Manor House Hospital, converted from the home of the Earl of Radnor, made a charming little hospital of 90 beds, and Manor Court and York House Hospitals each had an operating theatre and another 100 patients. In one of the operating theatres out of a series of 180 major operations, there were only nine deaths. Doctors Streatfeild, Wainwright, and Wilgress were assisted by the inevitable Dr Lewis, showing that as usual the Welsh had got in on the act. One interesting hospital was the Bevan Military Hospital in Sandgate that actually overlooked the sea. This was organised by the Kent VAD of the British Red Cross. Its central court was entirely devoted to open air treatment of septic cases, and, although quite small, 12 100 patients passed through it with 1552 major operations performed. The admissions book appears to reflect the artistic skill of some of the patients: I shudder to think of how the modern records officer equipped with suitable forms would cope with entries like these.

It is interesting to record that during 1915, before being

transferred to Salonika, Mr Lester Pearson served as a medical orderly at Folkestone, and he returned on Canada Day 1970 to lay a wreath at the Canadian Cemetery at Shornecliffe. Here, in perhaps one of the most beautiful and simple cemeteries on earth, lie the bodies of nearly 1500 Canadian troops who died during the first world war, and each year since 1916 children of the local schools have tended the graves and laid flowers on them on Canada Day.

Perhaps this simple tribute carried on lovingly by children who cannot even remember the second world war, let alone the first, poses the lesson for us all. Here lie buried side by side Englishmen, Canadians, and Irishmen. Whether they fought to defend their country, whether they fought because they were professionals—or even if they just joined in the biggest fight the world had ever known—here they lie, remembered by succeeding generations who are free because of their sacrifice, evidence of the truth recalled by Wolfe on the Heights of Abraham that the “Paths of Glory lead but to the grave.”

For Debate . . .

Priorities: some personal views

STEPHEN LOCK

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To illustrate the difference between the Austrians and the Germans, the story is sometimes told of the two communiques their High Commands issued just before the end of the first world war. The German one read: “Situation serious, but not desperate”; the Austrian one read: “Situation desperate, but not serious.” Much as I prefer rococo to baroque, Hofmansthal to Hegel, and Wiener Schnitzel to the Bauernbratwurst you get in Munich, I take the German view with regard to the present crisis in health care: it is serious but not desperate, and it can be solved even with our present resources. What’s more, this crisis is apparent or imminent in most of the developed countries. Even though the richest ones such as Sweden and the United States can still afford more EMI-scanners, or more pacemakers, or more kidney transplants, we’re all at the end of the road: the developments in medical technology have outstripped the money we’ve available to spend on health care.

I want to deal with some medical measures that have been relatively little discussed. This excludes, for example, possible social reforms, such as abolishing “poverty,” however this is defined. Even today, thousands of our population are paid less than a subsistence wage, particularly those working in shops, restaurants, and hotels; yet the plight of these people has received little attention by either of the bodies who could do something about it: the major political parties or the big unions. In Victorian times some have argued that social changes,

piped water, and sewage all did more for the public health than any advances in medicine. Today, even though they might not necessarily accept that overcoming poverty would have a similar priority over medicine proper, many doctors might well argue that much of the money spent elsewhere, for example on some social workers (with their allegedly low case loads, time spent in conference, and unavailability after office hours), might more usefully be given directly to the poor. I do not know enough of the facts behind such an argument to judge.

I shall also not consider priorities which the profession seems to be on the brink of introducing for itself, such as some form of clinical self-assessment, or of encouragement of better drug prescribing habits. All professions are rightly conservative and suspicious of change until the case for it has been proved. Nevertheless, once this has been done—as in the case of the advantages of health centres, career training for specialties, or restrictions on narcotic prescribing for drug addicts—the medical profession has always been quick to withdraw any objections and, most importantly, to introduce such changes itself, rather than have them imposed from outside.

My own priorities fall into three main time scales. Firstly, immediate: action which we should take now, by applying the knowledge that we have. Secondly, intermediate: we should alter the direction of some of our research. Thirdly, long term: a determined effort to involve the public in health education and in the debate on medical priorities.

