Tobacco in Australia

The Christmas and new year week brought good cheer to the antismoking movement in Australia, with media coverage of three major losses by promoters of the tobacco industry.

For the industry the slide started unexpectedly on Boxing Day in Sydney Harbour at the spectacular start of the annual yacht race to Hobart, 630 nautical miles to the south. Although disclaiming that it had any interest in publicity, the industry had a promoter's dream in the largest maxiyacht and race favourite, which had the name *Rothmans* conveniently registered by its sponsors in Britain.

Things started to go wrong for the sponsors in the first minutes. As *Rothmans* led the fleet down the harbour its tail was dogged by a motor boat flying a "Quit for Life" flag. The New South Wales Cancer Council said that the yacht was breaching the recent voluntary agreement between the industry and the New South Wales (NSW) state government.

As *Rothmans* sailed through the protests, the local company spokesman claimed no breach of the code and the yacht pressed on toward Hobart with hourly reports of its dominance of the race. As usual in the annual classic, however, planes with cameramen captured pictures of the leading vessels well out from shore. The denouement came when *Rothmans* was pictured on television and in the press flying a spinnaker with a huge logo of the cigarette brand, and the row started in earnest.

After capturing line honours for fastest time the yacht lost the race on being penalised a lenient 10% of its elapsed time for breach of rules (many yachtsmen believed that the boat should have been disqualified outright). Front page pictures in the mass circulation Sunday press ensured that most Australians learnt of the row. A lame protest was lodged and dismissed. One down to tobacco.

The Australian media are typically starved of news in the holiday week, except for sport, and the running story presented an ideal angle for splash coverage of the tobacco sponsorship issue. Mr Peter Staples, Federal Minister for Health Services, used the opportunity for gaining repeat coverage of a plan first announced in September for federal government intervention to prevent tobacco companies from sponsoring sport and the arts. A proposal, prepared jointly by Mr Staples and Mrs Ros Kelly, Minister for Arts and Sport, is now expected to be put to cabinet within a month. Issues of incidental or accidental broadcast or publication of material that might be regarded as tobacco advertising will be covered. Two down to tobacco.

Mr Staples also floated the notion that the federal government would take up the shortfall in income for major sporting and artistic events for a short period while non-tobacco corporate sponsors are persuaded to fill the gap. The latter idea, however, fell on deaf ears with spokesmen for the few large Australian corporations known for public largesse indicating uninterest, especially during the current economic recession. No score either way.

POPPERFOTO

The disallowed spinnaker on the British maxiyacht Rothmans

As if to reinforce the controversy, the concentrated summer season of test and one day cricket continued with sponsorship by Benson and Hedges. Though tobacco advertising has long been banned on television and radio, the placement of the brand name and logo strategically around the cricket grounds has ensured continual penetration of the nation's living rooms. One up to tobacco.

The divisions between federal and state legislations were also highlighted in the media. Though the Victorian government has been relatively tough on tobacco companies, the premiers of New South Wales (Mr Nick Greiner, Liberal party) and South Australia (Mr John Bannon, Labor party) continued to back the sponsorship by tobacco companies of grand prix motor cycle and car racing in their states (which assured media coverage). Two up to tobacco.

Right in the middle of the controversy boiling over the yacht race, a new federal government ban on advertising tobacco products in newspapers and magazines came into force. Three down to tobacco.

Characteristically, the industry is fighting fiercely to retain its diminished position.—
PETER POCKLEY

Headlines

Prescribing nurses: A nurses' formulary could be introduced if a private member's bill to be introduced later this month is successful. The bill would allow trained nurses to prescribe minor drugs and lotions and to alter the dosage of powerful drugs for pain relief that have been prescribed by a doctor. The proposals are supported by the RCN and the GMSC.

20 mph speed limit: The Department of Transport has agreed to the introduction of 20 mph speed limits in residential areas to reduce road casualties, particularly among children. At an impact speed of 30 mph death occurs in half of accidents involving pedestrians. Very few deaths result at the lower speed limit.

Scottish homeless: An extra £2m is to be made available from the government to prevent homelessness in Glasgow, Edinburgh, Dundee, and Aberdeen. The number of households assessed as homeless in Scotland in March last year was 10 962, an increase of 1340 on the previous year.

Renal physicians needed: The treatment programme for renal failure in Britain is "cost effective but cruel," according to Dr Tony Wing of the European Dialysis and Transplant Association. More specialists and treatment facilities are needed to bring Britain in line with other European countries, which have five or 10 times the number of renal physicians.

