programmes. Avoiding risky activities should be encouraged, but if homosexual activity is going to occur then safer sexual practices should be encouraged. Trained people from the community should be asked to help in such programmes.

Issuing condoms to prisoners is controversial but may in the short term be the only helpful means of reducing the risk of the sexual transmission of HIV. The virus does not pass through the intact membrane of latex condoms, and their use provides substantial but not complete protection against infection (R Detels *et al*, fourth international symposium on AIDS, Stockholm, 1988).

In Britain a homosexual act in private is not an offence provided that both parties have consented and are 21 or older. The act is not considered as private if more than two persons are present, and a prison cell is not regarded as a place of privacy. Issuing condoms is thus seen by some as condoning an illegal activity, but their anxiety must be balanced against the possible benefits of distributing condoms. For example, are all prisoners to be issued with condoms? If not from whom does the prisoner obtain them and how may confidentiality be maintained?

The only alternative to issuing condoms is, however, the enforced isolation and close supervision of prisoners during social intermingling. Minimising the work of HIV transmission among prisoners is clearly an issue for prison authorities to address urgently.

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Palliative medicine

A new specialty

After 21 years of pioneering work by Dame Cicely Saunders the hospice movement and other specialist agencies for dealing with the dying have come of age. In November 1987 the Royal College of Physicians recognised terminal care as a new subspecialty of general internal medicine and called it palliative medicine. Subsequently the Joint Committee on Higher Medical Training has approved a training programme for senior registrars in palliative medicine.

Two decades ago there were a handful of charitable hospices requiring few doctors and no consultants. In 1988 there are 93 independently managed hospices with 2349 beds and 31 units managed by the NHS with 476 beds. Six more units are planned to open in the next 12 months. In addition, there are 231 domiciliary teams that bring the skills of palliative medicine into the community and 21 teams providing similar services within hospitals. Unfortunately, financial expedience may render the word "team" a misnomer: sometimes it is only one or two nurses without medical, ancillary, or secretarial support. The initiatives of the royal college should eventually enable nurses to obtain the medical support they need and to form the interdisciplinary team that is essential for effective hospice medicine.[1]

These developments have been accompanied by two other initiatives. First, the Department of Health and Social Security asked all health authorities in February 1987 to review their services for patients who are terminally ill.[2] Many responded by forming a terminal care planning team to identify gaps in existing services, propose suitable remedies, and plan developments. Already this has led to a demand for more doctors trained in palliative medicine.

The second initiative was the formation of the Association of Palliative Care and Hospice Doctors of Great Britain and Ireland. After fewer than three years the association has 205 members, including 66 full time consultants or medical directors and 22 junior members in various training posts. Most of the remainder are radiotherapists, medical oncologists, physicians, surgeons, anaesthetists, and general practitioners working in or collaborating with specialist terminal care services. Eleven members are in full or part time academic posts in palliative medicine, nine of which are funded by Cancer Relief for up to five years. In addition to holding regular scientific meetings the association has subcommittees on education, training and manpower, and ethics and research. There is an active junior members' forum. Although not part of the association, there is also the *Journal of Palliative Medicine*.

The proposed training programmes will either train senior registrars for up to four years to become full time consultants in a hospice or a hospice team or provide up to one year's structured experience for those entering another specialty—for example, radiotherapy or medical oncology. For the first five years the scheme will be flexible with entrants having a broadly based medical background leading to membership of the Royal College of Physicians or other appropriate qualification, which will include membership of the Royal College of General Practitioners to ensure that senior posts remain open to family doctors.

The equivalent of four to six new consultant posts are expected each year for the next few years so any bottleneck seems unlikely in the short term even if blocked senior registrars from other disciplines pursue a career in palliative medicine. When the log jam in other cancer services is relieved by creating more consultant posts and by the proposed district cancer physicians[3] the ideal candidates for the future must be those who, after completing general professional training, wish to make palliative medicine their specialty.

Manpower planning for the NHS services will be provided by the Joint Planning Advisory Committee: no such planning mechanism yet exists for the independent hospices and teams. The hospice movement must face this challenge by controlling itself through the Association of Palliative Care and Hospice Doctors of Great Britain and Ireland and by persuading the Joint Planning Advisory Committee to include the independent services in its deliberations.

