"the only category of caring staff essential when active treatment is no longer possible."

However eirenic, the commissioners are not afraid to speak their minds. On fluoridation they are "certain that it is entirely wrong to deprive the most vulnerable section of the population of such an important public health measure for the sake of the views of a small minority of adults for whom its benefits come too late." They do not mince matters concerning the quality of, for example, recruitment into psychiatry, services for the mentally handicapped, and some urban primary care, where "the National Health Service is failing dismally." They recognise the less than altruistic pressure of pharmaceutical companies on GPs and make no bones about drawing up a limited list of drugs, eliminating "ineffective and unnecessarily expensive drugs."

Depending on your point of view, you will accept or reject the report in part or in whole. Of course, it will be a disappointment to those whose favourite remedies have not been exhibited or who, unrealistically, expected the heavens to open and the NHS to be transformed by "some blinding revelation." The commission is well aware that "there are no magic wands to be

waved." If accused of some complacency in their verdict that "we need not feel ashamed of our health service," which "is not suffering from a mortal disease," they could argue that their lofty view enables them to see the wood unimpeded by trees. Those of us working down among the roots may not be quite so sanguine. For me, however, the importance of the report lies in its perspective "overview," presumably free from sectional interest and given in good faith. Its overall attitudes seem healthy and should stimulate ideas and action. They are right that "our work can therefore be regarded only as a beginning." I hope, at a cost of £918 000, that the exercise will prove to have been cost-effective.

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A rather sad document

G P McNICOL

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I have picked on several sections of the report that seem to me, as a provincial professor of medicine and consultant physician, to be on the one hand particularly encouraging, imaginative, constructive, or intriguing or on the other, unhelpful, ill-informed, or potentially destructive.

In health, prevention is better than cure and there can be few areas of public health in which there would be a greater reward for a change in public habits than a reduction in cigarette smoking. The commission states its belief that the NHS should "encourage and assist individuals to remain healthy." Despite the massive evidence of the adverse effects of cigarette smoking, the commission's recommendations are largely confined to the statement: "There are major areas in which government action could produce rapid and certain results: a much tougher attitude to cigarette smoking. . . ." This bald comment is little better than the general statement of a proposition to be for virtue and against sin and will certainly do little to influence government policy in an important area. I have perhaps capriciously selected this item as a general indicator of the pious but evasive nature of many of the recommendations in the report.

NHS, the universities, and research

I was pleased with the general sentiments in this chapter but disappointed with the recommendations. The report acknowledges the major contribution made by the universities and medical schools to the Health Service and records the view that the universities' interests tend to be submerged in the struggle to deal with the daily problems of the NHS. When much of the

service has suffered from financial restraint, the teaching hospitals have felt particularly hard-pressed. The report emphasises that the health authorities have the responsibility of seeing that the joint NHS/university liaison committees work well and that the medical schools and their teachers participate in all planning which affects their interests and to which they can usefully contribute. In many regions the planning role of the universities is less direct and I hope that this recommendation can be fully implemented.

Somewhat platitudinously, the report points out that the important national and regional function of the teaching hospitals must not be allowed to suffer and that this places an important responsibility on the health authorities concerned. A firmer recommendation on the need to meet the special interests of the teaching hospitals would have been welcome and at least a partial return to the old board of governors formula would be desirable. The comment from the Welsh National School of Medicine that "Some way must be found to insulate the teaching hospital from the conflict between short-term patient care and longer-term needs of medical education" is germane and I think that the distinctive functions of the teaching hospitals are in danger of suffering unduly from the present financial constraints, with major longer-term harm to British medicine and the nation's health.

Medical education, according to the commission, should be "relevant to the major health problems of the day, and amongst these are geriatric illness, mental illness, disability and handicap, and the potentially preventable diseases and injuries which result from unhealthy life styles. There should be more emphasis on community care and the importance of continuity of care. There has been some change in these directions in the curricula of the medical schools since the Royal Commission on Medical Education reported in 1968, but not enough." But there is no evidence of inadequate change. Surely the objective of undergraduate medical education is to impart to the student the knowledge, skills, and attitudes that will enable him to be safe in and to benefit from the year of preregistration training and then to equip him to embark on a more formal vocational and specialist training, followed by a lifetime of continuing self-education.

The late Professor G M Wilson said: "Students who graduate today will still be in practice in the year 2020." No one can foresee what will be the shape of practice then. The best we can do is to hope that our young doctors leave their period of formal training competent for today's practice and with the capacity and drive to maintain their own education throughout their professional life-times.