Glue ear campaign: The National Deaf Children's Society has launched a campaign to alert parents, teachers, and general practitioners to the problem of glue ear—a condition affecting, it says, one in four children. Prompt treatment with once daily antibiotics is the advice, avoiding rotating courses of different antibiotics. Free fact sheets are available from the society at 45 Hereford Road, London W2 5AH.

Baby check: Paediatricians in Cambridge have developed a score card for rating illness in children under 6 months. Field tests reported in January's edition of the *Archives of Disease in Childhood* show that the card is highly effective at predicting serious illness and is acceptable to both parents and health workers. Dr Colin Morley, one of the authors, believes that widespread use of the card in the community should improve the detection of serious illness and possibly reduce hospital admissions for mild illness.

Wealthier are healthier, still

Ten years after publication of the Black report on inequalities in health Britain remains a divided nation and the "health gap" between the rich and the poor is widening, according to a report from the Association of Community Health Councils (ACHC). It calls for a "national political commitment" to confront the problem.

Mortality from almost all diseases is higher in manual than in non-manual workers. The overall mortality for men in class V aged 20-64 is more than twice that for those in class I, and manual workers aged 20-54 are now twice as likely to die from lung cancer as non-manual workers.

For men in this age group only one major disease has a higher mortality in the higher occupational classes: malignant melanoma. Among women three additional diseases show the same trend: breast cancer, brain cancer, and chronic lymphoid leukaemia.

These inequalities in health are increasing as mortality from the major diseases has declined faster among the rich than the poor. Heavier smoking, poorer diet, less exercise, and lower uptake of preventive health services by those in the lower occupational classes are all implicated. The World Health Organisation's "Health for All by the Year 2000" has been largely ineffective in the United Kingdom, says the report.

Comparison with the 14 countries in Europe offers little comfort. In 1984 England and Wales, Scotland, and Northern Ireland ranked respectively ninth, tenth, and eleventh in the European league table of infant mortality—regarded as an accurate indicator of living and health care.

But inequalities in health are not inevitable. The social gradient in infant mortality between classes I and V narrowed during the 1970s, possibly as a result of a reduction in the size of families, which was most marked in class V.

There is, says the report, a self perpetuating cycle of poverty and illness. "Poor education and a disadvantaged childhood lead to ill paid and more hazardous occupations, which lead in turn to poorer health and a poor upbringing for the next generation."

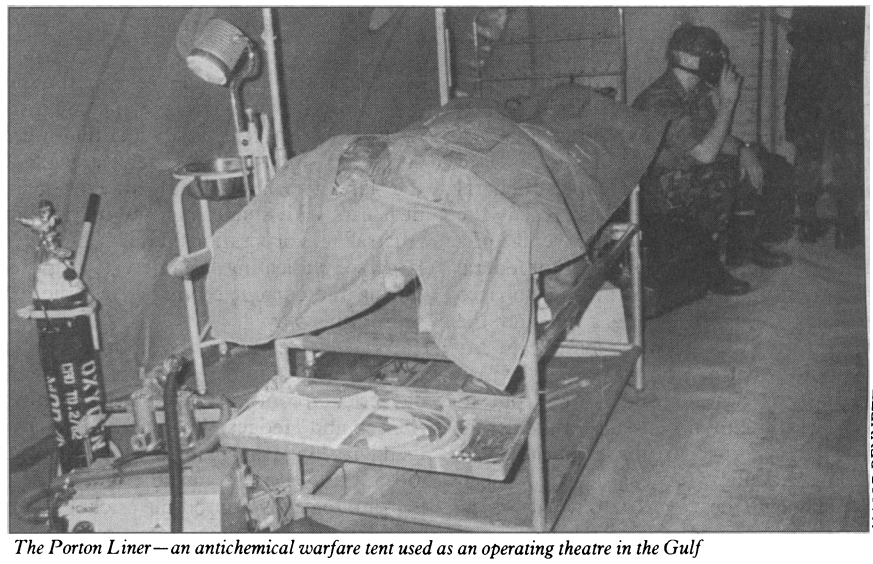
"The evidence is overwhelming," said

Antichemical warfare tent used for operation in the Gulf

Surgeons working at the British Army Field Hospital in the Middle East have operated for the first time inside a tent providing the most advanced protection against chemical warfare in the world.

