BMA AFFAIRS

The Week in Swansea

A personal view of medicopolitics: 2 to 7 July

The BMA's annual representative meeting met in Swansea for the third time this century for its 1989 meeting. The two previous occasions were 1903 and 1965. The acting chairman, Dr A W Macara, opened the proceedings in the magnificent Brangwyn Hall on Monday morning and later in the day he was confirmed as chairman to succeed the late Dr B L Alexander, who died in office during the year. Dr W J Appleyard was elected deputy chairman for 1989-90. The meeting elected Dame Rosemary Rue president for 1990-91 and at the council meeting on 7 July Dr John Marks was re-elected chairman for 1989-90.

On the Monday morning the Lord Mayor of Swansea, Councillor Lorna J Aldron, welcomed representatives to the city. We published a résumé of the chairman of council's opening address last week (8 July, p 129) and Scrutator wrote about the retiring secretary of the BMA, Dr John Havard (p 80).

The address given by the incoming president, Professor J B L Howell, is summarised at p 207. A selection of the representative body's decisions appear amidst Scrutator's impressions of the meeting, which start here. These are illustrated this year with drawings by Ms Yvonne Fuller.

SUNDAY

Was it a publicity plot by the West Norfolk and Wisbech Division? There I was, Sunday righteous and self satisfied under a bright blue sky, walking briskly (by my standards) from Swansea's elegant new marina to its 1930s municipal style Brangwyn Hall. Calculating the yard by yard drop in my serum cholesterol concentration, I was suddenly overwhelmed by myriads of cyclists enthusiastically translating the propaganda of Heartbeat Wales into bustling practice. (Some of the silhouettes needed the exercise.) My self righteousness collapsing like a punctured tyre, I crept unhealthily into the BMA's pre-conference briefing session for the press.

Aware of all those health and safety motions I knew were lurking throughout this week's agenda, I reached apprehensively for document ARM1 1989, the conference's authorised text. It fell open at page seven and there was a motion from West Norfolk and Wisbech: "That in view of the continuing high level of death and injury amongst cyclists . . . this meeting instructs council to investigate measures to effect improvements in the safety of cyclists and make recommendations" (no please or thank you in the proposal, just a no frills, East Anglian delivery). Perhaps the member for this division, disguised as a pedalling unfit Welshman, was at this moment pilot studying some improvements as he bumped and rattled round the city.

My fatigue engendered reverie ended abruptly as the brisk steps of the BMA secretary, John Havard, led his senior henchman into the Lord Mayor's parlour to launch his last ARM press briefing. The room was as full as usual but the questions were fewer and gentler than usual. Perhaps it was the balmy climate and the bewitching sound of distant waves; more likely it was that the media were satiated by months of health headlines. The agenda, at 378 motions, was short by BMA standards, but the year's acute controversies—the NHS review and the general practitioners' contract—had already had extensive conference treatment. Anyway, John Havard, helped by Dr Ian Field (his successor from 7 July), Dr John Dawson, who heads the BMA's professional and scientific division, and Michael Lowe, the deputy secretary in charge of the crafts' secretariats, tripped briskly through the ARM and SRM agendas, stopping at those items which they forecast—non-pejoratively, as is right and proper for the secretariat—would generate good copy.

The entrance hall

Dr Field's crystal ball was not overtaxed in visualising some sharp speeches on the government's decision to knock £1000 from the top of the consultants' 1989 pay award and on the controversial new charges for eye tests, as well as on the evergreen subjects of child health services, career prospects for women doctors, and junior doctors' long hours of work. On science Dr Dawson forecast toxic waste, road safety, and detoxification centres as providing headlines. Surprisingly, given the controversies at recent annual meetings, AIDS had spawned a mere three motions from divisions this year.

For novice medical reporters as well as for doctors new to the ARM the procedural rules of the meeting are unexciting, but knowledge of them is invaluable in making sense of what at times seems a working model of chaos theory. Dr Havard explained to the press what was meant by a P motion (always given priority in a section); a C motion (five chosen for priority debate in a ballot of representatives); an A motion (accepted by the council as policy); and an AR motion (would be accepted by the council as a reference).

The secretary brought his audience up to date with the BMA's campaign on the white paper, telling them that at the request of doctors the leaflets for patients had been translated into Welsh, Punjabi, Urdu, Hindi, Bengali, Gaelic, Cantonese, and Gujarati. We learnt too, that meetings organised by the BMA to give the public an opportunity to discuss the government's proposals had been a resounding success, attracting up to 500 people at each of those arranged so far. Between now and the end of July further public meetings are planned in Ipswich, Stockport, Solihull, Newport, Newcastle, and York, with about 30 meetings altogether to be held during the summer.

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The vitality of the BMA comes from a judicious blend of ancient customs and modern practice. The now traditional ecumenical service was held this year at the collegiate and parish church of St Mary, two stained glass windows of which commemorate the Welsh guardsmen lost in the Falklands War, many when the ship *Sir Galahad* was bombed. No fewer than nine clergy members of differing faiths joined in the ceremonies, with the sermon delivered by the chaplain to the University Hospital of Wales, the Reverend Chancellor Norman Autton. Touching on a topical theme, he reminded the congregation that the NHS was not just a high powered administrative structure: it was more a large family with everyone striving together to promote health and healing. Reverend Autton described sickness and healing as challenges, arguing that healing should be seen not as a static isolated event but as a dynamic process. Holiness and wholeness, after all, had the same derivation. He urged doctors always to treat patients as people and not to wrap them in a folder.

What sound advice. Even in the age of computers folders are useful and I expect that the BMA's local organising committee had a pile, including at least one to help in the successful daily transportation of several hundred doctors and their accompanying persons to political, scientific, and social engagements from 8 00 am to 11 00 pm. That part of the meeting alone is a taxing logistical exercise. For that and all the other planning and hard work essential for a smooth meeting Dr H J P Davies and his local colleagues on the committee deserved our thanks.

On Sunday evening coaches took us from church to our next venue—the Patti Pavilion, where Dr Paul Mellor welcomed us to supper on behalf of the West Glamorgan Division of the BMA. BUPA had generously helped the division fund the evening, which included that quintessentially Welsh event, a male voice choir. Ours was the Ystradgynlais Male Voice Choir; the singers and the opportunity the evening gave to meet old friends and make new ones provided the ARM with a friendly launching pad. So, suitably refreshed in mind, body, and senses, a few of us meandered back along the sea front promenade for some gentle exercise prior to starting the week in earnest on Monday morning.

MONDAY MORNING

Will 1992 find the BMA adopting the continental habit of starting conferences early? Maybe, but this year the first session started at a civilised 9 30 am, though I was on duty a little earlier to hear Sandy Macara and Michael Lowe explain to the medicopolitical novitiates just how to get to the rostrum—a necessary trip before starting a speech. There were two ways of speaking, said Dr Macara. The proper way was to fill in a speaker's slip ahead of the debate and hand it to the agenda committee, that gang of fraught, coatless (but not topless) individuals who nest restlessly behind the "Chair." They process the slip, and enough other bits of paper during the week to turn the Green party purple. The less conventional way to the rostrum—favoured by certain old conference lags—is to grab the microphone and craft a speech out of a question or a point of order. That doesn't always work but the chairman admitted to being occasionally generous. He warned that he was less generous if speakers ran out of time: they had to watch the traffic lights or they would be gavelled—the verbal equivalent of garotting. In my experience audiences are more impressed by a few straightforward points delivered clearly at a reasonable pace than by a gabbled essay.

Finally, Dr Macara explained that if representatives voted against a motion that did not mean that the opposite became association policy. Keen to translate his advice into action, representatives new and old soon filled up the light and airy Brangwyn Hall. The hall's acoustics gave no excuse to mumbling speakers, and its art deco interior was enlivened by Sir Frank Brangwyn's vivid wall paintings, which would entertain those representatives whose attention might just occasionally wander from the proceedings.

At 9 30 am the acting chairman's gavel descended and he introduced the Lord Mayor of Swansea, Councillor Lorna Aldron, who warmly welcomed representatives to what many of us had already discovered was a lovely city. Since the BMA was last here 25 years ago—and a few of us remember that stormy meeting in the midst of the family doctor charter negotiations—Swansea has changed. The docks—once the city's industrial heartbeat—have been transformed into a marina that is a successful blend of industrial, marine, and cultural heritage. And watching it all from a kitchen chair on the quayside sits a bronze Dylan Thomas with a wealth of restless life before him that he would have surely crafted into that inimitable, lilting, earthy poetry.

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However nationally prestigious it is and however professional its staff, any voluntary organisation depends on a dedicated band of members to serve on local and national committees and to keep it in touch with the "grass roots." Benny Alexander was an outstanding example of the BMA's dedicated band. He should have been in the chair at this ARM, which would have been the second of the chairman's customary three year term. Last year I wrote of his courage in chairing the Norwich meeting despite a serious illness. Sadly for his family and friends, the BMA and the profession, he died during the year. After three moving tributes from the youngest member of the agenda committee, Stephen Brearley, from a representative, Dr E B Allen, and from the acting chairman of the meeting, Sandy Macara, the representatives stood in silence having unanimously approved a motion from Birmingham expressing the meeting's "profound sadness at the death of Dr B L Alexander, chairman of the representative body," and recording its "sincere appreciation for his outstanding service to the BMA over many years."

Benny Alexander was an exceptional "BMA man" who would always listen and whose advice was always straight and honest. He set a standard against which other medico-politicians could be measured, and he was a general practitioner whom I would have been privileged to have as my doctor. All of us were sad that he could not be in the chair at Swansea, a meeting he had looked forward to because it was his wife Sonia's home town. Her courage in coming to Swansea provided a poignant reminder of an empty place in the association's top counsels.

Hong Kong is in the news, unfortunately, for reasons its population could do without. The crown colony has a BMA branch, and two members from Hong Kong, Dr Z Lett and Dr H F K Li, were welcomed at the ARM. The meeting greeted with applause the election of Dr Li as a vice president in recognition of his outstanding services to the association and to the medical profession in Hong Kong. Congratulations Dr Li.

The first agenda debate had been on the agenda committee's proposed shortening and reordering of business. Annual meetings usually last four weekdays, and Tuesday had been pencilled in for the special representative meeting with a consequential extension of the annual meeting's business into Friday. The special meeting's agenda had subsequently been compressed by the agenda committee meeting in London into Tuesday morning, with the end of the annual meeting reprogrammed for late Thursday afternoon. But the local divisions had not been consulted about this late change and Mr W I Jones, Wales's representative on the council, told the meeting that it would cause great inconvenience and upset among the local organisers. An embarrassed platform did its best to defend the revised timetable, but the representative body is acutely sensitive to local feelings and the agenda committee's plans were consigned to history. Further confusion was abroad, because the one day strike by members of NALGO, the local government workers' union, on Tuesday might have closed the hall as it is a local authority building. So with its timetable looking somewhat ragged the agenda committee was invited to turn up early on Tuesday morning and find a solution before 9 00 am.

After tributes and a standing ovation to the retiring secretary John Havard of whom I wrote last week (p 80), the heavyweight part of the agenda was launched. The chairman of council in his main address, summarised in last week's *BMJ* (p 129), declared that the association's unique brand of science and politics had made the BMA credible to the profession and to the public. That credibility was not effortless, Dr Marks warned: "it has to be earned and has to be maintained." Well, the representative body was about to do its annual quota of earning and maintaining. And with Dr A W Macara by now elected unopposed as chairman of the representative body for 1989-90 he called on Sir Christopher Booth, chairman of the board of science and education, to deliver his first report to the ARM. Touching on the

highlights of his board's activities, Sir Christopher, formerly director of the Clinical Research Centre at Northwick Park, reported that the working party on pesticides set up after the 1988 ARM was well into its task. He frankly admitted to a division among board members over a report on medical scientific research, with some favouring a national health research authority, as suggested by the House of Lords, and others not. Inviting comments on that subject from members of the meeting, he went on to speak of the continuing problem of anxiety and benzodiazepine dependency. Psychotherapy was, he said, replacing drug treatment, and I idly wondered whether the week at Swansea would boost attendances at psychotherapists' clinics. But perhaps some busy clinicians find the ARM itself a practical and economical form of psychotherapy. The board had had several successful publications during the year and he commended the report on control of infection as the outstanding success of the session. May Sir Christopher and the board have many more.

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The annual meeting has developed an astute sense of timing when deciding the time is right for the BMA to study a topic. So it was with toxic waste this year. Mr Fortes-Mayor from Walsall, which harbours one of the largest toxic waste disposal companies in the country, deplored the lack of national policy for waste disposal and wanted the BMA to call on the government "to produce a comprehensive national policy on the disposal of toxic waste and to reduce immediately the quantity of toxic waste imported into this country." It would be like voting for sin to oppose such a motion and needless to say it was passed effortlessly.

On the way to approval we heard Dr Fay Wilson, also from the midlands, warning that market forces should not be allowed to control the imports and disposal of toxic waste Dr J Inman from Leicestershire reporting that since 1987 the number of ports handling waste had risen from nine to 31; Dr D E Pickersgill from Norfolk commenting on the environmental damage wrought by mankind during its short tenure of the planet; Dr Lotte Newman pointing out Britain's handful of inspectors compared with Bavaria's 50 and Japan's thousands; Dr Simon Fradd highlighting the lack even of proper definitions for waste; and Sir Christopher Booth promising a full report by the board.

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From multiple toxic chemicals to another toxic chemical, alcohol, was but one small step on the agenda, with Dr W J Grabau from Great Yarmouth demanding random breath testing for vehicle drivers. This territory is well furrowed by the battles between health workers coping with the grisly consequences of drunken drivers and those who see random testing as an unacceptable infringement of civil liberties. Dr Grabau pointed out that such testing had proved popular and successful in other countries; Dr Ralph Lawrence, a midlands police surgeon, argued that the real deterrent was a driver's perception of the risk of detection not increased penalties, and Dr Caroline Marriott reported from Northern Ireland, where random testing was in operation and increasingly people were leaving their cars at home.

I was delighted that Great Yarmouth's proposal was overwhelmingly approved. I must pump up my cycle tyres.