The commission recommends that the Health Departments should as a matter of national policy fund chairs or senior lecturerships in priority specialties—for example, geriatrics, mental handicap, and rehabilitation. The academic functions of the universities must not be prostituted. There may be a case for occasional academic posts in such disciplines, but the justification for creating university posts or departments must be the reality of the academic content of the disciplines or areas of study concerned, and not a temporary service need. For example, a good case can be argued that geriatrics should be taken back within the fold of general internal medicine.

The commission also strikes a somewhat critical note on the selection of medical students and suggests that universities should encourage and monitor experiments in medical student selection that take account of factors other than traditional academic criteria. I do not know how you can predict in a nervous 18-year-old applicant what sort of doctor he or she will make at 50 and I would consider it obscurantist to throw away our traditional academic criteria. The report also recommends a more positive policy towards the admission of mature students to medical schools but produces no evidence that a significant increase in these students would benefit the community or the medical profession.

The report suggests that any NHS staff, if expected to teach students, should have that requirement written into their contracts. I hope this recommendation can be implemented rapidly. I also agree that to pay for teaching as an item of service would lead to endless wrangling.

POSTGRADUATE TRAINING AND RESEARCH

The commission notes, "We think that there should be a further effort to create a wider and more flexible base for . . . postgraduate education." Although apparently attractive in theory, this seems to be a highly questionable proposition in the real world. Postgraduate training in Britain is already longer than in most other Western countries and to make the training wider and more flexible would either prolong the training period, which I am sure would be quite unacceptable to junior medical staff and to the Treasury, or produce trainees who are less competent in their chosen disciplines. Increased flexibility, however, is desirable for young doctors who wish to pursue a career largely oriented to research and who are prepared to pay the price of a longer training. Furthermore, if the recommendations on the hospital career structure are implemented increased flexibility might be introduced at the assistant physician, surgeon, or psychiatrist level.

The commission points out that there is likely to be an increasing demand for retraining, and I am much happier with the proposal that it would be desirable to increase if possible the opportunities for specialists to enlarge or redirect their interests.

I was surprised to read that clinical research is funded by the Medical Research Council, the NHS, and the universities themselves—with no mention of the pharmaceutical industry, which in this country provides a major contribution to the support of academic clinical research in many clinical departments. I was also surprised at the firm recommendation that clinical research should be accepted as an integral part of postgraduate education. Clinical research is an important part of the postgraduate education for many doctors but I suspect that we would be deluged with rubbish if it became an integral part of the postgraduate training of every doctor, since many have no aptitude for or interest in research except as a means to promotion.

Hospital career structure

The section on the hospital career structure is one of the best. The commission concludes "Its [the present career strategy] main and very damaging disadvantage is that it has not delivered the goods; the career structure is further out of equilibrium than when the policy was introduced." The commission believes that its suggestions for a new staffing structure would be practical and more flexible, with the grades after registration of assistant physician (or surgeon, psychiatrist, or other specialist); physician; and consultant physician. The grade of assistant physician would be a training grade of limited tenure held for about four years. The grade of physician would be both a training and a career grade and all aspirants to consultant rank would have to enter and spend a period normally of at least three years in it. The grade of consultant physician would remain essentially as at present with regard to expertise, responsibility, and criteria for appointment. The commission will have justified its labours if only these recommendations can be implemented. They would bring sense and organisation to a career structure that is now in dangerous disequilibrium. The proposed changes would also have a major bearing on the NHS's staffing problems.

The report says that "separate payment for work outside office hours . . . undermines what has been described in our evidence as 'the traditional role of the doctor in assuming the total care of his patients regardless of times of duty or other commitments'." I hope that when the dust has settled an open contract will remain an option selected by many consultants, though anything other than an open contract for clinical academic staff is difficult to envisage.

DISTINCTION AWARDS

I was delighted to read of the commission's support for the distinction awards system and its view that it was desirable that there should be opportunities in the NHS for earnings which go some way to match salaries paid to distinguished medical men elsewhere in the world. The major advantage of the system is its ability to provide gradations of award, with a useful career ladder and incentive. I am less happy with the recommendation that health authorities should have a stronger influence over the distribution of awards so that the consultant who has been carrying the heat and burden of the day should more readily receive recognition.