The tents, called Porton Liners, are named after the defence centre at Porton Down where they were designed. A pressurised air system is used to maintain a safe internal environment against chemical weapons. All seals are airtight (and hence "chemical tight"). Special provision has been made to enable volatile anaesthetic gases to be used and to tackle the problems caused by heat and humidity. As a result surgeons can operate freely without the encumbrances of suits, respirators, and helmets. The tents are assembled in continuity with a special airlock to maintain the pressurised atmosphere when people enter or leave.

The casualty needing an operation was a 22 year old soldier who developed appendicitis while at the front line. Conditions inside the tent during his operation were cramped—rather like operating inside a rubber wet suit blown up to the dimensions of the back of a Ford transit van. The operating table took up most of the space so that there was not enough room for the surgeons to scrub up at the same time as the anaesthetist induced the patient. Temperatures reached 32°C during the operation, and the surgical team found that they rapidly became tired. The operation was uneventful, and the soldier was back at the front line three weeks after his appendicectomy.—MAJORS DUNCAN CHAMBERS, STEPHEN MILNER, JOHN BENNETT, and JOHN STONE



MAJOR BENNETT

The Porton Liner—an antichemical warfare tent used as an operating theatre in the Gulf

Toby Harris, director of the ACHC for England and Wales. "The wealthy are more healthy." Unless John Major takes note of this report, his dream of a classless society seems likely to remain just that.—FIONA GODLEE