East Anglia's doctors are a safety conscious lot because, as I said at the start, West Norfolk and Wisbech (geographically gentle cycling country) had put down a demand for improved safety for cyclists, whose accident rates had risen by nearly 30% since 1982. Even this was an underestimate, according to Dr W J Appleyard, a paediatrician, who said that many children's cycle accidents were unreported.

Sir Christopher had no trouble in accepting the motion and he now has another subject for the board to study and make recommendations about. I am sure that the board will note Swansea's exemplary contribution to cycling safety in its construction of a five mile cycleway from the marina to the Mumbles.

A short uncontroversial debate ending with an expression of grave concern at the likely severe effects on health care of the underfunding of scientific and medical research was followed by a longer, argumentative debate on random testing, not for alcohol but for the trendy estimation of cholesterol levels. South Glamorgan's Dr R D Jones invited the representative body not to support random cholesterol testing, calling instead for general health education for all. Such testing, he argued, did not take account of other risk factors.

Despite speakers opposing the motion for its vagueness, because it fell short of what was needed, or because random testing was better than no screening the meeting took the advice of the chairmen of the board of science and of council and supported South Glamorgan's request by a large majority.

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And so we come to pay, not so prominent a subject as it used to be, but, with inflation worsening, one that will surely creep up the ARM's priorities. In his opening address the chairman of council had described as appalling the government's decision to lop from the top of the consultants' salaries the extra £1000 recommended in the 1989 review body report. The meeting agreed, unanimously endorsing Worcestershire's motion which objected to the government's interference and its failure to fund a reasonable pay increase in full. The government had used as its excuse the fact that it was funding 100 new consultant posts—already announced in *Working for Patients*.

According to the Hospital Junior Staff Committee's deputy chairman, Dr Jeremy Wight, the juniors had given irrefutable evidence to the review body that the demands on the training grades were great and that the rewards were inadequate. The review body's solution of boosting consultants' pay to improve career prospects might have worked if it had been given a chance but the government had kicked the entire hospital sector in the teeth.

The government's other reason for appointing the 100 new consultants was that it would reduce the number of hours that junior doctors worked. Dr Joy Edelman scathingly invited someone—no doubt she had Kenneth Clarke in mind—to explain how half a consultant in a district could reduce the hours of junior doctors. How indeed?

With consultants strongly supported by the chairman of the General Medical Services Committee, Dr Michael Wilson, asking representatives to carry the motion unanimously, there was little danger of any dissentient votes. And after the chairman of council had put his knowledgeable boot into Mr Clarke for suggesting that if the review body had known of the government's plan for 100 new posts it would not have given consultants an extra £1000, the meeting supported Worcestershire to the hilt.

The meeting went on to deplore the delay in translating the NHS doctors' 1989 award to the pay of clinical academic staff. It resented, too, "the attempt by the Committee of Vice Chancellors and Principals to link the award to the dispute between university staff and the Association of University Teachers." This annual charade of universities reluctant to pay their clinical staff the same rates as NHS staff is sapping

the morale of medical academic staff. Does the committee of vice chancellors suffer from such tunnel vision that it cannot or will not see the long term damage being done to British medicine?

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During the past four years the number of medical managers has fallen by a half from 112 to 58. This was the bad news that Mr Russell Hopkins had to tell us. He chairs the general managers group committee and is on that committee by virtue of his post as a part time unit general manager. His other part time duties are as a consultant surgeon in Cardiff. I'm pleased to tell you that he has just been awarded the OBE, whether for his management skills, his clinical work, or because he successfully combines the two you will have to ask Buckingham Palace. I plump for the last.

What are the reasons for the decline in medical managers? Mr Hopkins suggested:

- The difficulty of managing anything in today's health service
- The lack of understanding of these difficulties by colleagues
- The unsatisfactory financial arrangements for medical general managers had been aggravated by a recent derisory offer from the department
- A desire to return to clinical work.

The profession, Russell Hopkins pleaded, should encourage clinicians to undertake the necessary training so that its members could participate fully in management. Doctors should listen to him. I well remember in my National Service days a wise surgeon advising me to keep better files than the administrators. "Then you can outadminister them," he used to chuckle. He did, and the lesson has remained with me.

The meeting speedily endorsed a motion from Mid Glamorgan urging the council to "pressurise the government to finalise the contract arrangements for those doctors who were part time general managers." Mr R B Broughton reminded the meeting that when the first 100 medical general managers had been appointed the department had promised a swift offer of a substantive contract. Not until February this year had a totally inadequate draft contract been offered.

Mr K O'Keefe was uncertain whether to support or oppose the motion. "If the government really wants us," he said, "they would create conditions in which doctors in management would flourish and increase." He wondered about the part time concept. In South West Thames Regional Health Authority the general manager had reviewed the management structure, making clear that general managers would be full time. This was a worrying development.

Quite so. Is Richmond House—the Department of Health's headquarters just a coin's throw from the Treasury—banking on medical managers melting away altogether? I hope not, but I fear otherwise unless doctors make a greater effort to participate in management.

I have spent some time on Monday morning not just because of its intrinsic interest but because much of Monday afternoon was spent traversing a plateau of fine print from which only occasional pinnacles of principle emerged. The afternoon's subjects were organisation, the *Memorandum and Articles of the British Medical Association*, and the constitution of the council, and while the journey was a necessary one for representatives it is not one that lends itself to vivid descriptions. (Any constitutional addicts are welcome to borrow the transcripts by the BMA's team of accomplished parliamentary reporters, without whose invaluable annual support The Week at the ARM would be a less substantial structure.)

But before identifying any constitutional pinnacles let me conclude Monday morning with a comment on the BMA Charities Trust. The trust's report was presented by Dr Alistair Clark, a representative for 40 years and a former chairman of the representative body, delivering his final address after six years as chairman of the association's charitable activities. During this time the charities committee has been transformed into a trust, a change of status that has not affected the objective of helping doctors and their dependants in need but has improved administrative and financial efficiency. Dr Clark asked representatives to inform the trust of anyone who might need help, and he also reported on the increasing number of students doing medicine as a second degree who were being helped by the Medical Education Trust—54 out of 200 applicants in 1988-9. This is an achievement for a fund launched only three years ago with generous support from the Wolfson Foundation and contributions from the BMA. Having paid tribute to their long time colleague Dr Clark for his sound and sympathetic stewardship, the representatives left for lunch, a chat, and a stroll in the sun.

On Monday morning the ARM . . .

- Elected Dame Rosemary Rue president of the BMA for 1990-91
- Elected Dr H F K Li of Hong Kong a vice president of the association in recognition of his outstanding services to the BMA and to the medical profession in Hong Kong
- Called on the government to produce a comprehensive national policy on the disposal of toxic waste, and to reduce immediately the quantity of toxic waste imported into the United Kingdom
- Wanted the government to introduce random breath testing
- Was gravely concerned at the underfunding of scientific and medical research and the severe effects likely to arise in the future for the development of health care and urged the BMA to campaign for an increased commitment to and funding of such research by the government
- Did not support the concept of random cholesterol testing, but urged the introduction of a general health education programme for the whole population
- Objected to the interference with the 1989 review body award and the failure to fund the recommended pay increase in full and deplored the delay in translating the award to clinical academic staff
- Resolved that pay awards to all NHS workers should be funded in full by the government

MONDAY AFTERNOON

The familiar and friendly figure of Dr M Hamid Husain was first to the rostrum after lunch. As chairman of the organisation committee he along with his colleagues had presided over the revision of the articles and by laws. A mammoth task, he described it, requiring the "reading, revising, and cross checking of over 50 000 words" which had called for patience and forbearance from all concerned, not least Lavinia Webb and the rest of the committee's staff, to whom Dr Husain expressed a "deep sense of gratitude."

No doubt he was privately hoping for equal patience and forbearance from the representative body. Debating the constitution is not an exercise that necessarily brings out the best in the ARM.

The BMA has always taken great trouble to represent the interests of minority groups of doctors. But this commendable principle occasionally collides with the practical politics of containing the size of committees and the council to manageable proportions. An attempt to persuade the meeting to restore the chairmen of the armed forces and occupational health committees as ex-officio members of council foundered on the reef of practical policies. The chairmen will, however, attend the council to present their reports, and the crafts will continue to have a representative on the council. Bill Dixon has been that representative and he also happens to have been chairman of the occupational health committee, and I can recall many occasions when a quiet and knowledgeable intervention from him has been invaluable to a council debate. He has been a notable example of the added dimension that a representative of a small but important group of doctors can bring to the inner counsels of the BMA. Long may such contributions continue.

To an outsider, the afternooon's constitutional debates were complex. Firstly, we had some free standing motions on the constitution of various committees and on a change of name for the Central Committee for Hospital Medical Services: it will in future be called the Central Consultants and Specialists Committee. Next came several motions from the organisation committee also proposing amendments to the constitutions of various committees. Then there were debates on the major proposal to replace the articles and by laws of the association with the document *Memorandum and Articles of Association of the British Medical Association*, which was published as appendix IV to the annual report of council 1988-9.

This document included the full details of the BMA's constitution, but another dimension was added to the debate because after the debate on the "memorandum" the representative body was to consider a report from the working party on the constitution of the council. The outcome of that report would then be incorporated into a further revised revision of the memorandum and articles. These would go forward for approval (as required by the Companies Act) to the BMA's annual general meeting. (They were approved on Wednesday.) Is that clear? If so you are eligible for a job on the organisation committee's secretariat. If not you can blame me, but at least you will understand why I'm reluctant to scramble round the clauses and subclauses of the BMA's constitution in what is intended to be a readable account of events at Swansea.

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When Hamid Husain had completed his gallant and largely successful defence of the new memorandum and articles, including the defeat of a motion from Dr D C Roberts of Hendon and Edgware to refer the whole document back, the meeting turned to—or more accurately on, given some of the passions generated—the report on the constitution of the council.

The reason why the working party had been set up and a council member with the experience of Sir Henry Yellowlees invited to take the chair was the outcome of the 1988 council elections. The 14 regional constituencies in England had returned 13 general practitioners and one community physician with the result that hospital doctors are underrepresented on the council. Sir Henry's task—and as a craft free member he had the asset of neutrality—was to achieve by constitutional means a more balanced membership. Before the Trade Union Act 1984 the association had by means of indirect elections constructed a balanced council, but that act, which compelled voting members of a union's executive to be directly elected by the membership, destroyed that balance.

Anyway with a balanced working party and after much consultation and confabulation the working party had recommended a revised and more fairly balanced constitution that met the legal requirement (20 May, p 1393). That was the principle, but in the view of Dr P J P Holden from Chesterfield the principle had not worked for crafts other than general practice and senior hospital doctors. He criticised the proposals as complex and causing as many anomalies as already existed. Refer them back, he pleaded with the representative body.

Dr Holden had support: Dr M J Illingworth described the report as a pig's breakfast; Dr Angela Thomas wanted the report sent back to the council after the meeting had debated it; and Dr Ruth Gilbert pointed out that junior doctors had only eight seats on a proposed council of nearly 70 members yet they represented 30% of the profession. But Sir Henry's supporters rallied to his flag. Jim Dunlop, the only non-general practitioner on the council from the English regional electorate pointed out that he represented all his constituents, warning that regional representatives "should not vote like sheep following the craft party line." (Good for him.) Dr

Tony Keable-Elliott, after commenting that council members had criticised but had not made a decision on the report, urged the meeting to do so, otherwise it would be three years before any new system could be introduced. Mr Jim Johnson, militant junior turned militant consultant, warned of a crisis of confidence in the BMA among senior hospital doctors, arguing that though the proposal might not be perfect it was better than the present arrangements. Despite a plea to the meeting from Dr Holden not "to construct a council constitution on the hoof in an emotional atmosphere," the meeting refused to refer back the report and went on to discuss a string of amendments.

Attempts to add to or to strengthen the representation of retired doctors, Scottish doctors, and junior doctors were rejected, though not without arguments on whether simple or two thirds majority were needed. The chairman had to have his wits about him and must have groaned inwardly—he is too courteous to have done so outwardly—when an amendment longer than the original report turned up from Peterborough. The meeting declined to swallow it though it had earlier swallowed (slowly) a proposition from Ayrshire and Arran that council elections should be conducted by the single transferable vote system. (The BMA secretariat will be hastening across to the General Medical Council to learn how it runs such a system.)

The debate continued on the main motion and although principle was a word that most speakers were carefree in using, I wondered what practical effect had resulted from the treasurer's warning that if anyone else was added to the council's membership there would be no room in the council chamber for the staff to attend.

The representative body eventually approved Sir Henry Yellowlees's report. He didn't pretend its recommendations were perfect and suggested that work should be continued. Meanwhile the BMA is in his debt: balancing craft interests is a fraught and thankless task. But let me end this long section of the agenda by giving the last word to one of the critics of the report, Dr Fay Wilson, because she talked some good sense. "We must not be divided into small, self interested groups," she cautioned, "council should be more than a meeting place for different crafts . . . we want it to stand for the whole profession, representing all its members." When the passions of debate have cooled that is a principle we should all subscribe to.

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Each craft has its own slot at the ARM and the "minority" ones—minority in number only—leaven the spaces between the large sections such as ethics and science. Major General R N Evans marched in after the long debates on the constitution to tell us that recruiting adequate numbers of properly skilled and trained medical officers was a problem facing all the armed services. As chairman of the armed forces committee he reported that, nevertheless, many service doctors did not think that the comparator used in determining their pay—that is, average earnings of NHS general practitioners—was incorrect. There had, the major general reported, been a major success: the financial clawback would cease from May 1989 for people who had entered as cadets and who left the service in future. What is the financial clawback, you ask. It is a system—inspired, I'll wager, by the Treasury—which allows the Ministry of Defence to deduct from the terminal gratuities of short service officers who have been cadets a sum equivalent to medical school fees and "that part of their emoluments deemed to be an educational grant." This was, he said, the most important improvement in the terms of service of armed forces doctors since the introduction of the cadetship scheme in the mid-1960s. It had been achieved thanks to a persistent campaign waged by the BMA in the past few years. It sounds a great change to me though one that sits uneasily with the government's aims of making students pay for higher education.

