

wrote their articles at home and most basic researchers at the office—giving, as Roland and Kirkpatrick dryly comment, the researcher one advantage over the clinician.

In other countries precise figures for the stages from hypothesis to publication would probably be different, though it seems likely that the pattern would be similar. In particular, the editorial delay for the Mayo articles might have been shortened by the prior "institutional editing" service for authors run by the clinic's excellent Department of Biomedical Communication (taking an average of 21 days, or 2.1% of the total time). For original papers in the *B.M.J.* the median delay between acceptance and publication is now two months. Another three weeks are spent between receiving the manuscript and deciding on publication, mostly aided by peer review. In a stimulating address at last year's Annual Scientific Meeting,² Douglas-Wilson attacked the refereeing system, saying that it was conservative, élitist, and even bigoted. While admitting the attraction of this argument (based as it is on our contemporary's great experience), we can only disagree; perhaps the ideal British compromise is the existing set-up—journals using both systems so that authors rejected by the one can still try the other.

Any delay in most editorial offices is still relatively small compared with that imposed by multi-authorship (eight months in the Mayo study), and postgraduate education in medical writing would almost certainly help to shorten writing time. Nevertheless, the fact remains that it takes a long time from the idea to submitting the article: "even if editor and journal processing were instantaneous, the average research idea would be about 40 months old by the time it was read." Roland and Kirkpatrick thought of their project on 24 August 1971; the article was published on 12 June 1975.

¹ Roland, C. G., and Kirkpatrick, R. A., *New England Journal of Medicine*, 1975, 292, 1273.

² *British Medical Journal*, 1974, 3, 326.

Prospects for the Future

Treatment should rarely be started before a diagnosis is established, and one of the few certainties about the reorganized N.H.S. is that there is as yet no clear agreement about its symptoms, let alone their pathogenesis. The three sessions of our Chichester conference showed the wide variations in individual assessments of the first year of the new Service: the lack of any consensus on what might or should be done next was hardly surprising. In such circumstances there are strong arguments for inaction. A major shake-up at this stage would be expensive, it would further erode the confidence of N.H.S. staff struggling to make sense of their new roles, and the last state might well be worse than first.

Much can be done, however, within the existing framework to correct qualitative defects in the way it has been working. The new system should have led to more rational policy-making, yet the familiar futile pattern is being perpetuated. The Department of Health's decisions on priorities are still issued as guidance without any recognition of their practical consequences. For example, the C.M.O. recently wrote¹ to doctors urging them to make greater efforts to secure cadaver kidneys for transplantation: presumably, therefore, the Department wants more money to be spent on the treatment of patients with renal failure, and that fact is reported in the national press. Where is the money to come from? Which

acute services are to be cut back to allow an expansion in this field? It is no answer to say that those decisions must be made locally, for if decisions on priorities should be decided by the district management team the D.H.S.S. should not pre-empt those decisions in a blaze of publicity.

The Department is also persisting in chasing unrealistic targets—for example, it has listed as a top priority the development of capital facilities for primary care, particularly health centres: yet many general practitioners want nothing to do with such projects. *Inflation and Priorities*,² an assessment of the current economic situation published this week, draws attention to the paradox in that decision: "priority is being given to precisely that sector of the N.H.S. where the health authorities have least control over the use to which the money is put. . . . If money is spent on family practitioners, it is anyone's guess as to who will benefit, and in what way."

Within the foreseeable future there is no prospect of any legislative action to bring the health and social services closer together; again a change in attitudes could do a lot to improve contacts. Time may lead to greater mutual trust and co-operation, but more positive efforts will be needed from both sides if real changes are to be made.

While the lack of any general agreement on any further restyling of the N.H.S. precludes national changes, there is no reason why local, experimental modifications should not be tried, and here the newly created community health councils could play a valuable part. Wales and Scotland seem to have had fewer problems in their first year than has England, and their example is a powerful argument for elimination of one of the tiers. Speakers at the conference differed on whether the region or the area could most easily be spared—or indeed whether a cross between the two might not be the ideal British compromise. There are, it seems, far too many committees, and members of district management teams argued the case for abolition of some of the advisory bodies which only duplicate each other's activities. Modifications of some kind will be needed in many parts of the country fairly soon—some district boundaries will need to be adjusted, for example, to make sense of catchment areas—and the opportunity could be taken at the same time to try the effects of putting some apparently superfluous parts of the structure into suspended animation (rather like the sleeping units of the Whitley Council system). Which committees should be phased out would be decided locally; and the practical results could then be seen of changes agreed and initiated by those most closely concerned. Surely local experimentation is better than waiting for some new set of tablets to be sent down from the mountain—mistakes may be made but they are less likely to cause any lasting rancour.

"Alarm feeds on uncertainty"²—as has been evident in the national economic crisis of recent weeks—and the prospects for the N.H.S. have been threatened in this way for far too long. There is still a reservoir of good will among doctors, administrators, nurses, and other N.H.S. staff, but it is being steadily eroded by their uncertainty about the Government's long-term plans for the Service (or indeed whether this Government's plans are compatible with those of any of its potential successors). Broad policy direction from the top on the distribution of resources between acute and chronic services, primary care, and preventive medicine, combined with devolution of as much decision-making as possible to the health districts, could lead to a revitalization of the N.H.S.

¹ Yellowlees, H., C.M.O. 16/75. See p. 107.

² *Inflation and Priorities*, ed. Rudolf Klein. London, Centre for Studies in Social Policy, 1975.