What I would say to the Royal Commission

Suggestions for reform

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To my mind, the main problems of the National Health Service are: low morale among doctors; the difference in responsibility between the medical profession and the administrators; the lack of resources to meet rising demand; the difficulties of economising; and the need for the medical profession to adjust to social change.

Low morale

Our low morale arises from the apparent erosion of our professional independence and prestige. This is in common with other learned professions and is part of the changing social pattern which demands increasing accountability by the professions to the public. Doctors, however, feel that, for political reasons, they have been selected for particular denigration: the bitterness, therefore, is deep. The absence of a consultant or a junior doctor as a representative on the Royal Commission not only makes interpretation of evidence concerning hospitals more difficult, but will be taken as further evidence of political ill will against doctors. This should be rectified urgently.

Bitterness over the issue of private practice has proved to be damaging to morale. As private beds within NHS hospitals is such a divisive issue, they should perhaps be phased out. Nevertheless, the Royal Commission should recognise the value of a strong and competitive private sector and insist that no private facilities from within NHS hospitals be removed until alternative facilities outside have been fully developed. (I hold a full-time contract.) This should be supervised by an independent body.

Doctors and administrators

The medical profession owes its primary responsibility to patients and not to management. It thinks, perhaps wrongly, that with administrators the reverse is true. The resulting differences of opinion are then attributed to vested interests and

there is mutual suspicion. The profession is now concerned that administrators, who they consider to be the new masters, will, under the guise of "accountability," quell the "troublesome opposition" of the profession by removing their independence, thus making them subservient to administrative dictates.

The Royal Commission should reassure the medical profession: it should emphasise that medicine is not simply a craft or technical service, and that for the profession to bear total responsibility for a patient equally demands commensurate managerial independence. In turn, the administrators need to know that such independence does not in any way reduce the doctors' accountability. It should emphasise that to reduce the profession to the level of "medical civil servants" will certainly make it more compliant but will eventually result in uniform mediocrity.

The Royal Commission should emphasise that better management can only be achieved by active co-operation between doctors, nurses, and administrators, based on genuine understanding of each other's problems. The reorganised structure of the NHS will encourage this. A further step will be the secondment of doctors and nurses to AHAs, RHAs, and to the DHSS.¹ This will become possible when the number of doctors increases. Conversely, administrators need to spend more time in the "field."

Lack of resources

Demand for medical treatment continues to grow. In the absence of a political decision actively to curtail resources, additional money will need to be found as rising costs cannot be met by increased efficiency or by redistribution.

The Royal Commission should take advantage of the fact that there is increased public awareness that social services can grow only at the expense of increasing personal wealth, and, provided that money is collected specifically for health, people may be more willing to contribute more. Over the next five or six years the following measures could gradually be introduced, each of which will raise £50m, and restore the growth of acute medical services, capital programmes, and research, which have suffered the most: 1p on a packet of 20 cigarettes; a flat rate of 4p on insurance contributions; a charge of 40p for each surgery or home visit, with half the patients exempt; an increase of 35p in flat rate prescription charges, with half the patients exempt; £6 a week hotel charges (in hospitals), excluding mental treatment, with half the patients exempt; an increase in income tax of 1p on the standard rate.² Additional charges for hospital casualty and outpatient visits, as well as further taxes on alcohol and foodstuffs³ known to damage health, could also be made.

Making economies

There are two major difficulties in economising. Firstly, the payment-by-result principle of manufacturing industry cannot

be applied directly to medical practice, as often there is no quantifiable end product. As the monetary value of "clinical confidence" and the "quality of life" cannot be readily measured, it is difficult to choose the cheapest way of delivering an "acceptable standard" of health care. Medical audit may raise standards but will result in even greater expense.¹ Secondly, there is no incentive to economise. To correct this, the Royal Commission should recommend the experimental introduction of a degree of budget control by doctors and ensure that those who are efficient get a part of their savings back to finance developments of their choice.

Despite these problems, present-day practice can be changed to make economies. The wider use of five-day wards, convalescent and community hospitals, together with the growth of geriatric and social services,² would reduce the need for acute medical beds. An increase in the number of consultants would, by staggering working hours from, say, 7 am to 7 pm, allow better use of outpatient departments and diagnostic services, (thereby reducing waiting lists). Some consultants, such as physicians, could carry out part of their consultation jointly with general practitioners in health centres, thereby saving outpatient department space. Further savings could be made by reducing unnecessary investigations and by using equally effective but cheaper drugs. Finally, a book-keeping economy: the AHAs should be reimbursed by the General Medical Services for the cost of drugs prescribed from hospital outpatient departments, thereby saving on the hospital budget.

