

## Pointers

**Area Health Boards:** Report sponsored by Welsh Committee (*Supplement*, p. 19). Leader on this page.

**Chronic Granulocytic Leukaemia:** Report by M.R.C. Working Party shows busulphan superior to radiotherapy in terms of survival and maintenance of haemoglobin levels. Busulphan therapy also improves quality of life, and probably increases its duration (p. 201). Leader at p. 196.

**Testicular Feminization:** Testicular secretion of steroids shown to be normal (p. 208).

**Altered Picture of Neurosyphilis:** Reporting seven unusual presentations, Dr. Ronald Joffe and his colleagues suggest that the Wassermann reaction today is of even greater importance than in the past (p. 211).

**I.C.I. 50172:** Reduced resting heart rate in patients with ischaemic heart disease, probably by a beta-adrenergic blocking effect (p. 215).

**Prognosis in Breast Cancer:** Discriminant based on urinary steroid values found of no prognostic use in individual patients with early disease (p. 217).

**Recent Rubella Infection:** Dr. Timo Vesikari and Dr. Antti Vaheri, from Helsinki, Finland, show this can be diagnosed by demonstrating IgM antibody in the serum (p. 221).

**Case Reports:** Suppurative pericarditis complicating myocardial infarction (p. 223). Physical stimulation of the heart (p. 224). Balloon septostomy in tricuspid atresia (p. 225).

**Drugs and the Liver:** Discussed by Professor Sheila Sherlock in her "Current Practice" article (p. 227).

**Today's Drugs:** Verapamil (p. 230).

**Giant Follicular Lymphoma and Radiation Nephritis:** Clinicopathological conference at Royal Postgraduate Medical School (p. 235).

**Skid Row Hostel:** Vigorous approach to foster an attitude of self-help in skid row alcoholics advocated by Mr. Timothy Cook and his colleagues (p. 240).

**Computers in Medicine:** Mr. M. J. R. Healy emphasizes that fullest collaboration between mathematicians and doctors needed for further progress (p. 243).

**Teaching Hospital at Liverpool:** Plans for new buildings (p. 245).

**Personal View:** Lord Taylor (p. 246).

**M.O.H.s Pay:** Revised scales (*Supplement*, p. 23).

**Prescription Charges:** Minister's letter (*Supplement*, p. 24). Correspondence (p. 254). Parliament (p. 259). Leader at p. 200.

**Monopolies Commission:** Restrictive practices in medicine (*Supplement*, p. 25).

## Twenty Years On

After 20 years the structure of the N.H.S. is out of date, but at least modernization and reform may be within sight. There have been demands from all quarters for a new service designed to meet the requirements of modern medicine, and the delay in making the necessary changes has undoubtedly been a major cause of medical emigration. Now, belatedly, the Minister of Health has expressed a sense of urgency when he announced<sup>1</sup> that the Government's views on the future administrative structure of the Service were to be set out in a green paper. The Minister is not consulting the many parties interested in the N.H.S. before publishing his proposals. The purpose of a green paper is to set out the Government's thinking without commitment—it is said to be an agenda for public discussion. The Government will want to publish its views before the closely related reports of the Royal Commission on Local Government and the Seebohm Committee on the provision of social and welfare services, which should appear later this year. The whole Welfare State pioneered in Britain after the war, and not just the N.H.S., needs to be recast for the changing needs of the community. So the sooner doctors say what *they* think should be done the better.

It is now five years since Sir Arthur Porritt and his committee, in their review<sup>2</sup> of the medical services in Great Britain, criticized the tripartite administration of the N.H.S. because it had "isolated doctors in the main branches of the Service." There has been some progress within the profession in bringing general practitioners closer to their hospital colleagues by access to diagnostic departments and clinical assistantships, and in expanding the scope of work done by local authority doctors and nurses. But really fundamental advances in this direction will need Government action to integrate the administration and financing of the N.H.S. The Porritt Committee stated: "At present funds are allocated both from central and local government to different authorities responsible in the same area for various parts of the Service. This method of financing has led to isolated rather than co-ordinated policies, and to loss of economy and efficiency." As examples of the adverse effects of these artificial divisions the report cited the maternity services and the provision of care for geriatric patients. The solution proposed by the Committee was that the Government departments responsible for all forms of health and welfare should be collected together under one Minister, and that the local administration, policy-making, and planning should be delegated to new bodies named area health boards. All health services—hospital, general-practitioner, pharmaceutical, preventive medicine, occupational health—should be the responsibility of a board, whose administrative area was to be based on population rather than on geography.

The B.M.A. Annual Representative Meeting in 1963 gave its support<sup>3</sup> to the setting up of area health boards, and in 1964 the Welsh Committee formed a subcommittee to prepare a pilot scheme for Wales.

