Safer food

At one of several conferences held to mark Food and Farming Year Professor Bevan Moseley gave an optimistic but qualified answer to the question "Are we ever going to be able to assure a microbiologically safe supply of food?" As head of the Agricultural and Food Research Council's Institute of Food Research at Reading, Professor Moseley is well placed to say whether the uncontrollable growth in reported cases of food poisoning—40 000 in 1988 compared with 30 000 in 1987 and 22 500 in 1986—can be curbed. Professor Moseley is pinning his hopes on computers, nucleic acid probes, monoclonal antibodies, flow cytometry, irradiation, and competitive inhibition. Current techniques, which can detect the cause of an outbreak only after it has happened, were "almost an art form based on Pasteur and Koch," he said. It takes five days to identify *Salmonella enteritidis* in food and nine to identify *Listeria monocytogenes*—too late to be any use in preventing an outbreak.

In the past 20 years agriculture has become more intensive and we have been eating more and more food cooked outside the home—such as fast foods and cook-chill meals—bought from one of the 300 000 outlets that prepare and sell food. The changes in food processing have lengthened the cast list of micro-organisms that can cause important outbreaks of food poisoning. Recently, salmonella and listeria have had star billing, but according to Professor Moseley several pushy ingénues are waiting in the wings. They include *Aeromonas* spp, *Klebsiella pneumoniae*, and other Gram negative bacteria.

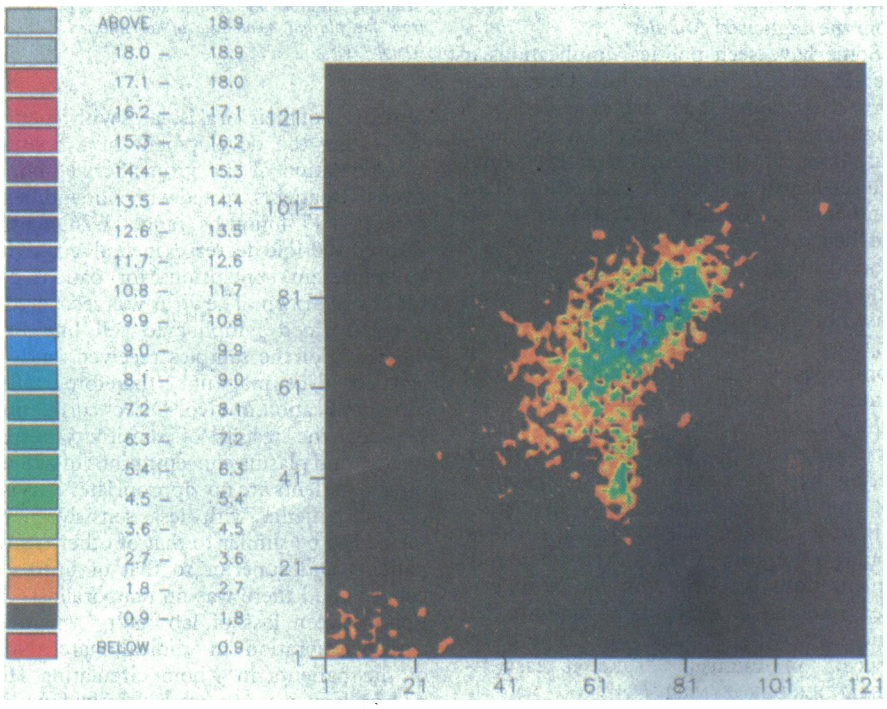
In future we may be in a better position to forecast potential troublemakers with a national database that is being set up by the council's Institute of Food Research at Bristol. Staff there hope that computer modelling, using published data and information from food manufacturers, will predict the impact of proposed changes in processing and in storage variables—such as temperature, pH, water content, and preservatives—on the growth of food organisms and the safety of the product. The correlation was good when a mathematical model was tested against growth of salmonellas in simulated meat products at different combinations of storage temperatures and salt content.

The growing consumer preference for fewer preservatives means that "gentler" combinations of chemicals and temperatures will have to be used to prevent spoilage and ensure safety. The council's computer modelling facilities and database will help food manufacturers to strike this balance without checking each food product retrospectively.

Progress is being made in other areas of the "forward surveillance" of foods—that is, detecting food pathogens before the product leaves the production line. Techniques used in molecular biology (including DNA and RNA probes, amplification of nucleic acids, and monoclonal antibodies) can greatly speed up and refine the detection of micro-organisms. Already there is a monoclonal antibody assay for *S enteritidis* that cuts the test time to 18 hours. But this is still too slow for on line use in a factory.

Fortunately, it looks as if flow cytometry, which has been around for nearly 20 years and has had a great impact on research in cellular immunology, will be sufficiently speedy for industrial application. The research cytometer at the council's Institute of Food Research at Norwich can examine a sample for bacteria in minutes (see figure). When it is tailored to a specific production line it should give a result in seconds.