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Proposed revisions in the payments for out of hours work, with visits by deputising service doctors attracting a lower fee, has put these services in the limelight. Dr Lionel Kopelowitz has been chairman of the central advisory committee overseeing the BMA's deputising services for many years and he has vigorously defended the interests of doctors who work in deputising services. He was predictably pleased to commend a motion from Southampton and South West Hampshire that supported the continuation of the BMA's services, which enhanced "the quality and provision of general medical services." Dr Kopelowitz reminded the meeting that though deputising services consisted of less than 2% of all professional contacts in general practice, without them the provision of general practice services would have broken down in major conurbations. The services were undertaken by trained doctors, the vast majority of whom were principals in general practice.

Dr C L W Webb wanted the meeting to show proper appreciation of the services. General practice had changed much in the past 25 years and it was reassuring, he said, for doctors to have well managed deputising services. He believed that general practitioners could be trusted not to abuse the services. The meeting supported the motion, but not before Dr S C Drew had shuddered at the prospect, arguing that deputising services might be a necessary evil but did not enhance the quality and provision of general medical services. How could passing over the care of patients to someone else raise the value of the care they received?

Dr Arnold Elliott chairs the committee on doctors and social work, and he is recognised as a valuable link between two professions whose work so often overlaps. He reported that in the wake of the council's working party report on child sexual abuse a BMA deputation was to meet the chief medical officer in August to discuss, among other things, the lack of information about the incidence of sexual abuse. More facts are essential but one depressing piece of existing information is the shortage of social workers; Dr Elliott told us that 600 cases of child abuse in London had not been allocated a social worker. That is a shaming statistic for a civilised society.

Dr Ralph Lawrence took up the theme of the lack of progress in his motion from Derby. A general practitioner and police surgeon, he told the meeting that in the first six months of this year the number of suspected cases that he had had to examine had already passed the whole of the previous year's number. So his division regretted that despite the council's working party report the government had still not announced any intention to institute "properly organised research into the incidence and prevalence of child sexual abuse."

On Monday afternoon the ARM . . .

- Resolved that the title of the Central Committee for Hospital Medical Services should be changed to Central Consultants and Specialists Committee
- Approved a more balanced constitution for the council
- Decided that elections to the BMA council should be conducted by the single transferable vote system of proportional representation
- Regretted that despite the recommendations of the BMA on child sexual abuse there still had been no announcement that the government intended instituting properly organised research into the incidence and prevalence of child sexual abuse

• Asked the council to do everything possible to urge the government to look into the matter of family courts to deal with child abuse cases.

However welcoming the hosts, attractive settings enhance a party. The Lord Mayor, Councillor Lorna Aldron, entertained the BMA on Monday evening at the Glynn Vivian Art Gallery. So we enjoyed the refreshments while admiring a collection of Joan Miro sculptures and the famous Swansea and Nantgarw porcelain as well as a large picture collection, soothed by the gentle sounds of a Welsh harp. Started in 1908 with the financial help of a local copper manufacturer, the Glynn Vivian gallery is one of Wales's finest. I was loath to leave but guests were in evening dress and ready to move on to the tribal dinners, the press dinner, or one of the other social occasions organised for the evening. And me? I would have loved to join the diners but I dutifully walked back to my hotel to write up my impressions of the day and speculate on what surgery the agenda committee would perform on Tuesday's timetable.

TUESDAY MORNING

Given the number of social events held the night before, a commendable number of representatives were on parade on the second morning to receive the agenda committee's revised timetable and to hear the treasurer, Alistair Riddell. With the meeting's timetable adjusted to finish mid-morning on Friday the treasurer would have to find some extra subsistence money for the representatives, but fortunately the association's funds could readily absorb that burden. Dr Riddell reported that in the year ending 31 December 1988 income from subscriptions had gone up from £7·9m to £8·3m, the result of a combination of more members and a subscription increase of 10% in the last quarter. There had, however, been an increase of 11% in the cost of professional activities from £8·6m to £9·6m. Income from fixed assets had risen, and this, a successful publishing year, and the sale and reinvestment of some investments had led to a healthy surplus.

The results reflected some shrewd husbandry by Dr Riddell and the financial director, Michael Bown, coupled with the BMA's rising popularity among doctors. But the treasurer sounded a note of warning in pointing out that the surplus on professional activities had fallen from £1·2m in 1984 to just £100 000.

Looking to the budget for the present year, Dr Riddell said that estimated membership subscriptions of £9·1m had been based on an increase in membership of only 1000 members, but the increase would be greater. Even so he was budgeting for a deficit on professional activities. By using the surplus from other activities, however, he hoped to keep the membership subscription down while at the same time allowing the reserves to increase in line with inflation. So far £2·4m had been committed to the campaign on the white paper, but the treasurer assured the meeting that he did not intend to sell property or shares for that purpose.

The meeting agreed without a murmur that the standard rate of subscription should be increased by not more than 9·2% with effect from 1 October, but the medical students successfully dissuaded the meeting from raising their subscription from its present level of £15.60. Mr Keith Reid (the students' elected representative on the council) and Mr Mark Callaway, who chairs the medical students' committee and had, he told me, just passed his finals, pointed out that the increase would bring in only an extra £6000 and that by freezing the subscription the BMA would be endorsing its long term commitment to the recruitment of student members.

* * *

Student members were discussed again in the next session on membership and regional services. Congratulating the BMA on the relaunch of the membership scheme for students, the Chesterfield Division wanted the BMA to improve the services for them still further "to overturn the recruitment inroads made by other trade unions." "And other student bodies" was added by the medical students as a rider. Dr P J P Holden reported that a defence society had set up a medical student organisation with a £10 membership fee so the BMA could not rest on its laurels.

Place of work accredited representatives—POWARs in trade union argot—are important activists for the BMA but there are too few of them. Their work often goes unsung and they were the subject of two motions on the agenda, both carried as references. Dr Harvey Gordon from Mid Surrey, Kingston, and Esher wanted the council to give POWARs the opportunity to meet regularly, nationally and regionally; and from Lanarkshire Dr A Addison suggested that the case reports of POWARs should be published. Both these ideas merit research and if Dr Ian McKim Thompson's department can sneak them past the treasurer they could enhance the work of POWARs, whose importance will expand if Kenneth Clarke's reforms are implemented. Furthermore, Dr Addison pointed out that it was the POWARs' responsibility to give initial advice to BMA members on contractual matters and they had a key role in recruiting and retaining members.

* * *

The BMA's trade union services were followed by its financial services. Presenting the report of BMA Services Ltd in the unavoidable absence of its chairman, Sir Anthony Grabham, Dr R A Keable-Elliott told the meeting that BMAS had organised 56 nationwide seminars to advise people about the changes in the law controlling pension schemes. These had been attended by 6000 members, and the advice, which he endorsed, was that the doctors should not opt out of the

NHS pension scheme. The general insurance business had gone up by 12% in the past year and there was a new high value household cover policy.

Putting complaints into perspective—they were the subject of motions on the agenda—Dr Keable-Elliott said that the Colchester office had received 51 complaints during the time that it had handled 80 000 separate policies. A motion deploring the inefficiencies of BMAS's motor insurance services was defeated after Dr Keable-Elliott explained that motor insurance was the most competitive area of insurance. The national renewal rate for car policies was about 65%; the renewal rate for BMAS was 82%, yet in the past six months there had been only four complaints about car insurance.

* * *

I sometimes think that a Scotsman can be found behind every other agenda in the committee rooms at BMA House. Angus Ford is a prime example of this medicopolitical phenomenon. Chairman of the Scottish council, he sits on the BMA council and the CCSC (the CCHMS's new acronym) and for 18 months chaired the working party on regional services and their relationship with the local craft committees, to the divisional structure, and with individual members. Dr Ford forcast that the working party had set the course for the next 10 years (the report was set out in appendix V of the annual report). The provision of services had to evolve constantly and the working party had seen its recommendations as guidelines. For example, since its establishment it has achieved greater importance because of the likely devolution of negotiations in the post-1990 NHS. The working party made 27 recommendations on industrial relations officers, POWARs, divisions, and regional councils. The council had already welcomed the report and within the financial constraints that might have to be applied the recommendations were being implemented.

Inevitably, Dr Ford said, the strengthening and expansion of services meant expenditure. "Such necessary investment in the future of their members had to be planned and a change had to come, by evolution and not by revolution."

With this canny Scots advice digested, the meeting supported a composite motion from the agenda committee calling for the divisional secretary to be an accredited representative of the BMA to the district health authority where possible.

On Tuesday morning the ARM . . .

- Complimented the BMA on the relaunch of the membership scheme for students but asked it to improve services to student members to overturn the recruitment inroads made by other trade unions and other student bodies
- Asked the BMA to provide training for all its health and safety representatives
- Believed that the existing BMA division structure and activity required alteration in keeping with the requirements of the profession in the next decade; that the divisional secretary should be an accredited representative of the BMA to the district health authority where possible; and that there should be a divisional executive of up to 20 members
- Asked the BMA to review the services provided by the association in view of the possible effects of *Working for Patients*.

The annual representative meeting then converted itself in the bang of the chairman's gavel into a special representative meeting to discuss the NHS review.

TUESDAY SRM

I confess to having had doubts about the point of calling another special representatives meeting so soon after the successful one in May. But I am a mere observer, so observe I did. The chairman of council reported on his meeting with Kenneth Clarke and went on to deliver a rallying speech (8 July, p 130) that was greeted with much enthusiasm by the representatives—a prolonged standing ovation and much stamping of feet no less. John Marks's concluding passage was directed at the public. He urged people:

- To wake up to what was really happening to their health service under the guise of reorganisation
- To speak up and make their views known to their government
- To defend what is one of Britain's greatest national assets
- To demand proper funding so as to provide the public with the best, most cost effective, and most comprehensive system of health care in the Western world.

The debates themselves went over ground familiar to those who were at the May meeting and subsequent craft conferences. An important advance was that to an approved motion reaffirming the decisions of the May SRM and regretting the subsequent actions of council the meeting added some positive suggestions to meet the aims of the NHS review, with which the BMA agrees. The intention was to spike Kenneth Clarke's repeated—and untrue—jibe that the association has made no alternative proposals to his white paper.

The representative body decided that the aims of the white paper could be achieved by:

- Adequate funding of the NHS
- Extension of the resource management initiative after proper evaluation
- Improving the system for allocating resources so that it responded rapidly to changes in workload and patterns of patient flow
- Further development of clinically led and properly funded medical audit
- Proper consultation with the recognised professional advisory bodies at regional level.

At the end of the morning representatives overwhelmingly supported a point by point refutation of Kenneth Clarke's accusation that the BMA's leaflet campaign had been untruthful. The SRM's debates went on into the afternoon and a report on some of them will appear in a future issue.

From the meeting's solid approval of the BMA's leaflet campaign, I shot off to a press briefing to hear details from a Gallup poll conducted for the BMA on the public's views on *Working for Patients*.

Over 900 people over 18 were polled at 100 sites between 21 and 26 June. Of those who knew anything about the white paper, 71% disapproved of the proposals and 75% believed that the white paper would result in cuts in NHS services. When asked this question 58% of Conservative voters thought cuts would result and 30% did not.

Were the proposals the first stage in the privatisation of the NHS? Asked this question, 73% of respondents agreed, 15% disagreed, and 11% were undecided. Responding to the same question, 53% of Conservative voters agreed and 33% disagreed.

Just over 60% of respondents believed that the proposals meant that patients would get the cheapest rather than the

best treatment; 21% disagreed, and more Conservative voters (39%) agreed that this would be the case than disagreed (35%).

Was the NHS safe in the hands of the Conservatives? Over 65% thought not, but among Conservative voters only 32% thought not.

Did all this mean, asked the reporter from *Today*, that the BMA was winning the hearts and minds of the British public? John Marks diplomatically replied that of those questioned who knew about *Working for Patients* only 15% had approved of it. He had told the secretary of state that the BMA would continue to tell the public what was happening. Michael Wilson, chairman of the General Medical Services Committee, pointing out that the proposals to change the NHS came from the government, suggested that the press should ask Kenneth Clarke whether he was winning the hearts and minds of the people. With good sense he declined to forecast whether the problems over the health service would lose the government the next election, which he pointed out, might not be before 1992. But Dr Wilson and the chairman of the CCSC, Mr Paddy Ross, both emphasised that it was doctors' responsibility to make clear to the public what was happening to the NHS.

Inevitably, I suppose, a questioner suggested that the leaflets and other campaign tactics were scaring patients. But Dr Wilson was adamant that the profession was alerting the public not alarming it.

TUESDAY AFTERNOON

Ophthalmic medical services is a section that tends to slip quietly by, and if not unnoticed usually unsung. This year, with the government introducing payments for eye testing, the specialty has had a higher political profile. Presenting the report, Mr P V Mills, chairman of the ophthalmic group committee, described as a disgrace the government's imposition of charges, which was contrary to its policy of encouraging preventive medicine. Mr Mills also criticised the recent concessions, reporting that the overall effect of the legislation had been a substantial reduction in the number of eye examinations in the ophthalmic services—and, incidentally, a fall in members' remuneration. He asked the meeting for support in encouraging patients to obtain medical eye examinations.

Mr Mills's comments were supported by Dr C P Stewart from Dundee in a motion criticising the government's short sightedness. Citing his own clinic, he said that 350 people usually attended each week and the number had fallen to 100, a change that could lead only to increased morbidity.

From the Mid Downs Division (formed in 1987) Dr H Bloom made not only his maiden speech but his division's first speech at an annual conference. As a general practitioner and clinical assistant in ophthalmology he disagreed with the government's view that general practitioners were as good as ophthalmic opticians in the early detection of eye disease. The changes would encourage people to go to their family doctors, who would feel bound to refer them to the hospital service. Working not far from Swansea, Dr J Cuthill also reported a fall in sight testing by opticians—60% in the more deprived areas. The result seemed to have been an increase in referrals to hospitals and longer waiting lists.

This sounds like market forces operating in a way the government would not welcome. Unwelcome market forces or not, the meeting supported Dr Stewart's pleas that the changes negated preventive medicine.