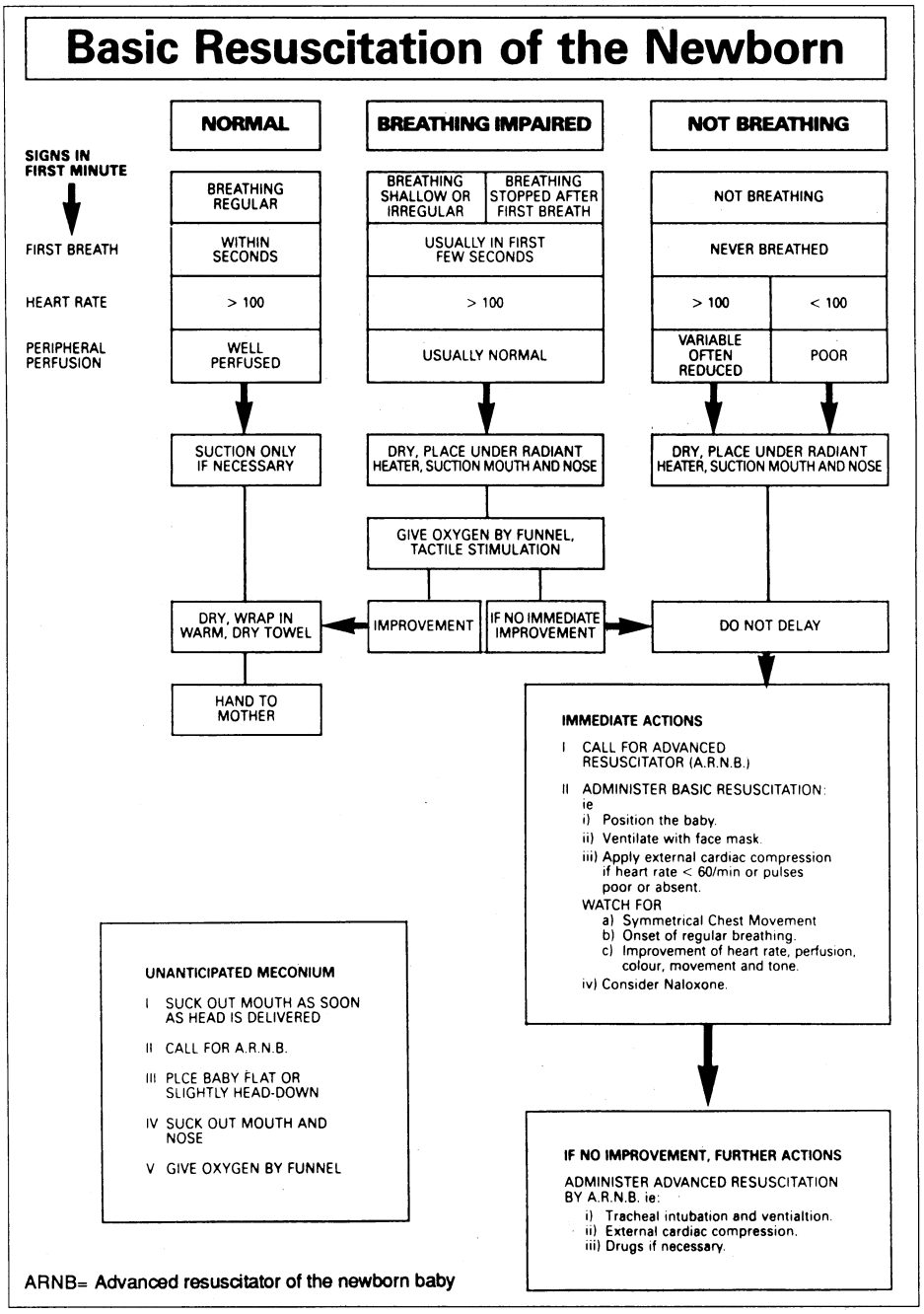
Waldegrave to review GP contract

Kenneth Clarke, the former Secretary of State for Health, believed that an assessment of the new general practitioner contract would take 12-18 months, but his successor, William Waldegrave, has said that he will review the contract now and make changes where necessary. He gave this undertaking when meeting with the negotiators of the General Medical Services Committee just before Christmas. Ian Bogle, chairman of the committee, said that he was under no illusion that much had been gained, but he did believe that some of the problems of the contract would be addressed. General practitioners are particularly concerned about health promotion, target payments for cervical cytology and immunisation, and the deprived area allowance.

Mr Waldegrave also told the general practitioners that he puts a high priority on boosting morale in the NHS, particularly among general practitioners and other doctors in the front line. He wants to establish a closer working relationship with the GMSC but also to receive combined advice from the committee and the Royal College of General Practitioners.

But the same meeting of the GMSC that heard that Mr Waldegrave was concerned about boosting morale also heard from many general practitioners about the difficulties they are having getting patients admitted to hospital. They put the blame firmly on underfunding and the government's insistence that health authorities balance their books for the beginning of the new NHS on 1 April. About 4000 beds are estimated to be closed, 1000 of them in London. Dr Arnold Elliott, who practises in Essex and who initiated the emergency debate, told the committee that he thought that this figure was an underestimate.

Dr Elliott told a press briefing after the meeting that general practitioners in north east Essex had been told not to admit patients to hospital unless it was an acute emergency or they suspected that the patient had cancer. This was putting extra pressure on doctors, particularly younger and less experienced ones. The fact that some doctors in London had been told not to refer patients directly but to use the Emergency Bed Service meant that they could no longer speak to another doctor on behalf of their patients. "Please do not refer again until the end of January" is a typical notice from health authorities, and Dr Judy Gilley, who practises in Finchley, told journalists that she felt more depressed and undervalued as a general practitioner than at any time in the past 16 years.—LINDA BEECHAM



Resuscitating newborn babies

Paediatricians, obstetricians, anaesthetists, and midwives have collaborated to produce the first comprehensive training programme in Britain devoted to resuscitating newborn babies. The programme is aimed at trainees in all specialties working on the labour ward, and it is hoped that it will teach them the necessary skills to resuscitate the 20 000 to 30 000 babies estimated to be born every year at "serious risk" of respiratory or circulatory failure.

The training programme is divided into two levels, basic and advanced. All trainees are expected to be competent at performing basic resuscitation—including ventilation with a face mask and external cardiac massage—and should have a working knowledge of advanced resuscitation. A more experienced member of staff (usually a paediatrician) should, however, be immediately available to perform advanced resuscitation when difficulties arise. The programme clearly emphasises the need to avoid unnecessary intervention in a normal neonate.

Two manuals, training videos, and a wall chart have been produced to promote the programme, which has taken five years to produce. A free wall chart is being distributed by the Department of Health to every delivery room in the country (see box). It is intended that trainees will be tested on the content of the manuals in their college examinations. "The task now," said Dr Harold Gamsu, consultant paediatrician and chairman of the working party that produced the training programme, "is to make as many people as possible aware of the programme and to get them to use it."—ALISON WALKER

Copies of the manuals, videos, and wall chart can be obtained from the deputy college secretary, Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London NW1 4RG.

Arbitrary coroners

Some coroners are arbitrarily withholding information produced at inquests that may be useful to researchers, according to the Campaign for Freedom of Information. Coroners have discretion over who may have access to statements of evidence read out in court or transcripts of the proceedings; the campaign suggests that this discretion should be restricted so that information that has been made public during an inquest remains publicly accessible.