Action

SMOKING

In proposing some actions, there is one obvious and absolute priority: to do something much tougher about the greatest medical evil of our day, the cigarette. We now know of the untold harm and nuisance this addiction is causing: in Britain

Based on contributions given at seminars at the Royal College of Physicians of Ireland, the Royal College of General Practitioners, and the universities of Kent and Newcastle upon Tyne between October and December 1976.

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alone responsible for at least 40 000 avoidable deaths in adults and 1500 extra perinatal deaths a year; implicated in most coronaries in people under 50; associated not only with lung cancer, arteriosclerotic disease, and bronchitis, but also with cancer of the oesophagus, kidney, and bladder, and with postmenopausal osteoporosis. All of these conditions cost the Health Service a vast amount of money to investigate and treat—not to mention in sickness pay and subsequent widows' pensions. As to the old chestnut that tobacco tax more than pays for the Health Service, in fact, the *total* care of smoking-related disease costs far more than the revenue such taxes bring in.

We know that most people now have some idea of the dangers of cigarette smoking. Yet clearly, as with other dangers in life, they do not believe that it can hold any risk for them personally. Consider also the unpleasant social aspects of smoking. Even though non-smokers are now in the majority in this country, most of us, though finding the habit unpleasant, have not the courage to insist that non-smoking should be the rule in public places. Yet if there was less opportunity to smoke, and smokers realised just how antisocial their habit was, I suspect that the amount of smoking would go down. For instance, I suppose one has to accept if the British Airports Authority is rebuilding terminal 1 at Heathrow that they should be able to herd passengers on domestic flights into those nasty plaster board temporary departure lounges. But why should they allow everybody there to be exposed to tobacco smoke, when the airlines have now introduced no-smoking compartments in the aircraft themselves?

So we need to stop shillyshallying around and to make smoking the exception rather than the rule in public places. From the medical angle, we should press for a swingeing differential tax between cigarettes, on the one hand, and cigars and pipe tobacco, on the other. Such a move should at least cut down the number of lung cancers, if not the coronaries, strokes, and bronchitis. We should also press ahead with an energetic research campaign into substitutes—for nicotine rather than a substance to be smoked.

But, despite the fact that most established smokers say that they get little pleasure from the habit, we must accept that most of them are hooked. So, most importantly, we should aim at stopping adolescents starting to smoke. This, I would suggest, means taking the glamour out of smoking—emphasising that it doesn't make you seem any tougher than your friend who doesn't smoke. It means stopping advertisements, which, as the magazine *Which?* has recently shown,¹ are still breaking the agreed code that smoking should not be associated with sport, sex, and wealth. It means banning tobacco manufacturers from sponsoring sporting and cultural events. This might mean that we should have to pay more for papers, sport, and culture. But surely anybody who really cares about the health of his fellow men should be prepared to find this extra money rather than accept a subsidy which is based, however indirectly, on disease and death? It is a pity that David Owen, the one minister who seemed really determined on action, left his post before he could overcome the official inertia which has characterised this topic.

Imitation has also been shown to have a major role in making adolescents smoke. We see public figures smoking cigarettes in newspaper pictures and on television. As Jo Grimond has pointed out, one of the main causes of disillusion in Britain at present is the wide gap between precept and practice: "don't do as I do, but as I say." Public figures have a special duty to practise what they preach, and the day is not far off when for them to smoke in front of their audiences, or for a schoolmaster in front of his pupils, or for a doctor in front of his patients, will be regarded as irresponsible and unethical.

PREVENTING ACCIDENTS

The second general priority for action, I suggest, should be in preventing accidents, whether in industry or on our roads.