* * *

The BMA's public affairs division was very active in the campaign against the introduction of sight testing charges. Only doctors who don't read newspapers or watch television would be ignorant of the profession's sustained campaign against the white paper. The association's public affairs division has masterminded that campaign, with Pamela Taylor and her staff working prodigious hours, travelling many miles, lobbying many MPs, and writing yards—sorry—metres of press releases in their successful endeavours to get the profession's views across to public and parliament. I have often rung the division's staff on a Sunday to be greeted courteously and provided with the information I want. I know that the press corps—whatever the political colour of the reporters' papers—has received similar attention. Kenneth Clarke's admission that the BMA was winning the publicity battle was a tribute to the public affairs division's effectiveness. The representative body gave its own tribute with a standing ovation.

* * *

From the media to the General Medical Council is a delicate step since this august professional institution is not noted for its affection for publicity, be it about doctors or about the GMC itself. Nevertheless, it is in the public and professional eye and cannot escape attention. But I live in hope. With the results of the quinquennial election due at about the time this column goes to press its membership may change and, who knows, the council may look more tolerantly at us hacks.

The association has a working party on the GMC chaired by Brian Lewis, an elected member of the profession's controlling body. He paid tribute to the GMC's recently retired chairman, Sir John (soon to be Lord) Walton. Briefly referring to the *BMJ*'s series on the GMC—articles not entirely to the liking of some of the council's senior members, I've heard—Dr Lewis spoke of an interim report on disciplinary procedures from a GMC working party. This had decided that the council should confine itself to matters of serious professional misconduct and not introduce a two tier

system, but the existing category was being widened to take account of public opinion and the perceptions of MPs. Dr Lewis reported that the working party would see what could be done about the small fringe group of private doctors who caused disquiet among the public and thus influenced attitudes about the rest of the profession. Describing the GMC staff's workload as enormous and carried out under difficult conditions, he concluded that the council was "grossly underfunded for the task it has to do."

* * *

Medical students don't need to worry about the GMC but they have more than enough else to worry over; for a start there are exams, but those have always been a student's lot. This year, however, they have had the twin threats of student loans—the government's favoured way of funding higher education—and the NHS review's likely effect on undergraduate education. Mark Callaway, chairman of the BMA's medical students group committee, reported that his committee had been active in resisting these threats, meeting ministers and MPs to put its case. The students had also polished up their BMA image this year with the launch of a new name and logo. Mark Callaway described it as a commitment by the association to medical students, and the group now "can and does represent the views of Britain's medical students on national issues." If the group can continue to find chairmen like him its members should go from strength to strength and compete effectively with other organisations claiming to represent students.

After the representative body had endorsed a critical motion on student loans and supported a plea from Miss Amira Dangoor for more practical information on junior doctors' working conditions to be made available to school leavers it turned to another subject of future rather than present interest to students: defence society subscriptions.

* * *

In any normal year, if such a thing exists, the crisis in defence society subscriptions would have been top of the medicopolitical agenda. As it is the NHS review and the general practitioners' contract dispute have taken top billing, with medical indemnity jostling for attention with juniors' hours of work and the inquiry into doctors' restrictive practices.

Readers worrying about their indemnity status may recall that the government's original promise was to start an NHS indemnity scheme in July, the date that the Medical Protection Society had unilaterally set for introducing differential subscriptions—the decision that had accelerated the inevitable crisis on medical indemnity.

The chairman of council brought the meeting up to date, telling it that the BMA had asked the Department of Health several questions, seeking an assurance that NHS indemnity for hospital and community medicine and health doctors was to be introduced and, if so, when this would happen.

* * *

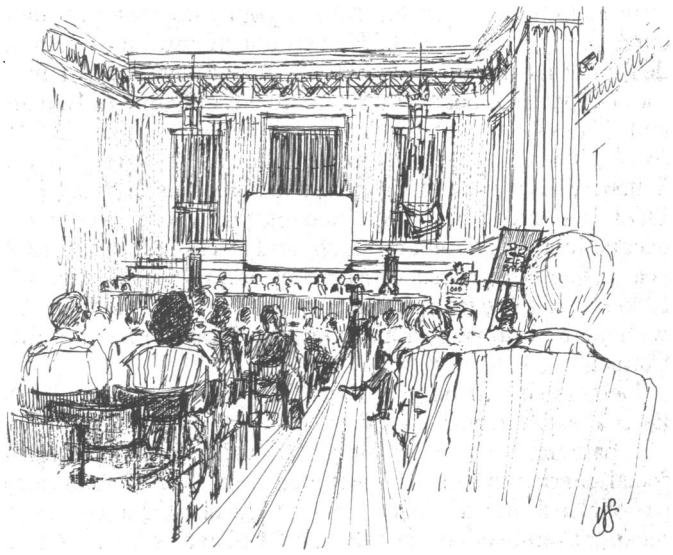
The latest news, said Dr Marks, was that the Department of Health had "not yet been able to take a firm decision on the scheme nor agree on a date of implementation." (Not a phrase to gladden doctors' hearts.) Meanwhile, he reported, regional general managers had been told that they should continue to expect doctors to remain in membership with one of the medical defence organisations or have appropriate insurance in lieu. The managers had also been reminded that the existing partial reimbursement scheme was still in operation and would remain so until 31 December 1989.

The departmental letter to the BMA had made several other points. Most replies received by the department to its consultation had favoured the proposal for NHS indemnity, although some had raised further questions. The answers to some of these—provided that NHS indemnity was introduced—were as follows:

- The department saw a major continuing role for the medical defence organisations because of their experience in handling claims for medical negligence
- The department expected health authorities to be advised by the medical defence organisations on which claims to contest and which to settle out of court, so there was no expectation of any great change in handling claims
- The authorities would take financial responsibility when they were legally liable, so they would have to provide services in the proper manner and ensure that doctors in training were given clear responsibilities and proper supervision, with doctors and management working together to facilitate that
- If doctors wished simply to be represented in defence of allegations against them the department expected that this would be in agreement with the health authorities, but authorities would have to be safeguarded against the costs of a practitioner who insisted on pursuing a hopeless case.

The government was discussing with the medical defence organisations, Dr Marks said, the possible transfer of "some part of the reserves related to the hospitals and community services. The appropriate proportion has yet to be established but the department intends that medical defence organisations should be left with sufficient resources for them to be able to compete on a fair basis for doctors not covered by the NHS indemnity." NHS indemnity would cover doctors and dentists when working for a health authority, but they would need to have their own cover for NHS work. The department expected the defence organisations to offer cover for other work at much lower subscriptions than had prevailed hitherto. I would hope so too.

The council had agreed to indemnity through the state, subject to certain provisos, Dr Marks continued. The provisos were that the negotiations were successful. But these were proving to be difficult negotiations between the department, the defence bodies, and the BMA. The difficulties stemmed from commercial implications. He concluded by warning that without some form of crown indemnity the



profession would have differential subscriptions as surely as night followed day.

Despite that warning the Derby Division wanted the ARM to recommend that doctors retained responsibility for medical indemnity. Nevertheless, the motion offered the meeting an opportunity to debate a point of principle with great implications for the profession and the NHS.

Opening the debate, Dr Ralph Lawrence urged that "professional independence within the NHS must be preserved: members will sacrifice it at their peril." Health authorities might want doctors to be more accountable and to limit their clinical freedom.

From the good debate that followed let me select some comments that caught my ear.

"The motion is unsupportable in financial terms, particularly for junior doctors." (Dr H W K Fell.)

"There is a direct conflict of interest if things are left to health authorities, whereas defence organisations are concerned for their members." (Dr C M Squire.)

"Dr Lawrence's arguments have been valid until recently but the sheer size of the sums for recent settlements means that force majeure has operated." (Dr R H Davies.)

"The motion sounds very good until you realise that it will be slightly more than one month of my salary as a junior doctor to pay my defence subscription." (Dr M Tomson.)

"I would prefer doctors to retain responsibility for their own indemnity, coupled with an improved system of subscription reimbursement and . . . no fault compensation." (Dr J W Chisholm.)

"Members are not in an ideal world . . . it is not a question of selling out on principles but of sheer finance." (Dr P C Hawker.)

"If the motion is passed it will put an end to any idea of crown indemnity . . . please do not fragment the profession." (Mr J R A Chawner.)

"Negotiation of these ill thought out departmental proposals represents the best way out of a very bad job." (Dr A Mackenzie.)

The chairman of council echoed John Chawner's view in declaring that to pass the motion would mean the rejection of crown indemnity, and despite a final plea by Dr Lawrence to his audience not to sacrifice independence for short term financial gains the meeting rejected Derby's motion. So the representative body's policy is for the BMA to make the best deal it can on NHS indemnity despite its obvious drawbacks.

* * *

It was encouraging to hear some good news from the chairman of the occupational health committee, Dr W M Dixon, that recruitment to the specialty was healthy. He was impressed by the high standard of young doctors wanting to enter occupational health. He was not so impressed with the decision that there should be only one academic department for occupational health in Scotland and only one in England and Wales—nor was the leader writer in last week's *BMJ* (p 74). The Institute of Occupational Health at the London School of Hygiene and Tropical Medicine was to close. This, Dr Dixon said, had been one of the leading centres of occupational medicine, research, and teaching for the past 20 years. The universities of Manchester and Surrey would be encouraged to develop research in occupational medicine but without additional grants from the Universities Funding Council.

Doctors should be glad that Bill Dixon has been able to keep a watching brief on what is happening in Brussels on occupational health and safety. He had helped to write the social charter, which had included provision of good occupational health and safety services. (The charter, readers may recall, is unloved by the Prime Minister, who sees it as socialism by the "Brussels back door.") The 11 other European countries had a "touching but rather unreasonable faith in the value of the laying on of hands by registered medical practitioners" to detect the onset of future occupational disease. In the United Kingdom it was thought that environmental control in the workplace was far more likely to prevent occupational ill health and injury and that routine medical examinations never prevented anything.

Two sensible motions were then approved, both from the Junior Members Forum, always a fertile source of ideas. Dr D McBride proposed "That the strengthening of the occupational health system for NHS employees should form a priority for the NHS, irrespective of the future management arrangements of the service." The health of NHS employees had been neglected in the past, he said. They worked in a potentially hostile environment and he cited the toxic effects of working with drugs and anaesthetic gases, the control of infection, not only with HIV but also hepatitis B, tuberculosis, and food poisoning. These were some of the reasons why an occupational health service was needed.

Dr Judith Jones wanted "a structured health promotion package . . . developed for all health service employees, introduced at the time of employment." This, she suggested, could include major and routine medical examinations, counselling leaflets, and screening programmes. Such a programme would spread the message to families and friends. (Like the green revolution health promotion attracts supporters by the day. And there's no wrong in that.)

* * *

Then came one of those motions that provokes passion among a few and discomfort among many. The Junior Members Forum—which this year enjoyed an excellent meeting in Northern Ireland—had decided to ask the BMA "to end the practice of using forenames of women yet initials for men." I cannot speak for the BMA, but I confess that the *BMJ* is as much at fault as anyone, and we tend to slip from initials to full names for both sexes—and back again. Dr Gabriel Scally—sorry, Dr G Scally—accused the association of having regarded him as a woman for some years and then deciding that he was a man. (Computers frequently have sexual identity problems—ask any hospital doctor.) He—and we—were relieved that he had now been correctly sexed. Some speakers argued that everyone should use their full forename. Fortunately, we were assured by the treasurer that the proposal, which was carried, had no cost implications.

But I am still confused. Do we use initials or forenames for men and women or should I say women and men, and if forenames which one? Imagine Monday morning at the *BMJ* as the final pages go to press. Which forename, I cry, does Dr A B Macsmith use—I think it's the one who spoke in the debate on curried eggs? There's more than one A B Macsmith, replies the assistant editor. It must be the female Macsmith who works in Glasgow, I suggest. Ah, but the *Medical Directory* has two women Macsmiths with the initials AB in Glasgow, I'm brusquely told. Probably a computer duplication, I surmise, but you'd better ring both addresses and find out which forename our Dr A B Macsmith wants to use.

I just hope that this *BMJ* comes out on time, initials or no initials.

On Tuesday afternoon the ARM . . .

- Concluded that the government had shown its own shortsightedness by introducing charges for eye tests though this change contravened its own declared policy of preventative medicine

- Welcomed the retention of the free sight test for those over 40 with a relative with glaucoma and encouraged the government to restore the provision of a free sight test to all who might be at risk from glaucoma
- Congratulated the press and public affairs division for its energy and skill
- Opposed any attempt by the government to phase out student grants and benefits in favour of a system of loans, asking the council to urge the government to increase the student grant to its 1979 value in line with inflation
- Wanted applicants for medicine to receive more information on working hours and conditions of junior doctors and called for suitable leaflets written by junior doctors to be available in school career libraries
- Defeated a motion recommending that doctors should retain responsibility for their own medical indemnity
- Wanted the BMA to consider how best to maintain the provision of independent medical legal advice to doctors should NHS indemnity be introduced
- Resolved that the BMA should "take steps to declare itself an equal opportunity employer"
- Declared that the strengthening and expansion of the occupational health system for NHS employees should be a priority, irrespective of the future management arrangements of the service.

WEDNESDAY MORNING

The well attended dinner and dance in the Orangery at Margam Park had meant a late night on Tuesday for many representatives. The chairman of the representative body and the retiring secretary had both spoken—and spoken well, I'm told—at the dinner but there they were in their platform seats sharp at 9 00 am. Indeed, before that they had both been at the agenda committee, which met most mornings at around 8 00 am, to decide whether the agenda needed massaging and to deal with any procedural problems that had arisen the previous day or might arise on the day's agenda.

Trying out a computer

Like much of the organisation of a well run meeting, and the BMA's annual meeting is well run, the agenda committee gets on with its often difficult job largely behind the scenes. Many staff are also required to keep proceedings going smoothly. The staff who courteously help representatives at the reception desk—and you'd be surprised at the questions they get asked—are just the public face of the 30 or more who in the BMA's office and press rooms, at the association's various stands, on the platform, and in the publication offices beaver away to ensure that at least logistically the meeting is a success. (Its political and social success is in the hands of the representatives.)

