform of the system to see that authorities should make transitional arrangements for patients in the system when a contract changes. Likewise it should be beyond the wit of doctors (with the help of managers) to claw back the issue of clinical priority in waiting lists. JIL Bayley sensibly suggests that auditable clinical criteria could be drawn up and used to select patients from waiting lists. The doctors' most telling structural criticism is probably about the failure to sustain specialist services. Bayley, for example, points out that in blunting the ability of consultants to pursue their own interests at the expense of local needs the reforms have also curtailed the NHS's ability to develop and sustain specialist services—and the better outcomes that follow.

Anyone seeking a masterly evaluation of the reforms so far won't find it here: there are too many unresolved points of view. But as a snapshot of what it feels like to be working in the NHS now—and the confusion of ideas surrounding it—this report has the feel of reality.—JANE SMITH, *BMJ*