Some may argue that this emphasis on specialist training will detract from the work, training opportunities, and status of the part timer or generalist in the hospital and the

community. The opposite is almost certainly true. More full time medical directors and consultants of high calibre will coordinate district terminal care services and improve undergraduate and postgraduate education. More general practitioner and medical rotations will incorporate some palliative medicine, while registrar rotations with other specialties, particularly radiotherapy and oncology, will become inevitable. These activities will raise the status of part time palliative care physicians as they develop a full range of services and participate in education and research.

Finally, recognition brings with it responsibilities. Doctors and others working in palliative medicine must continue to plan services, strive for long term funding, and be willing to submit themselves to audit and peer review. Only thus may the new specialty speak with authority.

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An inspector calls

An NHS inspectorate will work only with better routine clinical data

In its recent evidence to the government's review of the National Health Service the National Association of Health Authorities called for a national inspectorate to ensure that all hospitals meet required standards.[1] The Bow Group, a conservative think tank, has also just published *Inspect Health*, which makes the case for an inspectorate[2] and last week the idea was boosted by the Labour party (p 000). The idea is not new. It was suggested by the Ministry of Health in 1944[3] and more recently appeared in the Department of Health and Social Security's document *Patients First*.[4] Although previous considerations have come to little, the likelihood that internal marketing will be introduced soon suggests that the idea of an inspectorate should be taken more seriously this time. And even if health authorities maintain their virtual monopoly of supplying services there is a growing demand for an increase in their accountability to the public.

An inspectorate is an expert group that is independent of those responsible for providing a service whose assessment is based on widely accepted, explicit criteria and standards. There is less agreement about whether it should be able to apply or threaten sanctions or simply be limited to offering advice. We may learn something about the effectiveness of inspectorates by looking at those that already exist both in Britain and abroad.

Since 1973 the Joint Commission on Accreditation of Hospitals in the United States has made medical audit in hospitals a precondition for reimbursement from major insurance companies and from federal and state governments. In addition, the professional review organisations require assurance that federally funded services are medically necessary, meet professionally recognised standards of quality, and are of a proper degree of care and duration. Although these inspectorates are able to identify deficiencies in care, there is little evidence that they have improved professional competence.[5]

In Britain the various environmental inspectorates responsible for such measures as fire and radiation safety and food hygiene have been effective in improving conditions. Their tasks are, however, considerably easier than those envisaged by the National Association of Health Authorities for inspecting health services. A better model is the Health Advisory Service, established in 1969 to review and advise on local NHS provision for the elderly and mentally ill, although it is not strictly an inspectorate in that its views are based on implicit professional judgments rather than on explicit criteria. Analysing the 35 reports on services for the elderly undertaken by the Health Advisory Service between 1985 (when their reports first became public) and 1987, the authors of a recent review found that "remarkably little appears to have changed since 1969" as regards inpatient services: two thirds of buildings were unsuitable and decaying; three fifths of wards and day rooms were overcrowded; three quarters of hospitals had inadequate sanitary conditions; three quarters used restraint excessively; and 90% had inadequate or inappropriate staffing.[6] Community services fared little better. Indeed, so similar were the reports on local services in various areas that the authors half in jest suggest that an all purpose report with standard recommendations could be issued to districts, thus saving the £1m a year spent visiting.

What may Mrs Thatcher learn from the experiences of the Health Advisory Service as she contemplates the National Association of Health Authorities' suggestion? One important lesson is that without explicit criteria and standards an inspectorate is unable to monitor performance and may undertake only disaster spotting. Even if inspection based on criteria and standards were established it would be largely restricted to the assessing of inputs, such as the state of buildings, and of processes, such as waiting times in outpatient departments and the length of stays of inpatients. Such restrictions are not inevitable but reflect the current range and quality of routine health service information. Until there is a dramatic improvement in clinical information (which will require more radical changes than those that will result from implementing the Körner reports) and a serious investment in the research and development of measures of outcome the role of an inspectorate will remain limited. This is not an argument against establishing an inspectorate but simply a warning that the current limitations of routinely assessing the performance of health services should be recognised if an inspectorate is not to suffer the fate of other initiatives that have become discredited.

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