An abridged version of this subcommittee's second report appears in the *Supplement* at page 19. The Welsh scheme is based on the N.H.S. as organized at the present time, and as a result is somewhat limited in outlook. It is a document written mainly for doctors, perhaps with an eye to those whose enthusiasm for radical change is only moderate. No effective solution has been found for the problems that would arise from transferring services at present controlled by local government and financed largely from local taxes to a body such as a health board, which is not democratically elected and is not directly answerable either to Parliament or to the public. A scheme put up for discussion can afford to be daring and far-reaching. Could not the Welsh report at least have discussed the possibility that area health boards might provide the means for decentralization of the financial control of the health services and thus for more autonomy and liberty to experiment? These and other possibilities such as quinquennial grants were discussed in a series of articles in the *B.M.J.* last year.<sup>4</sup>

But the report should not be denied the welcome it deserves

as evidence of the interest doctors are taking in making constructive proposals. If it does no more than act as a catalyst for the exchange of opinions it will have served a most useful purpose. Answers are needed urgently to a number of problems that have long faced the profession. How can general practitioners best be brought within the hospital service? Can they retain their status as independent contractors in an integrated service, or would a salaried service be inevitable, and, if so, what sort? How can health visitors, district nurses, social workers best be used in the future? What is the best way of promoting self-help in local communities? If the medical profession sits back and waits for the answers to questions of this sort to be produced by others without deciding and stating its own views it will have failed in its responsibilities. It may be a long time before it gets another chance.

<sup>1</sup> *Brit. med. J.*, 1967, 4, 367.

<sup>2</sup> *A Review of the Medical Services in Great Britain*, 1962. London.

<sup>3</sup> *Brit. med. J. Suppl.*, 1963, 2, 83.

<sup>4</sup> *Is There an Alternative?* 1967. B.M.A., London.

## Treatment of Chronic Granulocytic Leukaemia

Radiotherapy and chemotherapy are both effective in producing temporary remissions of variable duration in patients with chronic granulocytic leukaemia. X-irradiation of the spleen was the treatment of choice for many years, but since the introduction of the alkylating agent busulphan (Myleran),<sup>1</sup> which is relatively easy to handle and effective, this drug has largely replaced radiotherapy in the treatment of chronic granulocytic leukaemia. However, the relative efficacy of x-irradiation and of busulphan remained to be established. It was possible that under certain circumstances one method was preferable to the other. Such information can be obtained only from an appropriately designed clinical trial, and in this issue of the *B.M.J.* the Medical Research Council's Working Party on Leukaemia report at page 201 the results of such a trial, in which a number of centres in the United Kingdom co-operated.

The trial began in September 1959. Details of the methods used have been previously published in reports on other trials.<sup>2,3</sup> Untreated patients in whom the diagnosis of chronic granulocytic leukaemia had been established were admitted to the trial. The selection of patients and the form of treatment were determined randomly. Though busulphan therapy was standardized, the technique of radiotherapy, which was usually x-irradiation of the spleen, was left to the discretion of the radiotherapist at each centre. The report points out that therapeutic trials inevitably raise ethical questions, and in this particular trial there was no double-blind element. The form of treatment for each patient was known by the observers, who had complete freedom to alter it if the patient's progress appeared to be unsatisfactory. Because the intake of patients into the trial was slow, decisive evidence for the superiority of one form of treatment over the other did not emerge until the trial had been in operation for over four years. At that time (January 1964), when it became clear that busulphan treatment was superior to radiotherapy, no further patients

were admitted to the trial. The shortest follow-up period was three years and the longest just over seven years. In terms of survival from the time of starting therapy and effectiveness in restoring and maintaining satisfactory haemoglobin concentrations, busulphan therapy was undoubtedly better than radiotherapy. But in long-term control of the size of the spleen the two forms of treatment showed little difference. The median survival for the group of patients on busulphan was almost a year longer than that of the group given radiotherapy, being 3½ years and about 2½ years respectively. In the busulphan group 20% of the patients survived just over five years, compared with about 3½ years in the radiotherapy group.

Of the 102 patients admitted to the trial 90 had died when it ended, blast-cell transformation accounting for death in 70% of these patients. Intercurrent disease unrelated to the leukaemia caused the death of the remainder. The causes of death were similar in the two treatment groups, and there was no evidence to suggest that blast-cell transformation occurred more commonly with busulphan treatment. Before the beginning of the trial there had been a suspicion that busulphan was more prone to produce blast-cell crisis than radiotherapy, but the trial showed that the onset of the terminal phase occurred earlier in the group treated by radiotherapy. Whereas in the majority of cases treatment with busulphan was continued until the late stages of the disease, a high proportion of patients in the radiotherapy group were transferred to busulphan treatment, because in most cases the disease was no longer adequately controlled with radiotherapy. There was no difference in supportive therapy in the two groups.

Though this trial showed that radiotherapy was not so good as busulphan in the treatment of chronic granulocytic leukaemia it is obvious that there were some important differences in the way these particular methods of treatment were used. The report points out that, with radiotherapy,

<sup>1</sup> Haddow, A., and Timmis, G. M., *Lancet*, 1953, 1, 207.

<sup>2</sup> Medical Research Council, *Brit. med. J.*, 1963, 1, 7.

<sup>3</sup> — *ibid.*, 1966, 1, 1383.