There is no research programme on food irradiation at the Institute of Food Research because "most of the important parameters have been established." Professor Moseley, who thinks that food irradiation does have a "limited role," forecasts that it will be legalised within the year—to the chagrin of 85% of consumers who have said that they would not eat irradiated food. They are more likely to be in sympathy with techniques



Flow cytometry identifies and counts biological cells. Each cell is analysed individually at high speed (up to 5000 cells a second) as it passes through a laser beam; measurements are based on light scatter and emissions by cells stained with DNA specific fluorescent dyes or fluorescent monoclonal antibodies. Signals fed to a computer for analysis can give information on a battery of variables, including size, shape, and DNA content.

This figure is a colour contoured analysis of the density of various particles in a culture of *Pseudomonas fluorescens* stained with the fluorescent dye ethidium bromide. The intensity of laser light scattered in the forward direction is plotted along the x axis, and the y axis represents the intensity of fluorescent light emission; both axes are logarithmic and span a range of 1-1000. Forward scatter is a measure of particle size (volume) and fluorescence is a measure of DNA content. Three distinct regions are visible. The large oval in the centre of the figure corresponds to the bacterial cells. The smaller region below this is a population of fluorescent latex microspheres 0·95 μm in diameter, which were added for calibration. Both regions are distinct from the region in the bottom left, which corresponds to non-specific particles and fragments less than 0·2 μm in diameter. Figure reproduced courtesy of Dr Andrew Pinder, Agricultural and Food Research Council Institute of Food Research at Norwich.

based on competitive inhibition, which are already familiar in yoghurt and other foods preserved by lactic acid bacteria. Unfortunately, research into a method of competitive exclusion, developed at Bristol, to protect chicks from acquiring salmonella by feeding them at a day old with bacteria cultured from the guts of healthy adult birds may have to stop because the government has withdrawn funding—in line with its policy of encouraging industry to pay for research with a commercial application.

But if the institute is adequately funded food producers and consumers can expect the flow of fresh ideas to continue from the 400 researchers working at Reading, Bristol, and Norwich. We need not be reduced to eating canned food and drinking ultra heat treated milk.—JANE DAWSON

Goodbye, Pasteur

A commotion has erupted in France about the loss of another battle in a war started some 30 years ago by General de Gaulle: the defence of the French language. The highly symbolic bastion that has fallen to the advancing Anglo-Saxon troops is the *Annales de l'Institut Pasteur*, first published a century ago to report on the scientific work of the Pasteur Institute. The *Annales* will now be published in English under the titles of *Research in Virology*, *Research in Immunology*, and *Research in Microbiology*. Pasteur's portrait will appear on the covers, and a subtitle will indicate that they were "Established in 1887 as the *Annales de l'Institut Pasteur*."

"It's not only scandalous but absurd," declared Alain Decaux, historian and ministerial delegate for the defence of the French language. For the French Academy, founded in 1635 and responsible for the establishment of the official dictionary, it was "an insult to our language and to the memory of Louis Pasteur.... The worst enemies of the French language are now inside France." Microbiologist Arnold Drapeau, professor at the Polytechnic School in Montreal, termed it "An abdication with disastrous consequences." Others called it "high treason" and "a stab in the back." President François Mitterand was reported as being concerned. The influential daily *Le Monde* ran a lengthy article entitled (in English) "Goodbye, Pasteur," and Hubert Curien, Minister of Research, asked for an appointment to have the decision reversed.

The unexpected uproar created by the announcement of the change, irate letters, phone calls, and official protests clearly took the Pasteur Institute's director, Maxime Schwartz, by surprise. "If I had foreseen that this affair would trigger such an emotion and that the very image of the house [the institute] would be questioned, I would have referred the matter to the administrative council. But I couldn't imagine it."

Professor Schwartz met last week with Messrs Curien and Decaux but maintained his decision. It was, he said, unavoidable and perhaps the only way to save the publications, whose readership started slipping in the 1960s when the English language moved to the forefront of scientific communications and new journals were created in "Anglo-Saxon" countries.

In 1973 the *Annales* started accepting articles in English, but this did not help: the readership plummeted despite efforts to modify the editorial policy and to increase the number of non-French referees. When asked how many subscribe to the *Annales* Schwartz answered: "It's a somewhat ridiculous level, about 1000 for each one of the three journals," adding (probably with the virulent protests voiced by Canadian francophiles in mind), "only 30-35 subscriptions in Canada, of which only eight are in Quebec."

Professor Schwartz pointed out that, increasingly, articles sent to the *Annales* have been written in English. "They represented about 10% [of the total] 15 years ago, but came close to 100% last year.... Our concern was not to be viewed any longer as the 'Pasteur Institute Journal.'"

