

potential of extremely low frequency electromagnetic fields must be weak. It may be that as the wavelength of electromagnetic radiation lengthens and the frequency decreases the carcinogenic effect diminishes.

Further studies to evaluate the health hazards from extremely low frequency electromagnetic fields should take into account the complexities of measuring the strength of magnetic fields separately from that of electric fields. A comprehensive, relevant, and valid method for assessing exposure is needed. Standards on limiting exposure to magnetic fields have been developed in several countries, and it would be useful to make these standards uniform by basing them on sound scientific data.

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A national health research policy

Needed to shift the emphasis of research

Last week's report on the nation's health spelt out clearly how poorly Britain has done with many public health measures.¹ The report came as no surprise: it is well known that Britain has performed badly with, for example, immunisation, cervical screening, mammography, preventing coronary artery disease, and reducing inequalities in health. One key reason for the failure is probably the absence of a national policy on health and of a national policy on health research to underpin it. A recent World Health Organisation conference in Tampere, Finland, showed how Britain's lack of nationally agreed policies on health and research is causing us to be left behind many other countries in Europe.

In contrast to Britain the European regional office of the World Health Organisation does have a clear policy, and in 1985 it published 38 targets for health for all in the year 2000.² Few countries if any will achieve all these targets, but their existence gives countries the chance to plan coherently. The European office soon recognised that countries would need to conduct research to help get close to these targets: research to provide new knowledge, to measure whether progress is being made, and to work out the blocks to progress. The conference in Tampere was held to publish two documents on the sort of research that needs to be done.^{3,4} *Research Policy for Health for All* is aimed at policy makers and suggests how they might reorientate research programmes³; *Priority Research for Health for All* makes specific suggestions to researchers on the sort of work that might be done.⁴

In a nutshell the aim is to make health research programmes more relevant to ordinary people and to those such as doctors who use the results of research. WHO does not want to knock down traditional biomedical research but rather to build up public health research, research into lifestyles and health promotion, collaborative research among medical scientists, social scientists, and economists, and health services research. In most countries in Europe, including Britain, medical research is conducted primarily under the auspices of the ministry of education rather than the ministry of health, which is one of the factors reducing the relevance of the research. The authors of the books, which were widely circulated before being finalised, are also concerned that the consumers of the results of health research — patients, doctors,

nurses, and other health workers — are often widely separated from the researchers. This not only further reduces the relevance of the research but also delays the implementation of the results.

This diagnosis of the ills of medical research is close to that reached by the House of Lords Select Committee on Science and Technology in its report on priorities in medical research,⁵ and the clerk of the committee, Douglas Slater, was in Tampere to talk about the committee's findings. The committee did not mention WHO's proposals in its report (although it had seen them) but advocated a National Health Service Research Authority to make sure that some of the problems it identified were tackled. The government has not yet responded to the report, but the idea of the special health authority seems to be a dead duck.⁶ Perhaps what is needed instead is a national health research policy.

As WHO emphasises, such a policy would have to be developed by all those who would be concerned — researchers, the bodies that fund research, health workers, and health authorities. Ideally, it would grow out of a national health policy, which should itself be based on the targets of health for all in the year 2000. Britain has associated itself with these targets,⁷ and number 32 calls for the setting up of a research policy. WHO suggests that the policy should establish goals, identify priorities, neglected subjects of research, and manpower and training needs, allocate resources according to priorities, and encourage the uptake of research findings. Experience from Japan suggests that the very process of drawing up such a policy would stimulate research.^{8,9}

British doctors reading this might think that it is all "typical WHO gobbledegook and fantasy," but the conference heard how Finland, The Netherlands, Spain, Hungary, Ireland, and Yugoslavia have already been through many of these steps. The Dutch research policy has just been published in English (p 816),¹⁰ and Dr Kimmo Leppo from the National Board of Health in Finland told the conference how Finland developed a research policy in the 1970s that made many of the shifts subsequently recommended by WHO. The extraordinarily high standard of epidemiology and public health research in Finland is one practical result as may be its infant mortality, which is the lowest in the world. Britain has also set

a high standard in traditional epidemiology but has done poorly at translating the results into practice.