I have already commended the essential contribution of the local doctors and their spouses and they will know first hand of the extensive planning and organisation done by Jill Draper, the BMA's full time meetings officer based in Tavistock Square. She and her assistant, Becky Meloy, advise the council's annual meetings committee, and their collective efforts start the moment a venue has been suggested for an annual meeting, usually at least three years ahead. For example, planning for the 1991 Inverness meeting is well in hand and next year's ARM in Bournemouth—when the *BMJ* will be celebrating its 150th anniversary—is a long way down the planning road, with representatives from the Bournemouth Division attending Swansea to see how it is all done, just as the Swansea organisers visited Norwich last year. We all tend to take the week's activities as a matter of course; the fact that we can do so is because so many staff and local doctors ensure a seamless occasion. Thank you, all of you who helped put the Swansea meeting on the road and kept it there.

* * *

At last we can glimpse the end of a long and tortuous tunnel. The representative body has welcomed the report of the BMA's child health working party. The saga of the future of child health services goes back a long way. Two years ago the meeting endorsed the principles and strategy of the child health forum report. A working party was set up, again under the chairmanship of Dr George Duncan, to promote detailed negotiations towards implementation of the forum's recommendations. The working party reported at the end of 1988 (14 January, p 124) with several recommendations covering a possible staffing structure for the future of community child health services, a possible method of review of existing senior posts in community child health, opportunities for appropriate training, and documentation.

That report has been the subject of widespread consultation among the crafts and Dr Joan Black (West Berkshire) urged the BMA to press for the proposals' early implementation.

But one issue needed to be clarified, the chairman of the HJSC pointed out. Dr Graeme McDonald wanted to add the words "with the proviso that secondary community child health care will be principally a consultant based service with training grade numbers in proportion to expected future consultant vacancies." Juniors are always concerned about manpower and their committee has been worried that doctors going into child health might be pushed into a second rate career structure.

At last, Dr Lindsey Davies pointed out, there was an agreement that made real sense—sense to the children, sense

to the service, and sense to the doctors working in it. Dr Davies, who chairs the negotiating committee for doctors in community medicine and health, described as robust the plan that had emerged. It provided for preschool surveillance to be undertaken principally by general practitioners and provided for a consultant led service with a proper career structure and training grades.

Dr McDonald's words were added to the motion calling for implementation, which Dr Davies hoped could be achieved within a year.

* * *

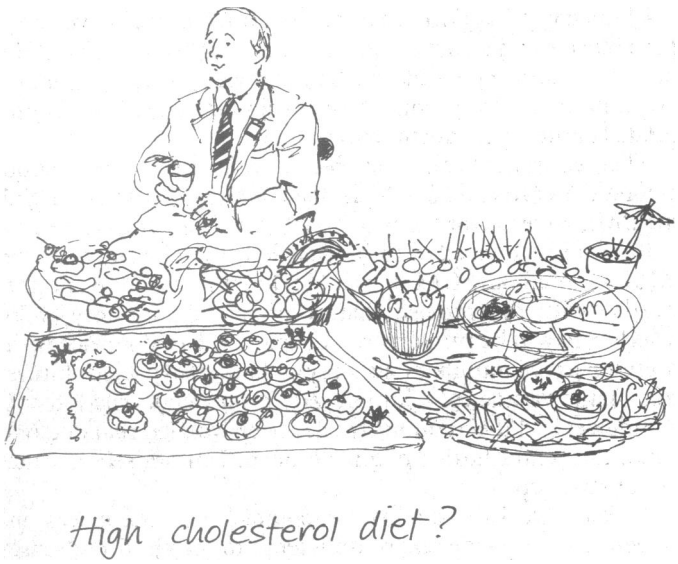
If any chairman had to face a motion of no confidence I would lay my bet on John Chawner giving a robust account of himself.

Ayrshire and Arran Local Medical Committee, in the shape of Dr J D Watts, a frequent occupant of the speaker's rostrum, proposed that the meeting had "no confidence in the private practice and professional fees committee." His reasons for this assault were the committee's "failure to grasp the implications of the Access to Medical Reports Act and its failure to obtain realistic fees for work carried out for life assurance companies by general practitioners." Dr Watts regretted having to move the motion—representatives never liked doing that sort of thing—but it was inexcusable, he said, to have failed to produce guidelines about the implications of the act. Furthermore, a fee of £16 was totally inadequate to extract records for insurance purposes.

He was supported by Dr D E Pickersgill, who said that the GMSC had had to prepare guidance at the eleventh hour after the act had come into force. If the private practice committee could not deal with a relatively straightforward matter members could have no confidence in its ability to act for them in other matters.

Cutting words but a member of the private practice committee, Dr Lionel Kopelowitz, pointed out that if any doctor thought that the fee for the work was inadequate he always had the right to approach the insurance company directly for an increased fee.

The argument waged, with the occupational health committee's chairman, Dr W M Dixon, sympathising with the private practice committee. The act had been badly worded and almost impossible to interpret. His committee had sent out advice but it had already been revised and the lawyers had advised waiting before issuing further advice until there was some case law available. John Chawner didn't like the criticism. But he pointed out that three sets of guidance had already been issued by other committees and his committee had been consulted by the GMSC. He accepted the criticism that the level of the fee might be incorrect but he thought there would be a profound effect on all negotiations if there was a vote of censure every time a committee failed to achieve what someone considered to be the correct fee.



Having repelled the censuring division, John Chawner announced that he would not be standing for the chairmanship again—he had done the job for seven years and had enjoyed it immensely. He was warmly thanked for this hard and, as we saw, sometimes thankless task. Politics is a rough game, but the representative body can be as generous as it can be critical.

In his opening remarks he had reported that the promised schedule of recommended fees for private consultant work would soon be available. This contained no less than 1400 recommendations, had been the subject of detailed consultation with specialist groups, and had been described as the longest suicide note in history. John Chawner emphasised, though, that the fees were recommendations only.

There had been successful negotiations with the Home Office on part time prison medical officers' remuneration; and all three provident associations had agreed to pay a fee for medical reports on prospective subscribers.

* * *

In my early experiences of the BMA I recall ethics as a somewhat subfusc subject, dealing with doctors' name plates and poaching patients, that was tucked away on the agenda at a time when the meeting might dip perilously close to its quorum. Nowadays it is perilously close to being a razmatazz subject with the agenda items split on two days so that media reporters on their toes for a story may have two bites at the ethical cherry. This year intimate body searches and advertising generated the copy.

But first to the chairman's report. Dr Sandy Macara put down his chairman's gavel, invited consultant paediatrician James Appleyard—elected (from four candidates) on Monday as his deputy—to take his place, and moved to the end of the platform to present his final report as chairman of the ethics committee. It had been a year of frustrations, he said, with the committee having to cope with the unwelcome report from the Monopolies and Mergers Commission on doctors' advertising, the NHS review, and the implementation of the Data Protection Act. His committee had condemned the NHS review's proposals "as replacing the sacred ethic of care with a secular, if not profane, ethic of cash." That is as good a one sentence critique as I have read of Kenneth Clarke's "reform."

The chairman concluded by warning that doctors were facing "cynical, sedulous, and calculated assaults" on their professional integrity. The profession could not command success but doctors could and should uphold their honour and keep the trust of their patients and the public they served.

* * *

Dr Macara, who speaks with the fervour of a Scottish evangelist leavened by touches of self deprecating wit, is a hard act to follow, but Dr V Leach from the Dukeries held the conference's attention with his plea to the council to follow up the BMA's 1985 report on torture. "The appearance of arrested Chinese students and the reports from Kate Adie [the BBC's reporter in Beijing during the student protests] of patients being removed from hospital, drips being torn down, and the courage of the doctors giving evidence bore witness to the fact that torture had not finished with the Third Reich." He spoke of increasing evidence of torture, hoping that a second report would help to clarify the position of doctors

involved directly or indirectly, voluntarily or compulsorily, in torture. What, he asked, was the position of doctors in relation to judicial punishment? A horrible dilemma indeed for them.

Several speakers supported the motion, including Dr Macara, who referred to increasing evidence of patients being abducted and assassinated, of army personnel interfering in treatment, and of harassment of the seriously and terminally ill. This public catalogue of horror must have persuaded the most doubting Thomases in the hall that a study of torture was a proper activity for the BMA, and the meeting voted unanimously for the motion. I am confident that the BMA's second report on torture will receive as much international acclaim as its first one.

* * *

Adopting the policy that no doctor should take part in an intimate body search without the subject's consent—despite the warning from a police surgeon that it would be a charter for terrorists and junkies—the representatives moved on to discuss the use of healthy volunteers in testing drugs. The meeting referred to the council a call to implement in full the Medicine Commission's four part protocol on drug testing in healthy volunteers. So far the government had accepted only one recommendation: that healthy volunteer testing was not obligatory before a drug was approved for use. Most speakers condemned this response as inadequate.

With one eye, no doubt, on Kenneth Clarke's competitive contract and its proposal to link (some) pay to annual examination of patients Dr M J F Crowe from Leicestershire and Rutland wanted the government to accept the right of the individual to decline medical advice in "investigation and treatment." With speakers divided—Dr W P Sanderson wanted the government to respect patients' rights, Mr K O'Keefe warned that the motion created uncertainty—the conference chose the easy route and sent the proposal to the council as a reference. No doubt the ethics committee will bring an opinion forward to next year's meeting in Bournemouth.

* * *

After the ARM had passed the priority motion that "no medical practitioner should take part in an intimate body search of a subject without that subject's consent" the press wanted to know whether this meant that the BMA was hindering the work of the police. Not at all, replied Sandy Macara, speaking as chairman of the medical ethics committee. The motion merely reaffirmed the association's policy that unless there were overriding circumstances no one should be searched without his or her consent. If there were exceptional circumstances they would have to be justified. He couldn't agree with those who said that it was a junkie's charter. Surely, asked one of the journalists, the GMC was unlikely to take a doctor to task for doing something for which under the Police and Criminal Evidence Act he had legal immunity? The point was, Dr Michael Wilson explained, anyone—even a doctor or a journalist—could be detained at any time and this guidance from the BMA was to protect the individual.

* * *

In contrast to recent years the number of agenda items on AIDS was small and only one was debated, and that in an emotional background far less highly charged than were the debates of 1987 and 1988. The motion read "That AIDS and HIV seropositivity be notifiable. . . ." Dr B T A Potter, whose small practice in Edinburgh has 10 HIV positive patients, said that the intention was to identify the patients and their present

requirements and to forecast their future requirements. A community physician, Dr J S Dodge, opposed the proposal because notification was justified only if it facilitated the treatment of the patient and provided information to make control of the disease in the longer term easier. From Sheffield Dr M C Hayes-Allen also opposed, arguing that notification would be counterproductive and would drive victims underground.

Though sympathetic to the motion's supporters, who, he said, spoke from their hearts, the chairman of council pointed out that there was already an informal notification procedure to the chief medical officer. The proposal was lost.

* * *

How many times has Michael Wilson taken the rostrum to talk about the proposed new contract for general practitioners—now out to ballot with the result due later this month? I don't know and I expect he has long stopped counting. On Wednesday morning he summarised for the representative meeting the history of the contract, the 110 hours of negotiations, the special conference of local medical committees, and the annual conference—which had rejected the commended package. He emphasised, as he has done many times, that "nowhere in the agreement reached on 4 May, said or unsaid, was there any precondition that, should the profession fail to accept the package, the profession's negotiators, one or all, should resign." But, whatever the result of the ballot, "we back that decision and support those who have the responsibility for taking it forward." But Dr Wilson's clearest message was to colleagues in other disciplines—"any agreement we may or may not reach in our contractual discussions will in no way diminish our opposition to those proposals in the NHS review which we believe will damage patient care nor our determination to ensure that our patients, the public, are made aware of our concerns for their National Health Service." This, needless to say, brought appreciative applause.

The general practitioners' major debating forum is their annual conference but the ARM has slots for all the crafts. So in the general practice section the meeting criticised the government for not agreeing to pilot the proposals in the NHS

review, refused a suggestion that a qualified accountant should join the GMSC negotiators when they met the department on financial matters, called for academic departments of general practice to be protected against the "damaging effects of the proposed new contract," and opposed the idea of zoning for hospital referrals. This last subject always causes anxiety and anger and the motion had the wholehearted support of the consultants' leader, Paddy Ross, who said that a general practitioner must have a right to refer a patient to the consultant who was most appropriate for that particular patient.

* * *

"It is astonishing with how little reading a doctor can practise medicine, but it is astonishing how badly he may do it." With this quotation from Osler the chairman of the journal committee encouraged representatives to support the *BMJ* publications. There are 13 special journals, some of which the association owns and some of which it part owns. The *BMJ* has recently agreed to buy a half share in the *Journal of Medical Ethics*, which Dr R A Keable-Elliott told the meeting would make an important contribution to the scientific range of the journals as well as to overall profits. The books division had gone from strength to strength, with profits in 1988 of £44 000.

I don't know if everyone realises that the *BMJ*, which has the third largest circulation of any general medical journal in the English speaking world, is distributed free to all BMA members—80 000 copies. That costs £5m a year and the welcome increase in membership in the past few months has cost the journal group a further £200 000. Despite this responsibility there was an overall trading profit in 1988, before tax, of £750 000.

With this welcome news the chairman ended his report with some kind words for the staff, commenting on its "clear, concise, and informative" reporting. I shall make no further comment.

One problem facing the production department for many months has been complaints about the late delivery of the *BMJ* and this was the subject of a motion from Liverpool, which was carried. This is all the fault of the Post Office, Tony Keable-Elliott explained, and he was as distressed as anyone else that not all members received their journals before the weekend. The publishing department will, I know, redouble its efforts to persuade the Post Office to provide the first class delivery service that it is contracted to do. The *BMJ*, is, after all, one of its largest weekly contracts.

* * *

The politics ended at 12 30 pm and representatives left to a choice of afternoon activities. The customary scientific seminar was held, this year at the University College of Swansea, where we had a good attendance despite the counter-attractions of a fine afternoon—a report on it will appear in a future issue; the traditional cricket match (sponsored by *BMA News Review*) between the senior and junior hospital doctors—the latter won the trophy presented by Paddy Ross; and the golf competition. No doubt everyone was glad of a break after the pressure of many hours plugged into conference medicopolitics. I know that I was.

On Wednesday morning the ARM . . .