Two problems have been confused. Either the system is set up to reward "distinction" or it is not and, if distinction is to be the yardstick, the selection of consultants for awards on the recommendation of their colleagues has much to commend it. Elsewhere the commission concludes that teaching hospitals are "an invaluable asset and are rightly called 'centres of excellence' which have served the nation well in advancing medical knowledge and pioneering high standards of care. . . ." It is presumably appropriate that those who make an outstanding contribution to patient care and clinical science in teaching and non-teaching hospitals should be recognised as "distinguished" and it is difficult to see how in one committee the identification of professional distinction can be weighed against the proper and important criterion of the "heat and burden of the day," which is perhaps best met by a loaded basic salary or an extended incremental scale tied to specific posts.

I am not satisfied that the health authorities can make a useful contribution for either function—that is, the recognition of distinction or the recognition of those who have served well under difficult circumstances. The remoteness of the authorities from the reality of what happens in hospitals could lead to arbitrary judgments based on inadequate information and inappropriate criteria. Neither am I satisfied that the relaxation of the secrecy provision is wise. To disclose the identity of those who have awards is also to disclose the identity of those who do not have them. It would make it harder for the advisory committees to

identify distinction in the relatively young as opposed to identifying for reward towards the end of a career those more senior who have provided long service in hard stations.

Measuring and controlling quality of patient care

The commission acknowledges that it is not easy to establish standards by which to measure quality of care. They suggest that randomised controlled trials should be used by the Health Departments as a matter of routine before new and expensive services are introduced. This is a sensible recommendation but the commission steps outside its area of competence in suggesting that the current experimentation with the use of problem-oriented medical records should be expanded and continued. I suspect that we have now passed the high noon of enthusiasm for these records, so the commission has nailed its flag to a decelerating bandwagon.

The report considers other techniques for evaluating the outcome of treatment and suggests that the trend towards the introduction of regular peer review sessions should be encouraged. I am sure that mortality conferences, clinical meetings, regular review of misadventures, etc are an important part of the life of every hospital. But in a subsequent paragraph the unacceptable suggestion is made that the joint higher training committees for postgraduate medical education should approve only those units and departments where an accepted method of evaluating care has been instituted. Who would make the judgment? What criteria would be adopted? In view of the admitted difficulties of carrying out assessment of patient care (summarised in earlier paragraphs) this recommendation suggests that the report was written in a metaphorical 1984 rather than in 1979. I think the commission has underestimated the opposition of the medical profession to the compulsory introduction of mechanisms for the regular assessment of the policy of their professional work. I await with interest the day vice-chancellors, solicitors, stockbrokers, bank managers, senior civil servants, and others submit themselves willingly to similar appraisal through a lifetime of practice of their professions. Only medicine has made sustained, and I believe successful, attempts to introduce prolonged postgraduate training under close supervision and to provide generous opportunities for continuing self-education for a working lifetime. So far as I know, there is no good evidence from the United States (where the practice has been widely implemented) that quality of care has been improved by professional audit.

Medical manpower

The report calls the DHSS discussion document *Medical Manpower—the Next Twenty Years* a “welcome development.” I regard it as superficially argued and on the whole unhelpful. Similarly the commission has given inadequate consideration to the closing down of opportunities for medical emigration to English-speaking countries abroad, and to the possible desire of women doctors in the future to work full-time for most of their careers. There is an inadequate review of the role of doctors in the primary care team and the possible greater use of non-medical staff for duties for which medical training is not necessary. The report also fails to take account of the implications for student numbers of a revised hospital career structure and of the possible growth of private medicine, which might make increased demands on manpower. While the overproduction of doctors in some EEC countries is mentioned, the possibility of a substantial influx of doctors to this country has not been integrated adequately into the argument.

The commission states: “Prediction of medical needs is a particularly hazardous business,” but goes on, “Nonetheless we chance our arm here. We think that the planned output of medical graduates is about right at the present, and that there is unlikely to be medical unemployment this century.” I agree that

there may not be formal unemployment but, remembering the costs of producing a doctor, I think it is important that doctors do only those things that only doctors can do. I am saddened that the commission reached such an important conclusion on the basis of a superficial treatment of the available complex evidence. No country has succeeded in finding a satisfactory means of assessing how many doctors will be needed and the consideration given to this critical matter in the report is largely *ex cathedra* and arbitrary.