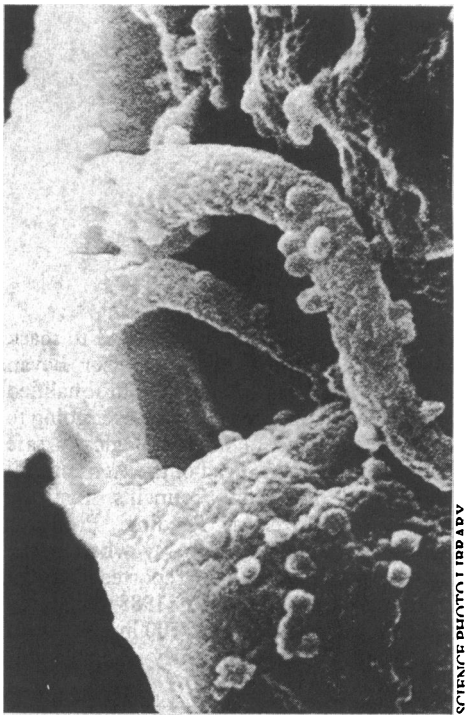
Professor Schwartz, however, has announced that the institute will launch another publication in French, called *Annales de l'Institut Pasteur: notes, débats et résumés*, which will carry translations of scientific debates and summaries of articles from the anglicised *Annales*.

Some have seen political implications in the decision *L'Humanité*, the Communist Party daily, stated that "the pre-eminence of English as a scientific language strengthens a real American domination over everything that accompanies scientific production. It is a non-negligible element of American power and hence of world capitalism. It is also a good ideological support for the Americanisation of society: if scientists lead the way, why not accept English as the universal language, the American way of life as the world model, and the multinational companies as the motor of the future?"

Le Quotidien du Médecin, a daily newspaper for doctors, took a more pragmatic stand, stating that "the problem of francophony is not simply that of the vigour of a language; it is that of a nation that would have had no trouble in imposing French everywhere if its contributions to the rest of the world had been essential in quality and quantity." It concludes with a piece of "impertinent advice," in English: "Take it easy."—ALEXANDER DOROZYNKSI, *Paris*

Zidovudine resistant HIV

The nucleoside analogue 3'-azido-3'-deoxythymidine (zidovudine, AZT) is effective against HIV in vitro and has been shown to have clinical benefit in patients with AIDS and AIDS related complex, suppressing but not eliminating replication of the virus. Recent work (*Science* 24 and 31 March) by Drs B A Larder and G Darby (Wellcome Research Laboratories, Beckenham) and Dr D D Richman (University of California) has disclosed the isolation of less sensitive strains of HIV from patients who have received zidovudine for more than six months. Most patients showed minor decreases in the sensitivity of their viral isolates with a pattern suggesting the development of a resistant subpopulation of the virus. Serial samples from five patients treated with zidovudine for a mean of 17·4 months (range 11-26 months) showed 100-fold decreases in viral sensitivity.



Scanning electron micrograph showing HIV budding from the plasma membrane of an infected T4 helper lymphocyte

At present conclusions for patient care cannot be drawn. The virus was recovered in a transformed lymphocyte cell line from only 30% of the samples received, and the isolated virus may not, therefore, reflect virus replication in vivo. Direct correlations between the results of sensitivity testing in vitro and plasma concentrations of zidovudine in patients are not appropriate. Survival of the patients with less sensitive virus seemed to be similar to that of other treated patients and superior to that of untreated cohorts, and there was no temporal association between loss of laboratory sensitivity and deterioration in clinical state. None of the patients in whom circulating HIV p24 antigen was suppressed by zidovudine showed a rise in antigen concentration with the development of less sensitive strains of virus. The number of patients studied was, however, small, and follow up, which is now in progress, is necessary to confirm this.

The five most resistant isolates were assayed for resistance to other compounds previously shown to have in vitro activity against HIV. Although they were also resistant to the closely related 3'-azido-2',3'-dideoxyuridine (AZdU), no loss of sensitivity was detected to 2',3'-dideoxycytidine (ddC), 2'-3'-dideoxy-2',3'-didehydrothymidine (D4T), and phosphonoformate (foscarnet). This is important as if clinical evidence of a reduced response to zidovudine is shown to correlate with a loss of sensitivity in vitro treating patients with other nucleoside analogues should still be possible.

Experience of resistance to other antiviral drugs is fairly limited, and attempting to

extrapolate from one virus to another may not be appropriate. Resistance to acyclovir, the highly successful treatment for herpes simplex viruses, has been rarely detected, and instances of resistance have been confined almost totally to the most severely immunocompromised patients. All the patients studied by Larder and colleagues were profoundly immunocompromised with low counts of CD4 lymphocytes throughout their treatment. No data are available as yet on isolates from patients who are symptomless or are not seriously ill. Another important finding is that virtually all isolates showing reduced sensitivity to acyclovir in vitro, due to a failure to produce a virus encoded thymidine kinase, are less virulent in vivo. It remains to be seen whether this is true for zidovudine and HIV.

Nobody should be surprised by the findings with zidovudine and HIV, particularly as resistance has been seen previously in severely immunocompromised patients treated with acyclovir and ganciclovir. Perhaps the high mutation rate occurring in the virus renders it more able to overcome the effects of drugs used in isolation. As the development of resistance to other antimicrobial drugs has been prevented or appreciably delayed by using additive or synergistic combinations these findings will increase the need to find agents active against different targets in HIV replication and to carry out clinical trials of combination treatments.