- Welcomed the report of the child health working party and urged the BMA to press for the early implementation of its proposals, with the proviso that secondary community child health care would be principally a consultant based service with training grade numbers matched to expected future consultant vacancies
- Asked the council to set up a working party to examine the continuing reports of doctors abusing their medical skills in relation to prisoners
- Believed that no medical practitioner should take part in an intimate body search of a person without that person's consent
- Applauded the government's plan to have pilot studies of junior hospital doctors' hours but wondered why such a sensible concept was not thought applicable to the proposed revolutionary changes in general practice
- Believed that the changes in the ozone layer required the government to act more promptly and more substantially than it had done so far
- Resolved that improved medical audit required increased resources of time and money; should remain under the leadership of doctors practising clinical medicine; and should not be used to force medical staff to process more patients to the detriment of patient care
- Declared that it was the responsibility of the Department of Health (*a*) to implement its guidelines regarding threatening and abusive patients and how to deal with them; (*b*) to encourage the reporting of all episodes of physical abuse to NHS staff; (*c*) to ensure that there was adequate security in hospitals; and (*d*) to ensure that compensation was paid to NHS staff who were assaulted at work.

* * *

The formal pinnacle in the BMA's calendar is the installation of the new president and the presidential address—at the ceremony called rather enigmatically the adjourned annual general meeting. At noon on the Wednesday the annual representative meeting adjourns and converts itself into the annual general meeting. This year was the 157th and the meeting duly approved the minutes of the 1988 meeting, approved the balance sheet and expenditure account for the year ending 31 December 1988, reappointed the auditors for a further year (at a fee to be agreed by the council), and approved the revised articles of association. This all passed smoothly despite some platform rumours that an attempt might be made to reopen Monday's debate on the constitution because the rules required a 95% majority for the approval of last minute proposals and the revised memorandum and articles fell into this category.

* * *

The meeting then adjourned its business until 8 30 pm, when we gathered in evening dress and academic robes in the refectory of the University College of Swansea. Even conference satiated hacks like me find the ceremonial impressive, with the colourful mayoral, university, and BMA processions making their way to the platform. Sir David Innes Williams installed Professor J B L Howell with the president's badge of office for 1989-90. Professor Howell is professor of medicine in the University of Southampton but he was born in Swansea before he had to "go abroad to England" to study and practise. His inaugural address is summarised at p 207.

Before his thoughtful address his wife had received the lady's badge from Lady Innes Williams, and he had presented the Gold Medal of the BMA to Sir Douglas Black, and the vice president's badge to Dr H F K Li, received delegates from kindred associations and representatives from overseas branches, fellows of the BMA, and the recipient of the certificate of commendation, Mr H B Watson (Solihull).

The citation to Sir Douglas Black was the longest I can recall. In his distinguished career he has been professor of medicine at Manchester, chief scientist to the Department of Health, and president of the Royal College of Physicians, of the BMA, and of the Medical Protection Society. He is fellow of

five royal colleges. For three years he was chairman of the BMA's board of science and education and his citation refers to his "dry wit, scholarly precision, and considerable literary skills."

The formal business completed, we moved out to enjoy our wine and strawberries and cream before the coaches took us back to our hotels or halls of residence. Normally at this stage of an annual meeting there is only one more half day to go. This year we had another day and a half to look forward to. No wonder some representatives and staff were beginning to look a touch frazzled at the edges.

THURSDAY MORNING

Thursday's (revised) agenda covered the whole spectrum of the BMA's activities, starting at 9 00 am with science—the *British National Formulary*—and moving on through superannuation, the Celtic reports, women doctors, drug abuse, and the craft committees and concluding at 6 00 pm with a motion (referred to the council) declaring that if the government did not provide adequate funds it, not doctors, should decide which services were too expensive to provide. I try to give readers an accurate impression, not just of the debates and decisions of the meeting, but of the atmosphere, too. Selecting items from such a kaleidoscope of motions, speeches, and activities over five days is a task which, however performed, is bound to please some and displease others. To those many proposers of motions and speakers who failed to make these pages I apologise. It in no way reflects the quality of their contribution: it is just that 35 hours of talking, plus several hours of socialising, do not fit easily into 20 or so pages—even though the excellent sketches by Yvonne Fuller tell you more than an equivalent acreage of prose.

The meeting had no dramatic peaks though two events raised the political temperature close to the high summer temperature in the hall. These were John Marks's rallying call on the NHS review and the meeting's angry reaction to a blunt speech by Russell Hopkins during the special representative meeting, in which, on behalf of the Welsh consultants' committee, he criticised the propaganda campaign by the BMA as alarming patients. (His comments were later picked up by a conservative MP in the House of Commons.) Despite the lack of drama or of "front page copy" decisions—press coverage was generally confined to the inside pages this year—there were many good practical debates which gave this observer a real feel for what is happening daily in surgeries, wards, and outpatients throughout the country. That is one aspect of these meetings that I cherish.

The *British National Formulary* is a bestseller that achieves this status with the minimum of fuss and advertising. The formulary also makes its joint publishers, the BMA and the Royal Pharmaceutical Society, a useful income. Dr G M Mitchell (until recently senior lecturer in pharmacology in Cardiff and a member of the *BNF*'s board) reported on its continuing success with two editions—over 320 000 copies altogether—published since the last ARM. This steady success story has attracted the attention of other countries, and the joint committee of the two professional organisations has set up a scheme for senior staff from developing countries to spend some time in Britain learning how the *BNF* is produced. An excellent idea, which I'm sure will benefit doctors abroad as much as the formulary itself benefits doctors here.

* * *

Dr Mitchell was followed on to the platform by another Welshman, Mr W I Jones, chairman of the Welsh council, who delivered an account of his third and final year in the office. He made a point that I know many representatives will have sympathised with—the increased demand put on elected committee officers not only in attending BMA meetings but in

The Guildhall, Swansea

serving on many other committees as a result. This affected the clinical service in the districts, and an approach to the Welsh Office has exacted a promise "to consider" the provision of locum cover in cases of special need. As I have said before one of the downside consequences of a reformed NHS in which doctors' activities may be more closely monitored could be an increased unwillingness among them to give up their time to committee work.

The BMA in Wales, Mr Jones reported, had spent much time on the NHS review and the views submitted to the Welsh Office showed "no major deviation" from those expressed in London. I was glad to learn that there had been no coercion of any hospital unit or authority to volunteer for self governing status. This probably reflected, said Mr Jones, the "thinking in the Welsh Office." Referring to the NHS having played a major part in the Vale of Glamorgan by election and to "excesses of medical verbiage," he "shuddered" at the thought that the health service would be such a political football at the next election. No doubt events at the by election contributed to the disquiet about the BMA's national campaign expressed on Tuesday on behalf of Welsh consultants. Mr Jones emphasised the Welsh council's aim to produce a better NHS without indulging in party politics. Having made that clear, he praised the chairman of council for his "superbly balanced" speech at the SRM and for targeting the way ahead.

After Mr Jones had spoken the chairman of council intervened to emphasise that the BMA was not a party political organisation and had played no part in the Vale of Glamorgan by election. Any member could stand for any office in a democracy and if a doctor candidate believed that the NHS was a vital issue and campaigned on it he or she should be allowed to do so. Health was a political football whether the BMA liked it or not, warned Dr Marks. What mattered to the association was the health service.

* * *

Superannuation did not seem quite the same without Benny Alexander, but Dr David Williams, who delivered the report from the committee, is a seasoned medicopolitician and no slouch on the fine print of the pensions regulations. I will, however, avoid the fine print, reporting only on the BMA's continued legal action on behalf of the right of doctors in Northern Ireland to buy added years—health boards there had failed to notify doctors of these rights—and the government's refusal to use quinquennial surplus in the NHS pension fund to improve employees' benefits. Needless to say, the BMA takes a dim view of that decision.

* * *

Next came women doctors. In fact women doctors are, I'm glad to report, becoming increasingly prominent in medicopolitics. So much so that their appearance on the rostrum is a normal part of the proceedings. And if I dare to say that, young or mature, they made some excellent contributions to debates I shall probably be hounded off the page as a sexist. An encouraging feature of the conference was the number of young medicopoliticians coming on; on this week's evidence the BMA need have no fear for its future. A continuing disappointment, however, is that the proportion of overseas trained doctors attending meetings is still much lower than the proportion in practice in this country. I would welcome more of them: they have much to contribute.

But back to women or, more exactly, their career progress as reported by Dr Fleur Fisher, member of the CCCMCH and the council and chairman of the working party on the subject. After touching on Isobel Allen's report of 1988 on women's career prospects, she listed five major factors that the working party had identified as limiting women's prospects:

- The long working hours of junior doctors
- Lack of flexibility in the career structure
- Lack of part time training
- Inadequate provision for maternity leave
- Poor child care facilities.

She highlighted a disturbing finding in Isobel Allen's report, since confirmed by another survey, that around half of the men and women who had recently graduated would not recommend medicine as a career.

Dr Anne McConville from the CCCMCH moved on behalf of the Junior Members Forum that the BMA and the colleges should "address the structural barriers to the career progress of women doctors." She declared that women doctors' commitment to practice was evident by them continuing to work despite "the adversity of the present system." The deputy chairman of the Scottish GMSC, Dr E M Armstrong, supporting the motion, drew attention to the president's address, in which he had spoken of the need to manage resources wisely. "There is no more valuable resource in patient care than the wealth of talent issuing from the medical schools, half of whom are women. Sadly, the profession's record in managing that resource is woeful," Dr Armstrong declared. Though I'm sure she sympathised with the aim, Anne Grüneberg, a consultant anaesthetist, was unhappy about the means. She wanted the BMA to focus its attention on its own working party, but with support from Dr Laurie Allan and Miss Connie Fozzard the motion was carried overwhelmingly. Now comes the diplomatic task of taking the colleges along the same path.

* * *

From an unhappy intraprofessional problem we turned next to an unhappy national problem: the consequences for patients of the precipitate rundown of mental handicap and mental illness hospitals and the inadequate provision of community services. This problem was brought forward by the Nottingham Division, which wanted the government to halt the closure programme until adequate community facilities were provided. I'm right behind Nottingham on that proposal.

What had started as a well intentioned move to bring the mental health service into the twentieth century had been hijacked by those who saw the savings to be made from closing large Victorian asylums, declared Dr M J Harris, the mover.

General practitioner Dr P M J Bennett condemned as a national scandal the fate of those discharged into inadequate community care. He appealed to the BMA to take the lead in using the word "asylum" in its decent sense of meaning warmth, shelter, and care. Dr C P Stewart from Dundee, whose poetic McGonagall motion at Norwich prompted BMA headquarters to provide facilities for wheelchair users, described the mentally handicapped as the silent majority, cared for by the NHS's unsung but dedicated staff working in shabby hospitals.

Dr Colin Berry, who had opened the session on mental health, warned the meeting not to send the wrong message. What was wanted was an acceleration of the community programme. (Perhaps some progress might result from the soon to be announced response by the government to Sir Roy Griffiths's year old report on community care. On the other hand, if progress costs money, it might not.)

Refusing to send the motion to council as a reference,

representatives approved it overwhelmingly, providing convincing evidence of their opinion of this national scandal.

* * *

Sir Christopher Booth returned to the platform for the second session on the BMA's scientific activities. The meeting had a crack at the government over its failure to increase taxes on tobacco and alcohol. Did you know that in 1610 King James I raised tobacco duty by 4000% and thus sharply cut its consumption? Chancellor Lawson should not only take that history lesson to heart but take out alcohol and tobacco from the retail price index, an overdue move forcefully argued by Dr G (for Gabriel) Scally. It was, he suggested, the government's fear of inflation that had stopped the taxes being raised.

A non-controversial call to train students in the safe disposal of all "sharps" was approved and followed by a proposal to set up safe places for drink and drug abusers. Neither police stations nor hospitals were suitable places to cope with these people, said the speaker. It took little time for the conference to support the proposal, which I see as long overdue.

* * *

Given the venue of the meeting, I was determined to give space to Wales. In two years' time the BMA will be in Inverness, where I'm sure the *BMJ* will ensure space for Scotland's problems. Meanwhile, I will risk the wrath of the Scots and simply report that Dr Angus Ford, chairman of the Scottish council, gave an excellent account of events during his second year in office.

Do I give Northern Ireland the Welsh paragraph treatment or the Scottish sentence? I'll make an English compromise and report that the chairman of the Northern Ireland council, Mr J A Halliday, told us of efforts in Northern Ireland to improve manpower controls—a later motion (approved) called for similar regional manpower committees to those in place on the mainland. The BMA is also trying to resolve with the Northern Ireland Office the imbalance between too many vocational trainees and too few vacancies for principals in general practice. I cannot resist reporting, too, Mr Halliday's words, "Many of you will be aware of reading from the *BMJ* that the BMA brought four test cases . . . on doctors' rights to purchase added years," a subject I mentioned in the superannuation section. A judge found that the fact that health boards failed to tell doctors of their rights was correct but that there was—unfortunately for them—no legal requirement on the boards to do so. The BMA is helping doctors to appeal.

* * *

The story from the next platform report was gloomy. Morale among civil service medical officers is going down the chute. Dr C J Bolt, chairman of the group committee, reported that the government had imposed the integration of doctors into a unified grading structure, a move that had adversely affected remuneration, provoked resentment, and would hamper recruitment. I sympathise with Dr Bolt and his colleagues; unfortunately, this government seems determined to run the country with as few experts as possible and that includes doctors. The Scottish council warned that the professional standing of doctors in Scotland's Home and Health Department was under threat. That threat is universal.

One serious consequence of all this is a crisis in the prison medical service—a service described as under pressure some years ago in a series of *BMJ* articles by Richard Smith—and a subsequent motion, well argued by Dr A L Hodgson from the City and Hackney Division, asked the council urgently to

consider "the function of and the incentives to improve the staffing of the prison medical service." Despite a plea from Dr H E Godfrey from the local medical committee conference that the prison medical service was already the most monitored, most audited medical service in the country—prisoners' relatives, prison visitors, MPs, the Home Office, and the courts were all in on the act—the meeting supported Dr Hodgson. Another inquiry for the council to launch.