Accidents in industry kill 1100 every year in Britain, in the home 8000, and on the roads 7000. The number of deaths, of course, is only a fraction of the seriously maimed, for life, and road accidents alone cost our community £850m a year. Yet in reading reports of the causes of accidents there is one depressing constant: that people are killed unnecessarily—because they are breaking the factory regulations designed to protect them; because they are ignoring known hazards, say, in the kitchen or on the stairs; and because they are driving obviously dangerous cars forbidden by the law, not wearing seat-belts, grossly exceeding the speed limits, and with a high blood alcohol concentration. In its wisdom our society has devised rules and laws to prevent some of these accidents, which often affect the innocent as well as the perpetrators. Yet how often are these laws enforced? We now have the fatuous spectacle of senior policemen saying that the public will not stand for enforcement of "minor" laws. Surely a law is a law, and it has been passed for compelling reasons: either it is enforced for the general good of the public, or it is repealed; the alternative is anarchy.

If I could cite another, if more minor, example of where laws are constantly broken for the public ill, there is food poisoning—a condition so common in our society that, though every one of us probably has an episode at least once a year, we accept it as people in medieval times did the plague. Now we know largely how to prevent food poisoning and there are sensible regulations on the handling, processing, and storage of food. Yet week after week one reads reports of outbreaks caused merely by neglect of sensible advice—and sometimes the sufferers die. Go into any food shop in Britain and see how your cheese, bacon, and cooked meats are handled by the assistant, and ponder perhaps that with good reason there is an Act of Parliament which forbids such handling. What is done to enforce it? Virtually nothing.

FLUORIDATION

So we would save ourselves much death and disease merely by acting to enforce regulations we already have. There are two other actions we should also take, rather different from these other examples. The first is to have the courage to act on another known benefit to mankind, the artificial fluoridation of drinking water supplies where this is indicated. Dental disease is the commonest preventable abnormality in our population and yet we shrink from applying a proved, safe, and cost-effective method to stop it. Why? We all know the answer: despite the weight of evidence presented by unbiased report after report, not to mention the experience of other advanced countries who have gone ahead with fluoridation, the opposition is noisy and effective. Why does our society still listen to these scrannel pipes, and why do the opponents of fluoridation not turn their energies and enviable organising abilities to dealing with the cigarette?

STUDENT NUMBERS

My fourth, and last major piece of action is again something rather different, but just as pressing in its way. We should, I believe, urgently review the number of students we are accepting for our medical schools. As Parkhouse has recently emphasised in a thoughtful paper,³ the subject is complex, but I wonder what is to become of the 4000 doctors a year Britain will be providing in the 1980s. The traditional refuges of the emigrant will no longer be there, and this country will not be able to offer them the right number or kind of jobs. Moreover, seemingly these graduates will not be so well trained as at present: the doubled student numbers will not be matched by double the number of teachers or facilities. To their credit, our junior doctors are actively debating this problem, which is going to be even more serious elsewhere in Europe: Finland, a country of 4½ million inhabitants, will be producing 800 doctors every year by 1979; Denmark, with 5 million people, between 650 and 700 doctors until 1980. Sweden will have doubled its total number of

doctors in the decade 1970-80. Do I hear somebody say "What about Willink?" My personal view is that, though their reasoning was faulty, the actual Willink recommendations were right: what was wrong was a Health Service that in general practice offered no training and, before the Family Doctors' charter, no real framework in which to practise good medicine; and, in the hospitals, again gave juniors little career structure or security and appointed them to consultant posts far too late. It was emigration that was a principal cause of the doctor shortage, not the Willink Report.

Research

My second area of priorities is in research, where I would back the Rothschild argument: that it should become much more consumer-orientated. Obviously we have to recognise the value of research as a discipline and for occasionally leading to some important discovery. But it should be said plainly that some research is piffle, and that there is expensive duplication of effort and far too much waste of men and materials that could be employed much better. Now obviously there are tremendous dangers when the taxpayers and the Government begin to interfere directly in matters that they do not fully understand. Much of the smoothness with which our society runs is based on buffers between it and the power of the Government; the University Grants Committee; the BBC governors; and, dare I say it, the old-style Review Body. But, as Lord Platt has observed, since the war all of the many worthwhile new drugs have come from the consumer-customer-orientated commercial drug houses and not from our academic departments of medicine.³ With a continual crisis on our hands we cannot afford to go on behaving as if we had an empire and a strong economy. Instead, we should divert *some* of our present funds on to more immediately worthwhile activities and create a climate in which it is intellectually respectable to study disabling and life-threatening common conditions such as schizophrenia and road accidents.