By law, public inquests must be held into any violent, unnatural, or unexpected sudden death and into any death in prison. The questioning of witnesses therefore takes place in public and can be reported. Although the press and public can attend the inquest and take notes of the proceedings, they have no right to documents. Who is entitled to access is someone who "in the opinion of the coroner is a properly interested person."

The campaign argues that what constitutes "proper interest" is not clearly defined, which has resulted in some coroners exercising their discretion in "an arbitrary and extraordinarily illogical way."

This month's issue of the campaign's newspaper, *Secrets*, lists some of the more bizarre decisions:

Transcript of a coroner's inquest? Only "properly interested persons" need apply

- A study funded by London Underground aimed at preventing fatal accidents on the underground has been denied information by one London coroner though others have been eager to assist. Conducted by the department of community medicine at Charing Cross and Westminster Medical School, the study is trying to identify high risk areas and see whether modifications to train or platform design might save lives. The coroner told researchers that he did not regard them as "properly interested persons" and refused even to meet them and discuss the project.
- A government funded study into fatal accidents in the home was denied information on seven of the 52 accidents it was studying. The research, carried out for the Department of Trade and Industry by the Child Accident Prevention Trust, sought to study accidents in which children had died after falling from stairs, to see whether the design of bannisters could be improved.
- The London Hazards Centre is researching deaths in the construction industry in London in 1987-8. One coroner whose catchment area covers parts of London where construction work is particularly intensive has denied researchers access to transcripts from inquests, depriving them of data on a quarter of the accidents they have been investigating.
- Researchers' status as "properly interested persons" may change according to what use coroners believe they will put their findings. Having granted a researcher access to the transcript of an inquest into a death occurring during the construction of the Channel Tunnel, the coroner reversed the decision after he read a press report quoting critical comments made by the researcher about safety standards on the tunnel project. The researcher was asked to confirm whether the quote was accurate and was told that he would not be permitted to see the transcript if it was.
- Between May 1988 and February 1989 five teenagers aged between 17 and 19 committed suicide in the remand wing of Leeds prison and 22 teenagers attempted suicide. Ignoring calls for a public inquiry, the government set up an internal investigation, which was held in private. Although some of the report's recommendations have been made public, the report itself remains secret. The Howard Reform League, the penal reform group, therefore set up its own inquiry headed by a QC. The Home Office refused to meet the inquiry team, which was denied access to the prison. The Leeds coroner refused access to transcripts of the five inquests, although they had been held in public. The team was told that its members were not properly interested persons.

Maurice Frankel, the campaign's director, said that many coroners went out of their way to help serious inquirers. But "some exercise their discretion in an obstructive manner. These coroners are not arguing that they are protecting the privacy of families, or that records are difficult to locate. They are saying that they do not accept that journalists, and even officially funded safety researchers, have a legitimate interest. The fact that the same researchers are allowed access by other coroners underlines the arbitrary nature of these decisions."

Dr John Burton, secretary of the Coroners' Society, said that coroners were extremely angry about the report, considering the amount of work they already do on behalf of researchers. "Most people would regard a nearly 90% response rate [for the London Underground and child accident studies] as good," he said. "It would be absolutely tragic if useful information was not made available, but the amount of work some of these inquiries entail is enormous. Unless studies are properly constructed you may not get answers to the questions you are asking anyway. Prospective studies are much more likely to answer the questions that interest you. In retrospective studies the data of particular interest may not have been collected."—TONY DELAMOTHE

Australian deep sleep report awakens anger

The release of the report of the Royal Commission into Deep Sleep Therapy just before Christmas marked almost the end of a medical scandal in New South Wales that has festered for about 27 years. It is only almost the end because there are still many families of dead victims and seriously injured former patients of Chelmsford Private Hospital in Sydney who are seeking substantial compensation from the state government.

The story goes back to the early 1960s when psychiatrist Dr Harry Bailey began admitting people to this small private hospital for barbiturate induced periods of unconsciousness—deep sleep therapy. The patients, who had been diagnosed as schizophrenic or addicted to drugs and alcohol, were usually treated without proper consent and often given electroconvulsive therapy at the same time. They had inadequate nursing care and medical supervision and suffered complications such as bronchopneumonia, deep venous thrombosis, and bed sores. Some underwent psychosurgery, of which Bailey

was a leading proponent. He believed that one indication for cerebral surgery was homosexuality. Bailey was later assisted by Drs John Herron and Ian Gardiner and the hospital manager, Dr John Gill, who was a shareholder in Chelmsford.