At present, in the absence of any evidence of clinical implications of these laboratory findings it would be inappropriate to alter the treatment protocols of patients receiving the only drug licensed for treating AIDS and severe AIDS related complex, which gives clinical benefit and prolongs survival.—D J JEFFRIES, *reader in clinical virology, St Mary's Hospital Medical School, London*

What is a cigarette ad?

European tobacco companies are finding ingenious ways round recent changes in the law governing cigarette advertisements. In Belgium Camel cigarettes used to be advertised by a poster showing a man lighting up a cigarette against a background of rugged splendour. When the law there changed and advertisements for cigarettes were allowed to show only the pack itself the same picture was converted into an advertisement for Camel matches. This is an example of what is known as "indirect advertising" as it advertises cigarettes by association, without technically doing so or breeching any rules. The deliberate use of tobacco logos on other products to get round restrictions is increasing, and in response the European Commission has proposed tougher measures on tobacco advertising.

Earlier this year the *BMJ* reported on the commission's draft directive (proposed law) on the labelling of tobacco products (4 February, p 278). This was the first of five measures emanating from the commission's Europe Against Cancer programme, launched in the United Kingdom personally by Mrs Thatcher. The second sets maximum tar levels and the third sets restrictions on smoking in public places (but was downgraded from a directive to a recommendation for technical legal reasons). The fourth—just adopted by the commission—will outlaw indirect advertising and will also control press and poster advertising of cigarettes.

An obvious weakness is that the directive does not cover broadcasting or sponsorship. In fact, broadcast tobacco advertising is dealt with in a separate directive on broadcasting, though its effectiveness remains to be seen. The omission of sponsorship from the directive, however, is the result of lobbying by the tobacco industry during drafting. It shows not only the power of the industry but also the difficulty of getting tough directives to prevent smoking if some member states are being obstructive, as some certainly are.

The main provisions of the advertising directive are that every advertisement for a tobacco product must carry a clearly legible health warning; the advertisements may show only the package and state the nicotine and tar yields; advertisements in youth magazines will be prohibited; indirect advertising will be banned; and tobacco products will not be advertised during sporting events. The health warnings have been specified and must include the statement "Tobacco seriously damages your health." The rules also specify the area of the advertisement that must be covered by the health warning, which are essentially in harmony with those that govern labelling.

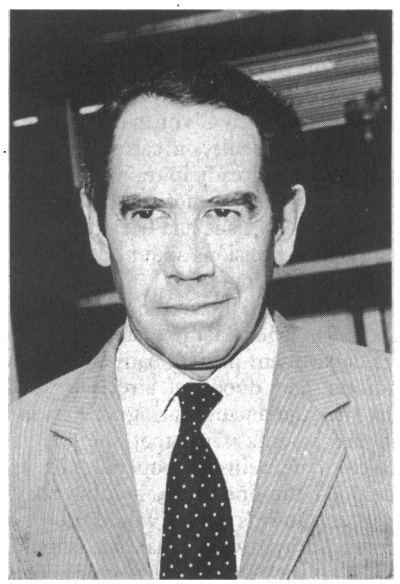
The directive is a compromise: it reflects not only the pressure already exerted by the tobacco industry but also the industry's expected struggle to prevent it becoming law. The commission has drafted a directive that it believes has a good chance of succeeding, as opposed to a tougher document which, it was warned, would have had no chance of being approved. Final approval is made more likely because these directives have been drafted under "Single Act" legislation (which will bring the single market into being in 1992), which allows them to be adopted by the Council of Ministers by a majority vote. This means that member states cannot veto the measure at the council, which is fortunate as the British government is now opposing the measures. There is still a long way to go, and there is no doubt that the tobacco industry will fight this measure every step of the way.—MARTIN RAW

Right to die

Britain's first "right to die" case, concerning a severely brain damaged baby, reached the Court of Appeal last week. The case, over the treatment of Baby C, a 4 month old girl with hydrocephalus, provoked questions to the attorney general from pro-life MPs, accusations from a right to life organisation that the official solicitor was "murdering" the baby, and offers from the Society for the Protection of the Unborn Child to pay for private treatment for the baby.

The appeal, though revolving around the wording of the original judge's order, was equally intended to allay public concern over the baby's treatment. This arose from a phrase in Mr Justice Ward's judgment, delivered in Leeds on 14 April, that the baby should be "treated to die" and his order that it should not be necessary to give antibiotics in case of infection or to give nasogastric or intravenous feeding. Early press reports had also failed to stress the medical evidence that Baby C was a hopeless case with no prospect of recovery.

The Court of Appeal deleted the paragraph dealing with the specifics of treatment, and Mr Justice Ward had already amended the controversial sentence by the time the case reached the Appeal Court. Instead of the original wording—"I direct that leave be given to the hospital authorities to treat the ward to die; to die with the greatest dignity and the least of pain, suffering, and distress"—the final judgment reads: "I direct that leave be given to the hospital authorities to treat the ward in such a way that she may end her life and die peacefully with the greatest dignity. . . ."



New president for the Royal College of Surgeons of England

Mr Terence English has been elected the next president of the Royal College of Surgeons of England. Mr English, who has been a consultant cardiothoracic surgeon at Papworth and Addenbrooke's Hospitals, Cambridge, since 1973, is well known to the general public as the director of the Papworth Heart Transplant Research Centre, a post that he has held since 1980. He will take over from the present president, Sir Ian Todd, in July.