* * *

A short professional step and we were listening to John Chawner urging the General Medical Council to require medical schools to include training for forensic medicine in their syllabuses. Two recent official reports had called for improvements. Too often, he said, forensic medicine was seen in medical schools as "one or two juicy lectures given by the local flamboyant forensic pathologist." That was certainly the case in my medical school but that was some while ago and I had assumed that teaching had improved since then. Obviously not, yet with the crime rate rising there is an indisputable argument for a sufficient number of doctors properly trained in forensic medicine. The meeting agreed.

On Thursday morning the ARM . . .

- Resolved that if the superannuation scheme was so well managed that a major reduction in contributions was required benefits should accrue to employees
- Called on the government to compensate any doctor infected with HIV according to established guidelines for employment related disorders
- Declared that the BMA and the royal colleges and their faculties should "take action to address the structural barriers" to the career progress of women doctors described in Isobel Allen's report *Doctors and their Careers*
- Was disturbed at the distress to individuals and families resulting from the precipitate rundown of mental handicap and mental illness hospitals and the inadequate provision of community services and called on the government to halt its closure programme until there were adequate and appropriate facilities in the community
- Called on the council (in a referred motion) to study the problem

of assaults on health service staff and who was best able to give early, practical advice to victims

- Believed that the government's failure to increase tax on tobacco and alcohol showed its lack of commitment to the promotion of good health
- Called for the establishment of appropriate places of safety for police detainees who were victims of alcohol or drug abuse and whose condition rendered police custody unsuitable and referral to hospital inappropriate
- Requested the DHSS in Northern Ireland to establish a regional manpower committee on the lines of that recommended in *Achieving a Balance* in the remainder of the United Kingdom
- Asked the council to consider the functions of and the incentives needed to improve the staffing of the prison medical service.

THURSDAY AFTERNOON

"A year that has seen the good, the bad, and the ugly." Thus did Dr Colin Smith judge the session from his viewpoint as chairman of the Medical Academic Staff Committee. The good had been the (eventual) full pay award for clinical academic staff. The bad had been the pay settlement for the non-clinical staff, who were now being paid a scandalous £15 000 less than their clinical colleagues. The ugly had been the white paper, from which it was clear, he said, that the government did not know the effect that the changes would have on medical education. Furthermore, he foresaw the teaching voice being "exceedingly small" in self governing hospitals. NHS cuts had already seriously jeopardised medical education. What would happen in a self governing hospital service, Dr Smith asked.

Motions calling for better careers advice, management training for junior doctors, and health promotion to be a mandatory part of the medical curriculum were effortlessly approved (the last as a reference) before Paddy Ross took Colin Smith's place to move that "the annual report of council under senior hospital staff be received." That was the constitutional starting gun for this section. (It is the same procedure for each chairman but it would be tedious to repeat it.)

Paddy Ross was pleased to report a rise in BMA consultant membership from under 60% of his craft in 1984 to 75% today, which meant 12 000 consultants were now members. He was quickly into the white paper and with no disrespect to him I won't go into detail as his comments, as critical as ever, were in line with those he made at the consultants' committee and the senior hospital staffs conference, meetings which have already been reported. Suffice it to say his committee does not like the proposals in *Working for Patients*—though agreeing with the aims—and is especially worried at the prospect of self governing hospitals, on which it (now working under the new title Central Consultants and Specialists Committee) produced an excellent guide (17 June, p 1650).

The major craft committees deal with their business at their conferences, which explains why their sections at the annual meeting carry so few motions. Discussed under the senior hospital staff heading were a call for full funding of the staff changes following *Achieving a Balance*—passed nem con; a passionate plea from Barking, Havering and Brentwood for the BMA to act vigorously on previous ARM decisions to prevent North East Thames Regional Health Authority from implementing its "questionable policy of doctorless blood donor sessions"—this was turned down after Mr Ross reported that the BMA had acted but that there was no evidence of any mishaps; and from Mary White (council and Worcestershire) a (successful) call for a clear commitment by the government to centrally agreed manpower policies.

* * *

Dr Eileen Wain, a community physician in Yorkshire, is the first woman to chair a major craft committee and she does so with a quiet efficiency that is an example to any aspiring chairperson. She presented the report from the Central Committee for Community Medicine and Community Health. As at her craft conference she spoke on the Acheson report, which identified the public health responsibilities of health authorities "not," she told us, "in any narrow sense of drains, bugs, sneezes, and diseases but of all those areas which affect the health of the public."

As for the white paper, community physicians were in a no win position, she claimed. If they expressed concern about the care of the disadvantaged sections of society it was interpreted as a "fictitious description of the likely effects." If they kept silent there would be the accusation of "you never told us" if problems developed. She saw the public health responsibilities of health authorities becoming difficult in a market oriented NHS, and who would disagree with her? Dr Wain concluded by paying tribute to the support her craft had received from other crafts.

* * *

What was an attack on water privatisation doing on the agenda of a non-political organisation? Dr G Scally told us in articulate Northern Irish English (surprising how many Celts use the English language better than the English.) It was the health factor not the political factor that worried him and this government blatantly ignored legitimate health concerns. The Department of the Environment presided over a "let them drink Perrier philosophy." Water quality had to be improved.

A fellow Irishman, Dr T McKinstry, opposing the motion, said that the talk of disasters (by previous speakers) in the nationalised industry had persuaded him that privatisation was the way forward. The meeting disagreed with him and decided to view with concern "the potential health effects" if privatisation of the water supply went ahead.

The community medicine conference had wanted a ministry of food separate from the present conglomerate Ministry of Agriculture, Fisheries and Food and the ARM willingly followed the craft down this path, with part time sheep farmer Stuart Horner, one of Eileen Wain's predecessors in the craft committee's chair, declaring that the priority given by the ministry to consumers was epitomised by the order of words in the title: food, like the consumer, came last. Ironic, isn't it, for a government that so constantly claims to place the consumer at the centre of its philosophy?

* * *

The hours worked by junior doctors has competed with the white paper for the priority medicopolitical subject of the session among young doctors. Dr Graeme McDonald reported that the HJSC, which he chairs, had changed its policy on hours of work and was now pressing for legislation to restrict hours, and one of the motions in this section was a call for support for such statutory limitation. Juniors' hours had become a public issue, said Dr Jeremy Wight, deputy chairman of the HJSC, and it was "a dreadful indictment of my craft that long hours have been allowed to persist and of the BMA as a trade union that it has been unable to sort out the problem."

Jim Johnson, a former chairman of the HJSC and now a

consultant surgeon on the CCSC, sounded a note of caution, however, arguing that the motion fell into the trap of confusing hours worked on call with hours contracted. Employing authorities would be delighted with a legal limit. "Whatever our strong minded friends down here think, they and I know that there are thousands of juniors who will continue to work excessive hours until sanctions are brought to bear on those who are putting pressure on them to do so."

Another former chairman, Dr Peter Hawker, also now a member of the consultants' committee, declared that though he was still concerned about ministers imposing terms and conditions of service times had changed and so had his views.

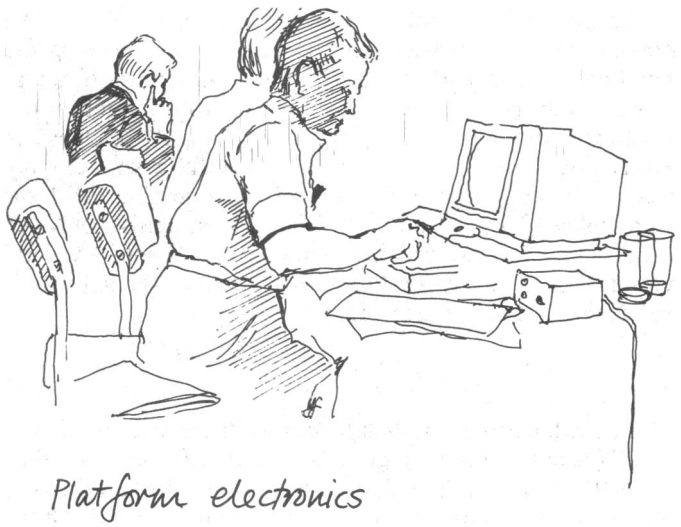
Dr Sam Everington of the HJSC, who had initiated some of the telling publicity on juniors' hours of work, said that pilots and lorry drivers had their working hours limited, adding that the Red Cross had said that if prisoners were kept awake for 24 hours that would constitute torture under the Geneva Convention. Ergo, juniors were being tortured.

Graeme McDonald told the conference that David Mellor, the health minister dealing with this problem, had explained why the government had killed off the private member's bill to restrict hours. It had contained no sanctions; to be effective any bill had to have sanctions so that health authorities could not break the law. Dr McDonald said that by October the results of the pilot studies now being done would be available. That gave the BMA time to plan some legislation for the next session.

The chairman of council summed up the arguments for and against, saying that the council had no policy of any legal restriction of hours of work and it was up to the ARM to decide one. Representatives did and approved the motion. Now comes the hard part, converting policy into law.

* * *

The rest of the afternoon contained a wealth of short but informative debates and even included "a suspension of standing orders," a—sparingly used this year—procedural device to allow debate on an urgent matter. Dr Eileen Wain persuaded the meeting to support a motion deploring the practice of health authorities advertising posts that contravened nationally agreed terms of service. She asked the council to take urgent action. Though the problems she referred to had arisen among community health posts she warned that whereas some health authorities had withdrawn proposals after discussions others had not, adopting a macho attitude. This had implications for all NHS doctors, she warned.



We heard from a relatively young group committee, the pharmaceutical physicians, in whose section Dr John Callander, chairman of the local medical committee conference, successfully moved a proposal urging the government to take appropriate measures to ensure the quality of imported generic drugs.

Dr Angela Thomas, a young mother who sits on the HJSC and the council, persuaded the representative body to campaign for hospital crèche facilities for all hospital medical staff, while Dr Jeremy Wight—with the help of the meeting—added a rider asking for an investigation into the feasibility of having similar facilities at the ARM and the craft conferences.

The afternoon ended on NHS finance. And who would dare disagree with a motion calling for a properly tax funded NHS (at comparable OECD levels) without any major management reorganisation? No one did, but representatives had doubts on a motion from Dr M C Hayes-Allen of Sheffield, which diagnosed the basic problem of the NHS as underfunding but wanted funds diverted from the defence budget. It was the second part that unsettled people, and the solution to their disquiet was the traditional "pass to the next business," which was the motion mentioned in my opening paragraph seeking to put the onus on the government to decide which expensive services to provide. Caution prevailed here, too, with a reference to the council, and at 6 00 pm representatives downed agendas and left to decide on their financial priorities among the menus of the diverse local restaurants.

On Thursday afternoon the ARM . . .

- Urged undergraduate and postgraduate deans to provide careers advice to medical students and doctors in training
- Declared that doctors should be trained in the general principles of management at an early stage of their careers
- Urged the council to ensure that the Department of Health showed its commitment to *Achieving a Balance* by fully funding the changes in medical staffing
- Called for a clear commitment to centrally agreed manpower policies
- Viewed with concern the potential health effects of the forthcoming privatisation of the water supply industry
- Asked for the support of the profession in maintaining necessary family planning and related services in the community
- Requested the council to negotiate adequate provision of study leave with pay and expenses for all working principally in the hospital service
- Supported moves to reduce junior hospital doctors' hours of work
- Believed that there should be a statutory limitation on the hours which junior doctors were contracted to work
- Deplored the government's response to the long hours worked by junior doctors and called for immediate moves to a maximum 72 hour week
- Supported the legal action of Dr C Johnstone and Dr A Malik against Bloomsbury Health Authority on their hours of work as junior doctors
- Urged the government to take appropriate measures to ensure the quality of imported generic drugs
- Deplored the practice of some district health authorities in employing, or seeking to employ, doctors in career grade posts on limited tenure appointments in contravention of nationally agreed terms of service and requested the council to examine this issue as a matter of urgency and to take appropriate action.

FRIDAY MORNING

The agenda was changed so many times that I expect I was not alone in becoming confused. But it was decided in the end to continue the meeting until mid-morning on Friday. I wondered if there would be a quorum but at 9 00 am we were well above the danger level and we stayed there until the end at 10 45 am.

The ARM congratulated Tim Albert and his team on *BMA News Review* for the continuing high standard of the monthly magazine and for the daily papers that appear each day at the ARM. I have a suspicion that representatives have a quick peep to see if they have been snapped at one of the social events before they turn to the reports of the day's events, just as juniors are reported as scanning the *BMJ*'s obituaries for potential jobs before turning to the heavy stuff.

Whenever anyone mentions the European Community—speaking as if the United Kingdom had nothing to do with it—it is usually to talk about 1992 and all that. But as the chairman of the BMA's EEC committee, Dr A J Rowe, pointed out, so far as the medical profession was concerned there were no barriers to be lowered by 1992. The obstacles to free movement of doctors and their right of establishment in other member states had been established by the 1975 directives, and well I remember Ralf Dahrendorf's special meeting of EEC doctors to launch that initiative. Many matters being discussed in Brussels affect medicine and Dr Rowe referred to liability for defective products; the general practice directive, which comes into full effect in 1995; the possibility of a supranational licensing authority for drugs; and the social rights charter, which refers to the maximum duration of working time per week.

Did you know that Spain has the only association of unemployed doctors, with 34 000 members? Rows over *Achieving a Balance* pale into insignificance beside that figure. Dr Rowe hoped that representatives would support the Europe against Cancer programme, particularly the October action week.

* * *

Despite the Department of Health's undertaking to introduce a code governing the disclosure of confidential health information to third parties nothing has happened. Bristol expressed serious concern about this, and Dr Judith Langfield from the conference of representatives of local medical committees told the meeting that a conference convened by the council in May had asked for a statutory code.

Some speakers were concerned about the narrowness of the motion. Their concern is best explained by Dr Simon Jenkins's contribution. The Data Protection Act covered all automated personal information, not only health information. The profession wanted a code of confidentiality covering the whole range of personal health information, automated and non-automated, in the NHS. There had been a delay in trying to devise a code and attach it to the NHS Act 1977. If the motion referred to that act rather than to the Data Protection Act he would have been a lot happier, he said.