From 1963 until deep sleep therapy ceased in 1979, under the eyes of the profession, health inspectors, and increasingly aggressive media coverage at least 24 people died as a result of the treatment, one of the charge sisters committed suicide with some of her patients' barbiturates, and Dr Bailey showed signs of delusional behaviour such as referring to himself as a Martian. Bailey also had sexual relations with his patients, one of whom committed suicide, leaving her estate to him. Soon after this Bailey had himself admitted for deep sleep therapy. Harry Bailey committed suicide in 1985.

The royal commission took two years and $12m to report. The commissioner, Justice J P Slattery, was highly critical of the state's health department (then called the NSW Health Commission) for inactivity when it knew what was going on. Justice Slattery referred material concerning the former chairman of the health commission, Dr Roderick McEwin, to the director of public prosecutions for possibly giving false testimony to the royal commission. The commissioner reported that Dr Bailey had falsified death certificates and had lied to coronial inquests going back as far as 1967. Justice Slattery also referred material on Herron, Gill, Gardiner, and a former matron to the director of public prosecutions on a range of matters including deaths and injuries to patients, altering and falsifying information, and charging for services not provided.

Even before the royal commission, the state government took a good deal of remedial action, particularly concerning the fact that few people in authority had listened or done anything during more than two decades. In New South Wales it is now very hard for serious complaints to go unheard. The revamped department of health has a health complaints unit to which members of the public can go directly; it can institute its own investigations leading to prosecution if necessary. The commissioner recommended that the complaints unit become more independent and that the courts should have a role in complaints about mental health services. Private hospitals are supposedly now inspected much more closely and the state's current minister for health has taken a strong position concerning controversial treatments in psychiatry—which, by the way, has created problems for the local College of Psychiatrists, which does not want to see psychosurgery totally banned, for instance. Since the report was released former patients have been arguing that the state government is obliged to compensate them for their suffering. The premier, Mr Greiner, while refusing ex-gratia payments has asked his officials to investigate whether there are any other avenues for Chelmsford victims and their families. It is also expected that there will now be several civil actions against the people named in the report.—NORMAN SWAN

Patients and *x* rays

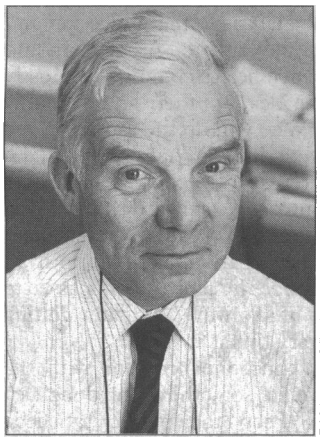
Hospitals were criticised last week in a survey published by the Consumers' Association for often failing to minimise patients' exposure to *x* rays.

Based on a sample of 502 adults who had been given *x* ray examinations during the previous year in a hospital, the survey found that nearly three in 10 of the women of childbearing age had not been asked whether they might be pregnant before an abdominal or pelvic *x* ray examination had been performed. The men had not had their testes shielded on just over 40% of occasions, and 52% of all those questioned said that nobody had asked them whether a film of the same part of their body had previously been taken, to reduce their unnecessary exposure to more radiation.

The survey follows close on the heels of a joint report published last September by the Royal College of Radiologists and the National Radiological Protection Board, which stated that unnecessary radiation from *x* rays might be responsible for between 100 and 250 of the 160 000 deaths from cancer in Britain every year. It also estimated that people might be getting up to twice as much radiation from *x* rays as was necessary.

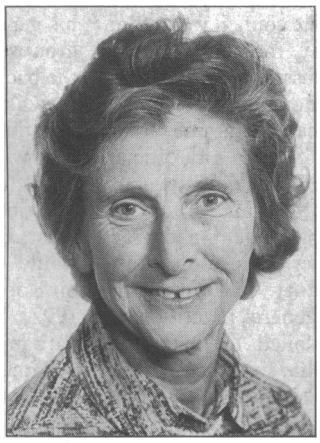
Dr Oscar Craig, president of the Royal College of Radiologists, said that while he was concerned about the amount of radiation patients received, the Consumers' Association survey had to be interpreted with caution. The findings, he said, were not