Paediatricians need not fear that the case heralds a greater intrusion by the courts in life or death decisions over handicapped babies. This case came to court only because the local social services department had decided before Baby C's birth that her mother would have difficulty in caring for a baby, and steps were already in train to make her a ward of court before her medical condition was known. Once she had been made a ward all important decisions about her care had to be taken by the court.

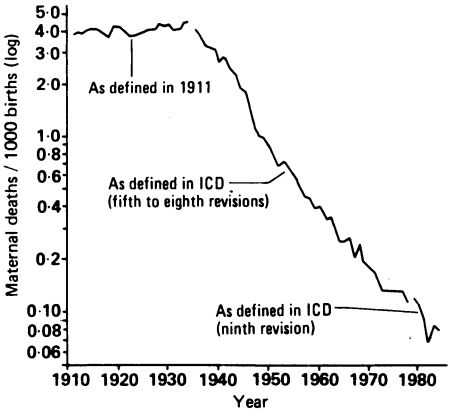
Baby C's case is the first to reach the courts since 1981, when Hammersmith social services department made a baby with Down's syndrome and duodenal atresia a ward of court after the doctors caring for her, in line with her parents' wish that she should be allowed to die, refused to operate. The court sanctioned the operation, holding that the life of a Down's child would not be so "demonstrably awful" that she should be allowed to die. In the same year a paediatrician, Dr Leonard Arthur, was acquitted of the attempted murder of a 3 day old boy with Down's syndrome, for whom he prescribed a sedative to suppress appetite and "nursing care only" in line with the parents' wishes. In Baby C's case damage to the cortex of the brain is extensive and abnormally severe. She seems to be blind and deaf and has generalised spastic cerebral palsy of both arms and both legs. A shunt operation in January proved to be no more than a palliative measure. At 16 weeks old she is the size of a 4 week old baby, apart from her head. Feeding her through a syringe is a painstaking and painful process.

The doctors caring for her sought a court ruling on her future treatment. A social worker had told them that the court would expect her to be given the same treatment as a non-handicapped child; the legal department, however, said that her treatment should be "appropriate to her condition." Lord Donaldson, Master of the Rolls, said that he had no doubt that the legal department was right.

Professor M had recommended that she should be treated to ease her pain, suffering, and distress rather than to prolong her life for a short time. Mr Justice Ward and the Court of Appeal agreed that this would be in her best interests— the test the court has to apply in making decisions affecting a ward of court. Deleting the part of the order dealing with specific treatment, the Court of Appeal held that this was inconsistent with another paragraph of the order directing that Baby C should be treated within the parameters of Professor M's report. He had not ruled out antibiotics, intravenous infusions, or nasogastric feeing but would leave it to her carers to decide what course of action would cause her least suffering.—CLARE DYER, *legal correspondent*

Maternal deaths

The Department of Health has just published its 11th confidential inquiry into maternal death. It covers the period 1982-4 and is the last to be restricted to England and Wales; future studies will encompass the whole of the United Kingdom. Authoritative and well written, the document should be read carefully by all those who are concerned with caring for pregnant women.



Source: OPCS mortality statistics

Maternal mortality plotted logarithmically, England and Wales 1911-84

Obstetrics, despite the current emphasis on "fetal medicine," has probably done more for mothers than their babies; it is worth noting that maternal mortality has decreased constantly over the past 40 years (figure) to its present rate of less than one death in 10 000 pregnancies. Before the second world war mortality had been more or less constant at 40 deaths per 10 000 since records had begun in the early days of the industrial revolution. Although considerable improvements have occurred since the days of Queen Charlotte's tragic confinement, maternal death is still one of the most devastating tragedies, and no effort should be spared in achieving further improvements in the safety of childbearing.

Britain is the only country which carries out an audit in the form of an in depth confidential inquiry into each maternal death, one of the main purposes of which is to identify avoidable factors and thereby recommend improvements in practice. Some recommendations concern specific aspects of clinical practice (for example, not eschewing group O negative blood in cases of prolonged haemorrhagic shock); others concern the organisation of obstetric services. Thus the authors of the document, led by Professor Sir Alec Turnbull, argue for establishing specialist teams with experience in dealing with severe hypertension, a point that is sure to be hotly debated in regional obstetrics and gynaecology committees.

Not only has the incidence of maternal death fallen appreciably but the proportions attributed to different causes have changed. Infections, which accounted for half of all maternal deaths at the turn of the century, were responsible for fewer than 1% of deaths during 1982-4 whereas pulmonary embolism and hypertensive disorders are, according to the inquiry, now much the commonest causes, followed by complications of anaesthesia, amniotic fluid embolism, obstetric haemorrhage, and ectopic pregnancy. Seven of the 243 maternal deaths in 1982-4 were associated with termination of pregnancy, and there were no reports of death after illegal abortion, compared with 80 such deaths in a similar period before the Abortion Act 1967. Together with the increased mortality after repeal of liberal abortion laws in Romania, these figures should dispel doubts about the link between legalised abortion and mortality in young women.