Lack of research funds

Ultimately it is research that will lead to the cure and prevention of illness: to reduce already meagre research funds, as has happened, makes little or no real savings and delays the progress of medical knowledge. The Royal Commission should recommend that Government medical research funds be substantially increased, but insist on four measures. Firstly, the economic consequences of new ideas should be investigated early on. Secondly, any commercial application should be fully exploited, preferably by British industry. By subsidising commercial development, the DHSS might be able to buy the product more cheaply for the NHS. Thirdly, there should be a greater emphasis on research aimed to improve the efficiency and standards of medical practice in the NHS. Fourthly, locally organised research funds, which are disbursed by RHAs to support short-term studies, should be used to finance long-term projects as well, and rather more generously. Such projects, carried out by those in permanent posts, such as consultants and

general practitioners, generally have more lasting value than short-term studies, and not infrequently lead to major advances in medical knowledge.

The Royal Commission should encourage closer co-operation in research among the NHS (including the academic units), the pharmaceutical industry, and manufacturing industry. The fear that this may lead to the "moral contamination" of the impoverished medical research worker by the "wealth" of industry is grossly exaggerated. We have much to learn from each other. Closer co-operation can only lead to more relevant and better research.

Five minutes as a witness

In my short time as a witness, I should like to underline the importance of the role of the medical profession. Changing social trends demand that we be more accountable. The Royal Commission should emphasise that this is a good opportunity for the profession to make itself more efficient rather than to put up the barrier of "clinical freedom," for the surest way to lose this precious commodity is to misuse it. Once we have proved that we are efficient, and yet sensitive to public needs, provided we remain accountable I doubt if the public will want to be consulted on all matters. Indeed, I feel that they will insist on us being left alone to get on with our work: a satisfied public will be the best guarantor of our professional independence.

The reorganised NHS allows for a better flow of information. As the number of doctors increases, more can be active in administration. The quality of decision-making will improve and simultaneously ensure that we, who bear the burden of clinical responsibility, will have a major influence on decision-making.

The price to be paid in the adjustment of our professional roles is substantial, but the prize to be won is great.

This paper is dedicated with deep gratitude to the memory of the late John Fowler Barnaby: a true friend.

References

- ¹ *Lancet*, 1976, **2**, 408.
- ² Hardie, M C, *Long Range Planning*, 1974, **7**, 2.
- ³ Joint Working Party of the Royal College of Physicians of London and the British Cardiac Society, *Journal of the Royal College of Physicians*, 1976, **10**, 213.
- ⁴ *Lancet*, 1976, **2**, 453.
- ⁵ Department of Health and Social Security, *Priorities for Health and Personal Social Services in England. A Consultative Document*. London, HMSO, 1976.

Is it possible to dissolve gallstones?

Yes, but not yet with a degree of certainty that makes it a reliable method of treatment. Chenodeoxy cholic acid, 1 g daily by mouth, may cause cholesterol stones in the gall bladder to disappear or at least diminish in size.^{1 2} The greatest success rate is about 25%, though treatment may have to continue for many months. The problem remains of distinguishing the cholesterol stones suitable for treatment. Large round transradiant calculi seen on the oral cholecystogram are more likely to be cholesterol; small multiple transradiant stones are likely to be pigment but not invariably. The faintest trace of calcification implies a mixed stone which cannot be dissolved. Besides straight chenodeoxy-cholic acid, the addition of β -sitosterol is said to improve results.³ An alternative regimen of cholic acid and lecithin is also described.⁴ The mechanism appears to be through a decrease in the relative saturation of cholesterol in the bile. The investigations may apply only to Caucasians as cholelithiasis in the Chinese is often caused by primary pigment stones, and there are other cultural and racial differences in this disease. Postoperatively, various solutions (and instruments)⁵ have been put down the T tube to remove remaining stones. There are so many alternatives that no one method is established. It must be remembered, also, that a gallbladder which has once produced stones will almost certainly do so again. Chole-

lithotomy fails for this reason and without a pathophysiology to explain the formation of stones no modification of life style can yet be offered to the patient.

- ¹ Bell, G D, Whitney, B, and Dowling, R H, *Lancet*, 1972, **2**, 1213.
- ² Thistle, J L, and Hoffman, A F, *New England Journal of Medicine*, 1973, **289**, 655.
- ³ Gerolami, A, and Sarles, M, *Lancet*, 1975, **2**, 721.
- ⁴ Toouli, J, Tablouski, P, and Watts, J McK, *Lancet*, 1975, **2**, 1124.
- ⁵ Castleden, W M, *British Journal of Surgery*, 1976, **63**, 47.

Is brachial neuralgia increasing?

It is impossible to answer this question directly, since there is no overall agreement on the definition of brachial neuralgia. The terms used for related conditions in medical certification vary so widely that comparison of frequency is impracticable. My impression from a large rheumatology clinic is that there has been no great change over the last decade. Most cases are probably related to cervical disc protrusion. The younger the patient the less likely are the x-ray films to show degenerative changes. The fact that more sedentary workers take part in violent sports and domestic tasks in their leisure time might have increased the incidence. The proportion of cases thought to be due to a viral adenopathy is probably too small to affect the overall incidence.