There are more obstacles to establishing such a policy in Britain than the natural reluctance of the British to think in abstractions. Firstly, the targets of the health for all programme are not well known and the government is doing little to encourage their dissemination. This is not surprising when the first target is to reduce inequalities in health by a quarter: in Britain we are going in the opposite direction.¹¹ Secondly, as several speakers at the conference emphasised, shifts in the pattern of health research are hard to achieve without extra money. If funds are going to have to be taken away from biomedical research to fund public health research then the research establishment—the Medical Research Council—is going to sabotage the plans. Thirdly, governments everywhere—and certainly the British government—are unenthusiastic about health services research because it illustrates their failures. They much prefer scientists to mess around with rat mitochondria.

Finally, a national research policy might be especially difficult to achieve in Britain because medical research is

effectively being “privatised”: industry and the charities are funding more research than the government.¹²⁻¹⁴ But, although this diversity may make the task of developing a policy more difficult, it also makes a policy more essential.

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Disciplining midwives

A better system is needed

Much publicity has recently been given to the United Kingdom Central Council (UKCC) for Nursing, Midwifery, and Health Visiting removing Jilly Rosser, an independent midwife, from the register (p 811).¹ Other cases have also been receiving press attention, but during the past three years the council has removed from the register 10 midwives, only the last of whom was in independent practice. In the case of Ms Rosser the press has tended to favour her over the council, and some biased reports have caused disquiet among other midwives. There is now a danger that public confidence in midwives will be shaken by accusation and counteraccusation. To reassure the public the relation of the UKCC to midwifery should be reviewed.

Midwifery in England used to be regulated by the Central Midwives Board, which in 1969 included only six midwives among its 17 members.² Most of the others were doctors. In 1983 the board was abolished, and control of midwifery passed to the UKCC and four national boards (English, Irish, Scottish, and Welsh) for nursing, midwifery, and health visiting. The national boards supervise education, and each has 45 members, 30 of whom are elected by the nursing professions. The UKCC is concerned with discipline and also has 45 members, seven from each national board and 17 appointed by the Secretary of State for Health. At present these appointees, who help to oversee 500 000 nurses and 30 000 practising midwives, include only three doctors, one of whom happens to be an obstetrician.

The UKCC differs in several ways from the General Medical Council, which is responsible for disciplining doctors. By law the General Medical Council must include lay people, but no such requirement applies to the UKCC. The General Medical Council is not ordinarily concerned with errors in diagnosis or treatment,³ but the UKCC concerns itself with clinical matters. Midwives are required to abide by the “midwives rules” which the UKCC inherited from the Central Midwives Board and subsequently modified,⁴ and

midwives are also guided by the UKCC's codes of practice and of professional conduct. These documents lay down detailed guidelines, and departure from them may result in a formal complaint against a midwife.

Such complaints come from three main sources—patients, colleagues, and professional midwifery managers. Most come from managers. A complaint to the UKCC is referred to the investigating committee of the appropriate national board, which reviews documentary evidence. If this committee decides there may be a case to answer the midwife appears before the professional conduct committee of the UKCC, which has the power to remove her name from the register. The committee, which has jurisdiction over nurses and health visitors as well as midwives, usually consists of five council members, who must be “selected with due regard to the professional field” under discussion. This means that a midwife is judged by midwives, some of whom are in practice, and probably by an obstetrician if the council happens to include one. A midwife disbarred from practice has the right of appeal to the high court or the court of session.

The first step in reviewing the relation of the UKCC to midwifery should be to appoint lay members to the council. The General Medical Council has several lay members (and the Central Midwives Board had one), and it is surprising that the UKCC does not include this safeguard against accusations that the nursing professions are monolithic. Although the UKCC professional conduct committee's proceedings are public (and are often held outside London), and although community health councils are invited to observe them, the public has no official voice on the council. The UKCC should also include more obstetricians. In disciplining midwives the most delicate questions relate to decisions about summoning medical aid, and obstetric opinions would help the council. Although midwives do not want to return to when their profession was supervised by doctors, the UKCC should not reject the help of obstetricians.