The rising rate of caesarean sections is a cause of great anxiety, but the number of associated deaths has continued to decline. The mortality rate is now less than four in 10 000. Analysis of the data according to the type of section would have been useful, but emergency caesarean sections have not been subclassified into emergency prepartum and intrapartum operations in the document. The indications for surgery, however, are given; half of all perioperative deaths were associated with operations for hypertension, haemorrhage, or medical disorders—all causes of maternal death in their own right. The attributable risk of caesarean section, especially elective sections, is now extremely low.—RICHARD J LILFORD, *professor of obstetrics and gynaecology, St James's University Hospital, Leeds*

Department of Health. *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1982-84.* (Report on health and social subjects 34.) Available from HMSO, price £8.20.

Tighter controls on transplants

"The government regards the sale of human organs for transplantation as abhorrent and unacceptable in a civilised society," said Mr Roger Freeman, parliamentary secretary for health, announcing the publication of the Human Organ Transplants Bill last week. The bill would make it a criminal offence to make or receive payment for an organ or to attempt to find a person willing to supply an organ in return for money. Advertising of such services would also be illegal.

The bill would also restrict transplants from living donors to genetically related people except under certain conditions to be decided in consultation with the profession. The details of how genetic relationships would be established have also to be decided, but DNA analysis is one of the methods being considered.

Only about 200 kidney donations were from living donors in the United Kingdom last year, and Mr Freeman does not think that the new proposals will reduce the number of organs available for transplantation. He emphasised the need to increase the use of donor cards. Health authorities are already drawing up procedures to identify potential donors and refer them to transplant units. They are also conducting audits of deaths in intensive care units to identify why some potential donors are missed.

The results of these studies will allow the government to assess whether "required request" (in which medical staff are obliged to ask the relatives of all dead patients to consider donating organs) would help to improve the supply. Asked about the possibility of adopting an "opting out" scheme (in which all people are assumed to be potential donors unless they have specifically

refused), Mr Freeman said, "That would have to have very broad public and medical support and is not on the cards at present."

The government expects all party support for the bill and hopes that it will become law before the summer recess. The clauses on payment would then come into force immediately, but those on establishing a genetic relationship and the exceptions to the ban on non-related donors would await the publication of specific recommendations.

Any member of staff who knew that the law was being broken would be liable to prosecution. Conviction under the act could carry a sentence of up to three months' imprisonment, but the consequences for the career of any doctor found to be guilty would extend far beyond that.—STELLA LOWRY

Letter from Westminster

Getting Mr Clarke off the hook

There is a whiff of compromise in the air. Down by the river swamp at Westminster the inhabitants have no desire for their quarrel with the doctors to become embittered and would welcome an accommodation, though not at any price.

The most important event of the past two weeks was a private meeting between the Tory tribal chiefs, who form the executive of the 1922 Committee, and Kenneth Clarke, Secretary of State for Health. A brief report in *The Times* said that Mr Clarke was rebuked for his handling of the dispute over the general practitioners' contract.

Doctors would be well advised not to take that at face value or to interpret it as a weakening of the government's support. The 1922 executive is not in the business of rebuking Cabinet ministers. But with MPs up to their knees in angry letters from doctors and their patients the executive felt in need of reassurance from the minister.

Far from being chastened, Mr Clarke by all accounts was in robust form. The outcome of the meeting served to consolidate backbench support for the Secretary of State and prepare it for what one member of the executive foresaw as a "sweaty summer." To strengthen his hand Mr Clarke promptly distributed a set of briefing notes to all Tory MPs, together with a model letter of reply to their general practitioners. Mr Clarke himself followed up with another "Dear Doctor . . ." mailshot rebuking the BMA for its "inaccurate and misleading" leaflet.

More interesting was the impression that Mr Clarke left with members of the 1922 executive. This was that his passage at arms with the BMA was the product of confusion between the general practitioner contract and the NHS review. He said that progress on the contract was awaiting the special conference of local medical committee representatives on 27 April. Only then, Mr Clarke hinted, could he offer concessions on the contract terms. Rightly or wrongly—possibly wrongly, given Dr Michael Wilson's comments to the General Medical Services Committee this week (p 1185)—the top Tories are convinced that once the contract is out of the way the BMA will change its tune. Moreover, they have also been led to believe that the expected concessions will cost the Treasury what one of them called "real money."

By coincidence, a similar interpretation was advanced by Dr David Owen, leader of the Social Democratic Party, when on 18 April he initiated the first Commons debate on the NHS white paper *Working for Patients*. How was the government to get off the hook, he asked. His answer was to get the general practitioner contract out of the way as quickly as possible and "stuff their mouths with gold" as Bevan did. It would not be the first or the last time that governments had paid up.