NEW PROJECTS

We also need to set up entirely new research projects. How can we decide objectively on medical priorities, and between medical and social ones? What sort of size is right for health units? What sort of audit of clinical procedures, if any, should we be trying to achieve? What about the role of individuals in decision-making (the "prosopography" of Sir Lewis Namier, who emphasised that, though conventionally history is described in terms of abstraction, in reality it is determined by individual likes and dislikes)? What is it about one Minister, for instance, that can bring a renaissance in a Health Service and about another that can equally well virtually destroy it, in a relatively short time?

Role of the public

If all these proposals sound idealistic and unworkable, virtually all of them have been implemented successfully in other countries. Sweden is about to tax the cigarette differentially and is trying out nicotine chewing gum; Norway has banned cigarette advertisements; while most civilised countries now have much stricter control over a wide range of non-smoking areas than Britain. I am told that factory regulations are much better enforced in the USA than here; woe betide the motorist who breaks the laws in Switzerland, while New Zealand (with a population and traditions very similar to Britain) has managed to ban jay-walking in its streets. Germany enforces a high standard of food hygiene (and is also, incidentally, one of several countries to have abolished brucellosis—a state which is still a few years off in Britain); Eire routinely fluoridates its

drinking water; and Canada is acting to limit the number of medical students. And you could choose from among any number of countries that have a more consumer-orientated research programme.

Yet if we are to make these fairly radical changes in British practices we shall need public co-operation and a much more informed population than we have at present. Even the well-educated of our population know little about the human body and its workings, and even less about illness. There is no debate about health priorities of the sort that goes on in Canada and Scandinavia, or that goes on in this country about, say, comprehensive education or whether State money should be spent on British Leyland. And it must be said that, with few exceptions, the record of the press is lamentable. Our newspapers concentrate on the trivial, the anecdote, the irrelevant campaign, and some papers rarely fail to miss an opportunity for doctor-bashing at the same time. Their facts are often wrong, and their comments ignorant or one-sided. They do harm with their scare stories about side-effects of life-saving drugs or the pill, exaggerate the dangers of pollution, over-inflate the value of trivial discoveries, and ignore the major changes of our time. Even more serious is the recent tendency of newspapers to give clinical advice on matters that need expert judgment. I hope we won't see another polio epidemic in this country in a few years' time, but if we do it may well be because of unbalanced newspaper comments on immunisation against pertussis, which laymen may have thought applied to immunisation in general.

AN IMPOSSIBLE TASK

Now I do not blame most of the medical correspondents, many of whom are personal friends. They have been set an impossible task by their editors, who rarely seem to stop to think that, if it takes a man seven or eight years' full-time study to get any worthwhile medical knowledge, a competent reporter is unlikely to acquire it in a few days. A profession or subject is best examined—and attacked, if that is the principal aim—by somebody who knows what he is talking about. Almost always this means a member of the profession concerned. Editors recognise this in other fields: the educational correspondent is likely to have been a teacher; the legal correspondent to have a law degree; the South American correspondent to have been to South America. But any non-expert is good enough for medicine: seemingly anybody can tackle it, often in their spare time from other important assignments in the paper. Even the BBC, responsible for hundreds of hours of radio and television a week, does not have a doctor as a medical correspondent on any of its services. It is all rather like the advice which a father in one of Hilaire Belloc's rhymes gave to a son who had not made the grade

"We had intended you to be
The next Prime Minister but three . . .
As it is . . . my language fails!
Go out and govern New South Wales."

In this case read "cover medicine for the paper" for "New South Wales."

