

tually pharmacological blockade of dyskinesias may prove possible. Dopamine agonists are unlikely to be useful in most conditions associated with levodopa failure.

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- ¹¹ Cotzias, G C, et al, *New England Journal of Medicine*, 1970, **282**, 31.
- ¹² Cotzias, G C, et al, *New England Journal of Medicine*, 1976, **294**, 567.
- ¹³ Calne, D B, et al, *British Medical Journal*, 1974, **4**, 442.
- ¹⁴ Lieberman, A, et al, *Neurology (Minneapolis)*, 1975, **25**, 459.
- ¹⁵ Del Pozo, E, et al, *Journal of Clinical Endocrinology and Metabolism*, 1972, **35**, 768.
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Hasty, ill-considered legislation

The Health Services Bill¹ is now a reality. Though less extreme than Mrs Castle's consultative document²—Lord Goodman's modifications³ are clearly apparent—it is nevertheless unwelcome to doctors. It would have been politically naive, however, to expect the Government's attack on independent practice to have withered away because of a new Labour Prime Minister and the departure of Mrs Castle. What is disappointing is her successor's failure to defer Parliamentary consideration of the Bill to allow sufficient time for real consultation with the health authorities and professions on which 1000 pay-beds would be closed.⁴ At least Mr Ennals could have modified the quite unrealistic six-month deadline that the legislation will impose on the Health Services Board for the removal of the first 1000 beds and for its countrywide assessment of privately used outpatient accommodation in NHS hospitals. Prompt legislation may well be part of an off-stage bargain with trade unions or perhaps the Government scents an early election. And, of course, the ex-Secretary of State will be no silent backbencher. But whatever the reasons the NHS will suffer from this hasty, ill-considered legislation.

The BMA's policy is unchanged. At the ARM last year representatives resolved: "This Representative Body (a) believes that the public has a fundamental right to opt for private medical care; (b) deplores and will resist by all means the closure of private facilities in NHS hospitals; and (c) will

not accept any attempt to limit the development of private medicine outside the National Health Service." The Council and its standing committees have kept to this line, and have been energetic in deploying sanctions, publicity, and their lobbying skills according to the circumstances.

The General Medical Services Committee was the first major committee to meet after the Bill had been published. It looked askance at Clause 9, which at first sight seems unduly restrictive on the use of health centres for private practice, and it will be seeking to have this clause amended. The Central Committee for Hospital Medical Services met last week, when opposition to the Government's plans was as determined as ever. But faced with the Bill CCHMS members decided it was sensible to obtain as many amendments to it as possible. Mr Ennals has, apparently, been conciliatory about possible changes in how the legislation will operate—provided the Bill's principles stand—and the Opposition parties have been listening carefully to the BMA's views. As the delayed committee stage starts an already long list of amendments should ensure that the Bill will be fully debated and, possibly, some of its more objectionable clauses modified. The success of one amendment—total rejection of Part III (the section of the Bill containing the licensing requirements for private medicine outside the NHS)—would be a particularly notable achievement. Common waiting lists based on "medical priority alone" is another impractical proposal that deserves defeat.

Meanwhile advertisements appear and planning consents are sought for the expected expansion of the private sector outside the NHS. The unhappy coincidence of the Health Services Bill—which in its effect is a unilateral abrogation by the Government of part-time consultants' contracts—with an incomes policy which, as our correspondence columns have recently shown, has hit young consultants especially hard has thoroughly demoralised senior hospital doctors. How many part-time consultants will be able or willing to adjust their professional activities to suit changed local conditions of private practice? While a mass flight to the private sector is an unrealistic consequence, more than a handful of specialists in acute specialties may do so in certain areas. Some more are bound to emigrate; the remainder will cause no surprise if they withdraw their good will. This would have a far more catastrophic effect on the Service than local or international migration and could well be the equivalent of losing hundreds of consultants. Then there will be the destruction of the principle of geographical whole-time consultants—another sacrifice in manpower that the NHS can ill afford. Finally, there is the uncertain professional future that will face young hospital doctors, with many of them as bitterly critical of the Health Services Bill as are their seniors.⁵

Would that proverbial passenger on the Clapham omnibus discern any benefits for a beleaguered NHS of this restrictive legislation affecting barely 2% of medical care? Certainly few doctors can do so.

¹ *Health Services Bill*. London, HMSO, 1976.

² *British Medical Journal*, 1975, **3**, 497.

³ *British Medical Journal*, 1975, **4**, 771.

⁴ *British Medical Journal*, 1976, **1**, 670.

⁵ *British Medical Journal*, 1976, **1**, 603.