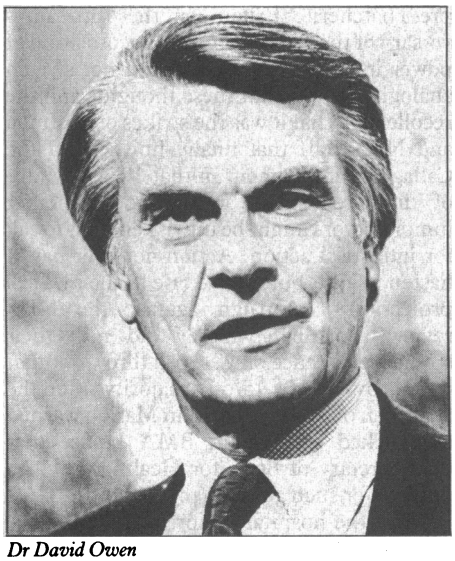
Dr Owen thought that criticisms of the contract could be overcome by modifying the targets for immunisation and screening. But he feared that the restructuring of general practitioner payments would be not an incentive but rather a stick pushing them in the direction of the so called "voluntary" practice budgets. As for the white paper, Dr Owen said that the government seemed incapable of realising the depth of opposition to the proposals.

The short Commons debate was very much second division level and unworthy of the subject. Labour stayed away, and less than half the House voted, so that the government's proposals were carried by 215 votes to 85. Dr Owen had hoped to tempt four or five Tory sceptics who, he said, would have most impact on No 10 Downing Street. Potential critics—Sir Barney Hayhoe perhaps—listened closely but kept their powder dry. Instead, the Tories went in for BMA bashing from Dame Jill Knight—"This leaflet from a profession that will not agree to advertising"— and Mr Ray Whitney—"I urge my friends on the front bench not to be discouraged by the extraordinary performance of the BMA."

Ready to alter course

Their front bench friend, David Mellor, Minister for Health, was more conciliatory. "We are looking for a genuine dialogue and we are only too ready to alter course and change practical details if that is required," he said. While the government had a duty to set the direction in which the service should go, Mr Mellor denied that it was seeking to ram changes down the throat of the profession: "As we receive representations the voices will be heard and we shall not hesitate to change our minds."

One of the voices will be from the social services select committee. Its report on the white paper is due to coincide with this issue of the *BMJ*. In advance there was a question whether the committee, which has lately changed its composition, could produce an agreed report. Assuming that it does, it is expected to echo the Joint Consultants Committee's call for a breathing space and for the proposed reforms to be tested in pilot schemes (1 April, p 849).



UNIVERSAL PICTORIAL

Dr David Owen

Meanwhile, the select committee has sounded an alarm about one aspect of the white paper in respect of pay and conditions for the 40% of NHS staff who come under the Whitley councils. In its third report last week the committee concluded that the Clarke changes were the death knell of Whitley councils. Mr Clarke will shed no tears. He dislikes centralised pay bargaining and wants local flexibility, with self governing hospitals leading the way.

The MPs, however, do not regard local pay deals as a magic bullet that will solve the manpower problems of the NHS. They believe that the government should not lose control of the overall pay bill and recommend the retention of some form of national pay determination, even if it is modified to meet local circumstances.

The Department of Health, in a note to the committee, puts the emphasis the other way. It wants more scope for geographical pay variations in review body and Whitley council settlements. The ever widening pay gap between these groups in favour of review body staff perplexes the committee. It enters a plea for lifting Whitley council pay rates to a higher baseline, with the government thereafter funding the full cost of settlements.

Boldly the report declares: "We believe that pay awards should not be rigidly constrained by uncompromising notions of what the NHS can afford. The staff which the NHS employs are its essential resource: they are not merely a cost."

We are about to see just how uncompromising or otherwise are Mr Clarke's notions about what he can afford.—JOHN WARDEN

Juniors reject industrial action on review

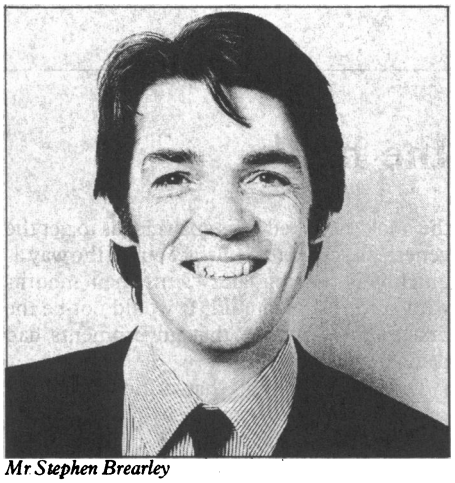
Do I detect a political whiff of the 1970s in the air? Unofficial walkouts on the London underground, a threatened dock strike, live programmes disrupted at the BBC, engineering and power station staff girding themselves for industrial action, a rising balance of payments deficit, mounting inflation, and pressure on sterling seem to herald a return of pre-Thatcherite Britain on the 10th anniversary of the Prime Minister's acquisition of power in May 1979. We should not stretch analogies too far, but these thoughts and the recollection that it was the strikes of dustmen and NHS staff that finally finished off the Callaghan government in that 1978-9 winter of discontent made me wonder whether junior doctors might be unwise enough to call for industrial action. Action not over pay, I hasten to add, but to give bite to the medical profession's campaign against the NHS review. Fortunately, they did not; their special conference on 22 April threw out that option by a three to one majority after the chairman of council, Dr John Marks, warned the packed meeting at BMA House that the Secretary of State for Health would be praying for such a result (p 1188).