Medical new year honours

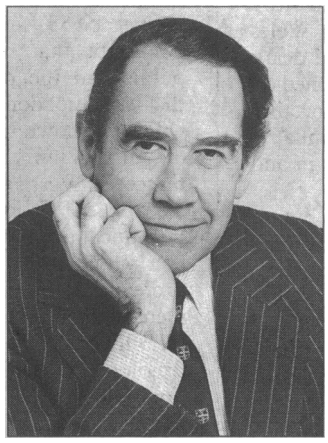


Dr Stephen Lock

BMA NEWS REVIEW

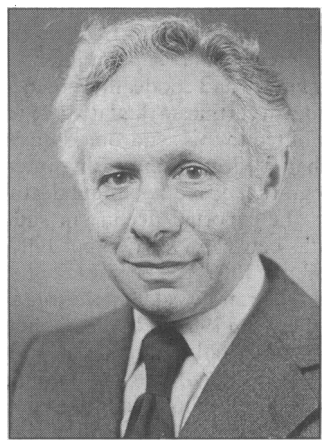


Dame Margaret Turner-Warwick



Sir Terence English

UNIVERSAL PICTORIAL



Sir Anthony Epstein

The editor of the *BMJ* and the presidents of two medical royal colleges were among those who received awards in the new year honours announced last week. Dr Stephen Lock, who has been editor of the *BMJ* since 1975, receives a CBE, four months before his retirement in April. Professor Margaret Turner-Warwick, president of the Royal College of Physicians of London and the first woman to hold the presidency in the college's 472 year history, becomes a DBE. The president of the Royal College of Surgeons of England, Mr Terence English, former director of the Papworth Heart Transplant Research Centre, becomes a KBE. Professor Anthony Epstein, emeritus professor of pathology at Bristol University, foreign secretary of the Royal Society, and discoverer of the Epstein-Barr virus, also receives a knighthood.

Some will see in the timing of these awards to the presidents subtle signs of the government's softer attitude towards the medical profession. Dame Margaret and Sir Terence have both been honoured within two years of taking office—the traditional length of time for royal college presidents. Two of their immediate predecessors who very publicly criticised the government's handling of the NHS—Sir George Pinker, past president of the Royal College of Obstetricians and Gynaecologists, and Sir Ian Todd, past president of the Royal College of Surgeons—had to wait almost three years for their knighthoods.

The full list of medical honours is published on p 119.

applicable to all *x* ray departments. Those women who were concerned that pregnancy had not been excluded, for example, may not have been aware that the possibility had already been ruled out and had been indicated on their *x* ray request form. In other cases correct coning of the *x* ray beam might have meant that gonadal shielding was unnecessary. Dr Craig conceded that old machines exposed patients to higher doses of radiation and careful shielding would be needed in those instances. "Caution," he said, "is needed at all times, to make sure that patients are only *x* rayed where necessary—and this," he added, "relies on clinical judgment."

Meanwhile, the Consumers' Association is advising patients to tell their doctors about previous *x* ray examinations and to question the need for pre-employment chest *x* ray examinations and the need for a mammogram in women under 50 unless there is a family history of breast cancer. Patients should also indicate if they might be pregnant, and ask for gonadal shielding.—ALISON WALKER

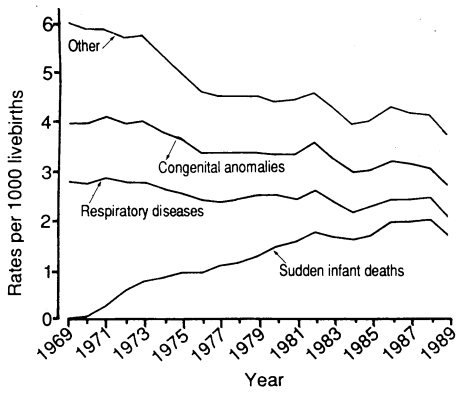
Sudden infant death syndrome—a false dawn?

In the latest *Office of Population Censuses and Surveys Monitor* much of the fall in the infant mortality rate between 1988 and 1989 is attributed to a decrease in postneonatal mortality (deaths between 28 days and 1 year), in particular to a striking fall from 1593 to 1326 (16%) in sudden infant deaths.

In 1971 the OPCS started to identify deaths registered in England and Wales where terms like "sudden unexpected death in infancy" and cot death were mentioned on the death certificate; and up to 1982 mortality attributed to this syndrome rose continually, perhaps reflecting increasing interest in and recognition of sudden infant deaths.