MEDICAL CORRESPONDENTS

So I would argue strongly that all (instead of a few) of our so-called quality newspapers should have doctors, or at least some sort of health professionals, as their medical correspondents. This would mean finding a number of doctors who were able to write clearly, or to learn to do so. It would also mean their abandoning any stuffiness associated with medical absolutism, that was so common only twenty years ago but is now a thing of the past. But the gains—for the profession, the public, and medicine—would be immense. In case anybody thinks this recommendation aims at preventing criticism of doctors and their practices, may I cite Dr Donald Gould, whose articles sometimes hit doctors hard because they are based on

knowledge. In case anybody thinks I believe that only doctors will do, may I cite Karl Sabbagh, of BBC 2's "Inside Medicine," and Ronnie Bedford, of the *Daily Mirror*. Both have rare qualities among those handling medicine for the media: knowledge of the facts; willingness to consider both sides of an argument; and not making up their minds on an issue at the beginning. Certainly, even on grounds of public expenditure alone, for a service that is the largest employer in Britain, it is about time that this "trivialisation" of health by our press stopped.

Of course, other sections of the community also have important parts to play in a fuller debate on health; ultimately we should have health as an important subject in the "O" level syllabus. If they abandoned their preoccupation with local politics, community health councils could have an important role, while the community physician has an ideal opportunity to influence local decision-making about important matters such as fluoridation of the drinking water as well as to develop local schemes of health education. Just as important is the role of the family doctor, who at every consultation with a patient is in a unique position to talk about health from a personal point of view. Finally we need some sort of central policy-making body, composed of individuals of proved worth, which would constantly debate health issues and priorities. This could possibly resemble the French *Commisariat du Plan*, which has played such an important part in the economic recovery of that country.

Persuasion, and rewards

All these schemes sound good on paper, but they need a lot of impetus to get started. Both the public and the doctors need to be convinced that they would be worth while. But health must surely benefit from more and better public discussion than it gets at present. To take one obvious example, there is the plight of our hospitals. Few laymen realise the extent to which these are being, and will be, run down. Although many of our consultants were content to start their careers in patched-up

workhouses, the oft-repeated promises by politicians that these would soon be replaced has now been broken, and these dirty, inefficient, and depressing buildings will still be serving the public at the end of the century. Add to this the shortage of junior staff (and, equally important, of nurses), and the stupid Illich-type idea in many lay minds that hospitals are full of arrogant A-award specialists doing useless procedures, such as uncommon transplants, and (political troubles apart) it is not surprising that the cream of our new graduates has been emigrating or is now going into general practice. Yet the press are quick to criticise missed skull fractures in casualty departments; the Ombudsman has recently commented on a three-hour delay in an obstetric clinic; and there was a storm about the failure to provide facilities to isolate patients with suspected Lassa fever.

Through ignorance or antipathy, or both, our newspapers omit to say that these deficiencies are none of the doctors' doing: indeed, for years doctors have been pressing to have something done about them. They omit to say that, rightly or wrongly, somebody has preferentially allocated money to swell the ranks of the administrators at the expense of a new casualty department, or even that the effect on the country's balance of payments of a week's strike at one of our car factories probably costs the country the equivalent of a new district general hospital. In fifteen years' time our district hospital service could be almost run down, with your prognosis for survival if you are run over outside Slagthorpe Infirmary totally different from that if a similar accident befalls you outside UCH. It was public pressure that created the Health Service to abolish this differential: it is public pressure that must see that it does not return.

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Personal Paper

On the probability of a committee meeting

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In the beginning, when we were few, we would meet often in various formal and informal guises. The difference between a conversation and a committee was marginal. Now we are numerous. We have adopted a constitution and bylaws and set up a structure of standing committees which seems to work quite well. Nevertheless, ad hoc matters are always arising to which the normal response is to convene a committee to ensure broad representation and participation. As the school gets

larger these ad hoc committees get larger and more difficult to convene, so they are arranged further in advance and after normal hours. These responses—planning ahead and working harder—seem laudable, but we are doubtful. The analysis described below not only lends respectability to our doubts but is so sobering that we think it worth sharing with those similarly afflicted.

Varying probabilities

We considered the probability of an ad hoc committee meeting, assuming that the members of such a committee have a working week—that is, are "on the premises"—of 40, 45, and 50 hours in each of which 20, 25, or 30 hours are committed. We further assumed that the committed and uncommitted hours

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