But the outgoing chairman of the medical ethics committee, alias the chairman of the meeting, who by chance comes from the Bristol Division, pointed out that the motion called for a statutory code to govern disclosure; it did not say the code should be under the Data Protection Act. The meeting accepted his explanation, and Bristol's motion expressing serious concern at the government's failure to introduce a statutory code to govern the disclosure of confidential health information under the Data Protection Act was carried.

Dr Langfield also sucessfully proposed another motion from Bristol. This called on the council to urge the Department of Health to issue fresh advice to health authorities concerning the composition and functions of local ethical research committees and to discuss proposals for a national ethical research committee with the BMA.

She had support from all the speakers, Dr F O Wells pointing out that some desirable and essential clinical research was being frustrated by the activities or non-activities of some ethics committees. Under European law there would soon be a requirement for all clinical trial protocols to be submitted to such a committee. A national committee could have an educative and advisory role, particularly in the context of multicentre trials, both in hospital and in general practice.

* * *

The final major debate was on advertising—five divisions had put up motions on this. They didn't like it. Gloucestershire had the starred motion—"That the association, while recognising the need to inform patients about medical services, strongly opposes advertising by doctors." The subject had arisen, of course, because the Monopolies and Mergers Commission had asked the BMA, the General Medical Council, and the Royal College of General Practitioners to consider, within six months, how advertising by general practitioners could be extended. The commission's view was that at present the advertising rules were too restrictive.

The motion was supported overwhelmingly. As Dr D J Roper put it, "Advertising will show up good advertising and it will not show up bad practice." There was a great difference between advertising and disseminating information about practices. And Dr D A Seamark said that the purpose of advertising was to make you buy something you did not necessarily want or need. Dr Macara also found fault with the Monopolies Commission for failing to distinguish between information and advertising, which was "wrong, wrong, wrong, and will always be wrong. Advertising is good only for bad doctors and we must resist it."

* * *

The readership of the *Independent* is different from that of the *BMJ*, but I would not go as far as did Nicholas Timmins, its health correspondent, in suggesting that the real focus of interest of the meeting was outside the conference hall "at the

conference dinners, and in the hotel bars where scheming had been positively Machiavellian." The focus, he argued, was the council meeting on Thursday at which a successor was to be chosen to John Marks, who had served the customary five years as chairman of the council. Understandably, the election absorbed the interest of council members and others in the committees. I saw many of them grouped in corners, chatting on steps, and conferring over coffee. That is quite normal in a democratic organisation. But the majority of representatives, though well aware of the medicopolitical implications of the choice for the chair, were I'm sure just as interested in the fate of their motions or in the debates. In the event Dr John Marks was re-elected chairman in an unprecedented extension of the normal five year term, but these are unprecedented times. I wish him well in carrying on with the daunting task of representing the profession and defending the NHS.

The long week ended with the customary rounds of applause for all those many people who had helped in the organisation and the running of the meeting. The hospitality and friendliness of Swansea and of the doctors and spouses of the local divisions were much appreciated. It had been, as Dr David Watts summed up in his thank you speech to the chairman, above all a happy week with few of the procedural arguments that sometimes mar the annual meeting. As the proceedings ended Dr Macara invested Dr James Appleyard with his deputy chairman's badge—until then his status had merely been acting deputy chairman though his assured manner in the chair belied the title—and Sandy Macara himself formally became chairman of the representative body and a chief officer of the association. He could look back with pride on a well run conference. As he bade farewell to the representatives, whose attendance record held up to the end, there was a familiar Scottish accent from the floor, crying "what about item 317." That constitutional puritan, Dr Jim Dunlop, had noticed that the traditional final motion by the chairman of the meeting had not been taken: "That the chairman be empowered, on behalf of the meeting, to approve the minutes of the meeting." It was the chairman's only—well almost only—constitutional slip, and the omission quickly rectified, we were on our way back to resume our multitudinous medical duties around the country.

SCRUTATOR

On Friday morning the ARM . . .

- Expressed serious concern at the failure of the government to introduce a statutory code to govern the disclosure of confidential health information under the Data Protection Act 1984 and instructed the council to press for action
- Called on the council to press the Department of Health to issue fresh advice to health authorities concerning the composition and functions of local ethical research committees and to discuss with the BMA its proposals for a national ethical research committee to support local committees and facilitate good research
- While recognising the need to inform patients about medical services strongly opposed advertising by doctors.

President's Address

Doctors' partnership with society

On 5 July the new president of the BMA, Professor J B L Howell, professor of medicine at the University of Southampton, gave his presidential address in the University College of Swansea. He talked of the medical profession's dilemma in coping with limited resources, which caused a conflict between doctors' duty to their patients and to society.

After the address, summarised here, Professor Howell presented the Gold Medal of the association to Sir Douglas Black. He also presented the vice president's badge to Dr H F K Li and received overseas delegates and newly appointed fellows of the association.

So often, Professor Howell told his audience, people devoted a disproportionate amount of time proposing solutions before defining the problems. He believed that many of today's difficulties and controversies stemmed from failing adequately to define the problems.

Speaking as a consultant physician and for the past six years as a chairman of a teaching district health authority, he gave a few personal perceptions of some problems he considered to be important. The list would not be exhaustive and some might disagree with his conclusions, but that was part of the difficult process of defining problems to their limit.

Why are we experiencing problems now? One reason was the rapid rate of expansion of knowledge of biological processes, of medicine, and of technology. In exploiting this knowledge and technology resources had been consumed at an ever increasing rate. This had led to another problem—the potential for conflict in doctors' duties and responsibilities.

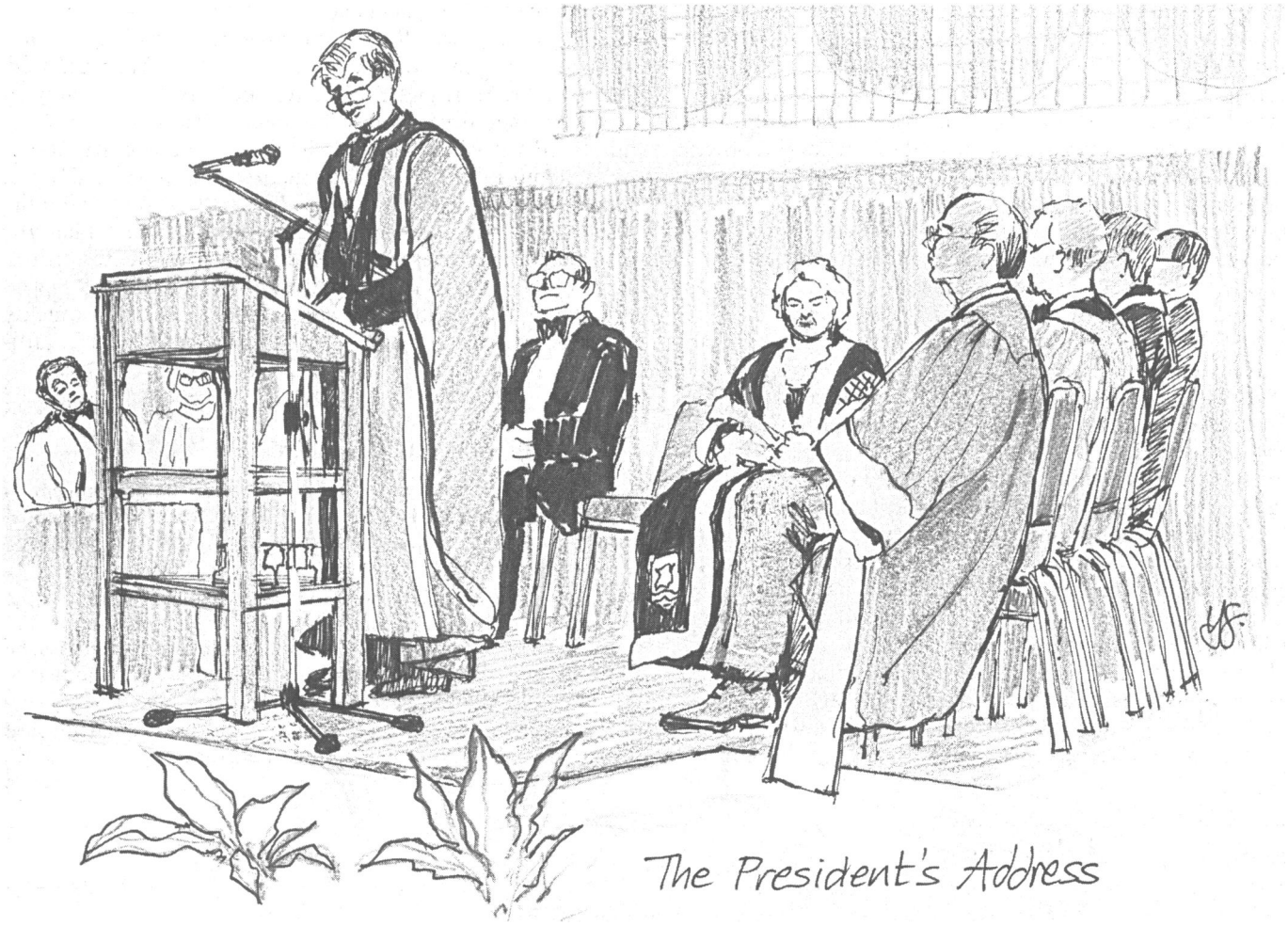
Nearly 2500 years ago the duties and responsibilities of doctors had been expressed in the Hippocratic Oath. There had been no reference to the doctor's duty (to society) to use resources responsibly because virtually none had been used. It was now self evident that there was a responsibility to use resources prudently and not to waste them. So increasingly there was a conflict between a duty to the individual patient and a duty to society to use the resources efficiently. When resources were sufficient to meet the demands of society there was no conflict of interest. The difficulty came when resources were limited.

The medical profession, the president pointed out, already had experience of coping with limited resources. For many years it had not always been able to give treatment to patients when they needed it. But doctors had usually been able to avoid making the decision not to treat such a patient by the device of deciding when or in what order to treat patients—that is, by means of the waiting list. There were, of course, special circumstances such as war or other calamities when the medical profession had to decide whom to treat and who should be denied treatment. Such decisions were unacceptable at normal times because they conflicted with the fundamental medical ethic—the duty to the individual patient. The relationship between doctors and their patients required trust by patients that the doctors would do their best for them. It was inconceivable to Professor Howell that normal medical practice could work without that trust. If resources were to be rationed the decision about who was to receive treatment and who was not should be decided openly in advance, not decided at the bedside. He hoped that doctors would never have to make decisions based on cost benefit or the worth of the individual.

Not an inevitable gap

Professor Howell argued that the gap between demand and resources and their provision was not inevitable. Since the introduction of the NHS the cost of medical care had increased exponentially and this increase would undoubtedly continue. But it was mainly in the past decade that the gap between demand for and availability of resources had become a matter of everyday concern. The reasons for this gap were not solely that needs and costs had accelerated.

In the first 33 years of the NHS expenditure had risen on average at a rate of 3·4% a year. This increase was sufficient to meet the rising demand. But in the past seven to eight years expenditure had increased at little more than 1% a year while demand had continued to rise. This had been met by substantial improvements in efficiency.



But it was no longer possible to extract savings at this rate and further increases in the efficient use of resources would require a longer time scale.

"Does this mean that we have reached or even are approaching the limit of our ability to provide for the increasing demands of the NHS and that 1% a year growth is the most that we can reasonably expect?" the president asked. Clearly not when the national economy had grown by about 3·5% a year over the past six years.

But if society was able to provide more why didn't it do so? Professor Howell suggested some of the reasons for the lack of will.

- There was a belief that the principles on which the NHS was based—that is, care available to all, free at the point of delivery, funded from taxation—were no longer the ideals of society
- There was a philosophical reason which could be summarised as the bottomless pit model of health care—that is, no matter how much was allocated it would never meet all the needs. But this model was a misleading irrelevance. It implied that there could be a bottom to the pit—that is, there could be a final goal of complete and perfect care. The falsity of this concept had been argued by Sir Karl Popper in his refutation of Marxism *The Open Society*
- There could be no final goal, there would always be the possibility of further change. Progress consisted of identifying immediate problems, producing the solutions, and continuing in this step by step, trial and error way. The analogy with the NHS was evident—there could be no final Utopian goal for health care
- There was a perception that the existing resources were not used efficiently and effectively.

Self interested, profligate, and unaccountable?

Many saw the profession as being self interested, profligate, and unaccountable. How could these charges be answered?

The profession had a duty to be self interested, Professor Howell maintained, where this was needed to maintain a strong and vigorous profession best able to serve the needs of the community. This was one of the BMA's primary roles.

Profligacy and accountability had to be considered together. "We all know that with exceptions we do not account directly, other than to ourselves and our colleagues, for our time, the amount and quality of our work, and our use of the resources provided, and therefore cannot disprove the suspicion of profligacy."

Until recently no one had required doctors to be accountable and doctors had not perceived a need to be so. Resources had not been stretched and their careful management had not been a problem. No one had provided the time, nor the complex information systems which doctors now saw as essential if they were to account for what they did. Accountability was also a new requirement and the BMA had supported its introduction. The resources needed to provide accurate, rapid information to become fully accountable should be provided as soon as possible.

Related to the criticism that doctors lacked accountability for the use of resources was the criticism that they did not measure the outcome of their work. Outcome audit was already routine in several disciplines but the criticism was fair and Professor Howell had no doubt that the profession should set about measuring outcomes as part of everyday work so that doctors could learn what was and was not worth doing and what could be done better.

It was not easy to measure outcome. Much of what doctors did was not quantifiable—quality of life, reassurance, caring, easing the burden of the dying and the chronically sick.

Finally, the president had concerns about the uses that might be made of information. If outcome measurement improved the effectiveness of what doctors did they would embrace it. But if the information asked doctors to decide that one type of patient should be treated rather than another this would conflict with their professional ethic—the duty to individual patients.

Health care, he concluded, was a major part of the fabric of society. It could not be considered separately from the ability and the will of society to provide the profession with the means to deliver it. "We are in partnership with society and to the Hippocratic Oath has been added another clause—namely, our duty to use what society provides efficiently, effectively, and accountably, and we and society have yet to come to terms with it."