What the hospital junior staff conference decided—among a substantial tranche of resolutions—was to call on doctors to consider a boycott of Kenneth Clarke's proposals. Mr Stephen Brearley, a past chairman of the HJSC, said that the proposals for general practice budgets and self governing hospitals were dependent on doctors for their implementation. He urged the BMA to "write to every doctor and say, 'we want you to undertake not to act on these proposals until we have had a satisfactory dialogue with the Secretary of State.'" The calls for "responsible industrial action"—albeit unsuccessful—and for a boycott reflected strong opposition not so much to the aims of the government's proposals as to its plans for achieving them. Juniors saw these as destroying the fundamental principles of the NHS.

Modify review or stop it?

The lively opposition of the junior doctors contrasted with a meeting in the same council chamber the day before. Then the Central Committee for Community Medicine and Community Health had opposed the government's proposals but in somewhat low key terms. The meeting will be reported in a future issue; meanwhile, let me report that as well as the meeting approving motions for debate at the special representative meeting on 17 May one or two speakers suggested that as it was unlikely that doctors were going to stop the government the profession should be realistic and set its sights on modifying the politicians' plans.

This is a sentiment I have heard voiced in discussions among doctors. I accept that the government has the political power to ram through legislation on the white paper *Working for Patients* at Westminster and that it may well do so regardless of opposition from doctors, other NHS staff, or, indeed, public opinion. Nevertheless, I don't think that doctors should just stand back and make practical suggestions about the decoration while the government substantially rebuilds the NHS mansion. I believe that they have a responsibility to the public and to the future of medicine to voice their objections clearly and contest the government's intentions to the limits of parliamentary democracy. And that includes telling patients of doctors' fears—pace Mr Clarke and his latest outburst against the BMA's leaflet campaign in doctors' surgeries.



Mr Stephen Brearley

When the profession is certain that the government is pressing on regardless—and with the Prime Minister's personal flag flying on this particular vessel of reform that is a strong possibility—doctors should decide at that point whether and how to organise a boycott. For the present the boycott weapon should be kept in the courtyard of BMA House—preferably until the representative body's meeting in Swansea, which would be an appropriate time to consider whether or when to prime it.

Let me turn to another criticism I've heard—namely, that the profession is shouting no to every proposal while failing to offer any constructive plans of its own. People's memories are short: the BMA, the Royal College of Nursing, and the Institute of Health Services Management in 1986 and 1987 produced joint reports offering critiques on the financing of the NHS accompanied by responsible proposals for improving its funding. Remember, readers, it was chronic underfunding of the service—particularly of the short stay services—that precipitated this crisis.

The government has with some political skill deflected attention from what should be the core of the argument on the future of the NHS—namely, inadequate resources—by producing an agenda on restructuring the service, without providing any worthwhile extra funds. So why should the BMA or any other organisation be expected to respond in like manner with structural counterproposals? The association should not let itself be driven into a corner on this one. Broadly speaking the NHS staff and the public are content with the present basic structure of the NHS, so why should they join in the political game of its partial demolition and reconstruction based on plans that have not been tested?

I don't pretend to believe—and nor do doctors, patients, or the public—that the NHS is a totally satisfactory institution. Clearly, it is not, and doctors would, I'm convinced, be more than willing to discuss with the government improvements such as universal medical audit, consumer sensitive improvements in surgeries and outpatient departments, effective information systems, ways to shorten waiting lists, and more accountability for doctors. Lack of genuine consultation is an aspect of the white paper that has angered doctors almost as much as the proposals themselves.

JCC to meet Kenneth Clarke

I make no apology for constantly writing on the NHS review: the outcome could profoundly affect Britain's health care for the foreseeable future. The fact that five major meetings at BMA House this week devoted substantial time to discussing it is sign enough of its importance: the Joint Consultants Committee (Tuesday, p 1184); the annual meeting of secretaries and chairmen of regional hospital committees (Wednesday, p 1189); the General Medical Services Committee (Thursday, p 1185); the CCCMCH (Friday); and the junior doctors' conference (Saturday, p 1188). All criticised the review, but the most impressive—and without doubt the most influential—was the JCC, which represents hospital medical staff across the spectrum of medicine. A capacity occasion with many college presidents present, it was significant for the quiet but determined criticism of the government's proposals from all round the table. No flights of oratory in that knowledgeable forum, just telling, analytical comment. The JCC's judgment was, I hear, admirably summed up and forcefully presented by its chairman, Sir Anthony Grabham, to the chief medical officer, Sir Donald Acheson, and the chief executive to the NHS Management Board, Mr Duncan Nichol, later in the day. They listened, I was told, with close attention. I am sure that they will have presented the committee's views unfiltered to ministers because ministers need to know the breadth and depth of doctors' opposition.

In any case the committee will have an opportunity to present these views directly when its chairman and representatives meet Kenneth Clarke on 26 April, after this edition has gone to press.

SCRUTATOR