Is the reported decline in sudden infant deaths between 1988 (2·3 per 1000) and 1989 (1·93 per 1000) the beginning of a long term trend? Certainly, a fall in the infant mortality rate between 1987 and 1988 was not paralleled by a similar fall in the rate for sudden infant deaths. The fall in sudden infant deaths among boys, who accounted for 62% of the deaths in 1988-9, was bigger than the fall among girls, which remains broadly constant.

Cumulative postneonatal deaths by selected causes, England and Wales, 1969-1989



The OPCS cautions that there were other, more specific, causes of death in at least 8% of the 2767 postneonatal deaths in 1988-9 that mentioned sudden infant death on the death certificate, with 23% of postneonatal deaths in 1988-9 with a respiratory condition as the underlying cause mentioning it on the death certificate.

Professor Tony Milner, department of paediatrics, St Thomas's Hospital, London, warned that unless the downward trend was confirmed in later years the fall should be regarded as a statistical blip.—JANE DAWSON

This week's contributors

Linda Beecham is an assistant editor of the *BMJ*

Majors Duncan Chambers, Stephen Milner, John Bennett, and **John Stone** are members of the Royal Army Medical Corps

Jane Dawson is technical editor of the *British Heart Journal*

Tony Delamothe is a senior assistant editor of the *BMJ*

Fiona Godlee and **Alison Walker** are editorial registrars with the *BMJ*

Peter Pockley is a science writer in Sydney

Norman Swan is a medical journalist and broadcaster in Sydney

The Week

Ever since the General Medical Council began in 1859 the president has had the difficult task of simultaneously satisfying the public and the profession. Thomas Wakley, the first editor of the *Lancet*, proposed early in the nineteenth century that doctors be regulated not by themselves but by a team of lay inspectors. And there are several people making similar proposals today. Sir Robert Kilpatrick, currently president of the council, told me at lunch last week that he sees it as his job to make sure that the public is satisfied by the council so that such proposals make no headway. It's not easy.

Public dissatisfaction focuses particularly on cases where the council seems to fail to respond adequately to doctors who consistently perform badly. Three such cases were highlighted in a television programme shown last autumn (15 September, p 558), and the council was left in no doubt that many members of the public and the profession were shaken that it had not done enough in these cases. One case shown in the programme—that of Alfie Winn, the 8 year old official mascot of West Ham Football Club—has led the MP Nigel Spearing to try to introduce through parliament a charge that would be an alternative to "serious professional misconduct." Alfie died of meningitis after his general practitioner, Dr Oliver Archer, failed to make the diagnosis and told Alfie's mother: "If he cannot be bothered to open his bloody mouth I shall not bloody well look in."

Sir Robert became president of the council when a working party on discipline was having great difficulty knowing what to do about cases where doctors had clearly behaved badly but had not been guilty of serious professional misconduct. The difficulty arises, Sir Robert believes, because serious professional misconduct has to be proved over one or more specific events, and because the penalty of erasure is so severe the case has to be conducted in a legalistic and adversarial manner. Poor performance, in contrast, is likely to be long term and is best investigated in an inquisitorial rather than adversarial manner. This is how the council deals with sick doctors, and Sir Robert is now proposing similar machinery for dealing with doctors who perform poorly. In response to a complaint or referral the doctor would be investigated, and if he or she was judged to be performing badly then some retraining would be prescribed.

The council has opted for the broader term performance rather than competence. Sir Robert gives as an example the real case of a surgeon who refused ever to see relatives. He was not incompetent, and the professional conduct committee would be unlikely to find him guilty of serious professional misconduct over any particular episode. But clearly, says Sir Robert, this was unacceptable professional behaviour, and something needed to be done.

Sir Robert has now embarked on selling his general analysis to the profession and groups like the Patients' Association and the back bench health committee. Mostly they like the idea, but there are inevitably questions: Who will do the assessing and how will it be done? What will happen if a doctor refuses to cooperate? These questions must be answered, and a bill must be drafted because the changes would require parliamentary approval. Sir Robert hopes he can get a bill passed in 1992, but it's always difficult getting parliamentary time.

Time is thus one problem with the proposals: can something be done fast enough to keep the public satisfied? Breadth of coverage is another potential problem: once the machinery is operating will it deal adequately with the range of issues that bother the public? The final crunch may well be resources. Such machinery is likely to be expensive, and the question is whether the profession will be willing to pay for it. Already the retention fee has been more than doubled this year, and substantially larger increases may be necessary. It was the doubling of the retention fee in 1972 that led to thousands of doctors refusing to pay. Can Sir Robert persuade doctors to pay for self regulation?

HART