Overseas doctors

I approve of the commission's conclusion that there is an obligation on the UK and interested governments overseas to make it clear to doctors who want to come here what their prospects are and I support the recommendation that the UK government “takes the necessary steps.” The commission also wisely recommends that universities and Health Departments should consider developing postgraduate medical education and training specifically geared to the needs of overseas countries, perhaps concentrating efforts in a few centres. In general, I believe overseas doctors from the Third World should stay in their countries of origin, which have devoted such a large share of their scarce national resources to their training and where medical needs are so much greater than ours. It is immoral to use doctors from desperately poor countries in the tropics to support our Health Service and to fail to provide them with adequate training and experience. Training in this country should be reserved for a small number of carefully selected doctors from overseas who can return to their own countries to be leaders in the development of indigenously relevant postgraduate training and assessment.

Private practice

In an increasingly mechanistic and monolithic state it is desirable to retain as broad an area as possible for free choice by the public. It is also desirable to maintain significant numbers of doctors who are at least partially independent of the state and can speak with an independent voice. The royal colleges play an important part in maintaining an independent and impartial view of the Health Service and of the maintenance of standards in it and I was disappointed not to find an explicit statement of welcome for their contribution to national health.

In the chapter on the objectives of the National Health Service, the report sets out several aims for the NHS, including the provision of a service free at the time of use. I am not convinced by the report's inadequate arguments that this sacred cow should be kept at pasture and not sent to the slaughterhouse. Certainly, the NHS must provide a safety net but I do not see any major point of principle in extending the scope of the circumstances under which those who can afford to pay make a contribution at the time of use, either directly or through insurance, for some of the benefits provided by the Service. The commission considered that the NHS should be available without restriction “to all patients living in the UK.” Certainly visitors from abroad can reasonably be provided with emergency treatment but I do not see why non-UK citizens should be provided with the benefits of the Service “without restriction”—their treatment would be perfectly appropriate for private practice, and such private treatment is indeed an important source of financial support for the academic activities of many university clinical departments.

The recommendation that the Health Services Board should be given power to consider and regulate the aggregate number of beds in private hospitals and nursing homes is an unacceptable intrusion on personal freedom. I was also disappointed that the commission did not give more sympathetic consideration to the “geographically full-time consultant.” This system works well in hospitals abroad and would I think have attractions for Health

Service staff, clinical academic staff, and patients. There should be patient and where necessary firm negotiations with the Health Service unions to circumvent the politics of envy which have made the continuation of pay-beds in NHS hospitals so difficult.

Organisation

There can be few senior people who work in the NHS who would disagree with the recommendation that there is one tier too many in the administrative structure. The commission proposes that the regional health authorities should be the main planning authorities and that the structure below should be simplified with only one tier. Below the region I would like to see a return to the pre-1974 structure of committees of management and the restoration of the boards of governors for teaching hospitals, with a slightly tighter integration of the board into the regional district management structure, but with the boards retaining at least some financing direct from the DHSS to meet their functions for undergraduate training and their specialised regional and supraregional clinical services.

The commission recommends the retention of consensus management, with perhaps stronger guidelines from the Health Departments about the jobs of the members of the consensus management teams. Consensus management function has been a recipe for mediocrity, indecision, lack of imagination and drive, shilly-shallying, and procrastination. Consensus management groups often seem to be a stamping ground for prima donnas of both sexes. One of the major problems is the difficulty encountered by the consultant and GP members of a team in playing an appropriate part. Unlike, for example, the nurse, the administrator, or the treasurer, the doctor has no troops to command and no resources to deploy, which weakens his position in negotiations. He has to operate with the consent of his clinical colleagues, whom he can only advise and persuade;

and unlike the other members of the team may come to know the ropes only when his term of office is drawing to a close. The alternative method of management proposed by the commission is the appointment of a chief executive and it would be worth while to examine the possibility of appointing a medically qualified chief executive with strong professional advisory machinery.

NHS and the public

In the chapter on the NHS and the public I am concerned about the comments on the complaints procedure and in particular the suggestion that more vigorous steps should be taken to draw the patients' attention to the way to make complaints and the proposal that the Health Service Commissioner should be allowed to accept cases concerning clinical matters. In such cases the proper procedure is a determined attempt to resolve the complaint informally at a local level; thereafter the due process of the law is appropriate and I share the concern about the problem of double jeopardy, to which I see no solution. The commission states, "complaints procedures may operate against the best interests of patients," and I agree that informal arrangements and sympathetic staff attitudes are much more important than formal machinery.

As regards public participation in the organisation of the NHS, I cannot see that community health councils have served a major useful purpose. They should be abolished, the community interest being represented by public membership of the regional health authorities and management committees/boards of governors of the hospitals.

I was pleased to read that the commission has not recommended the transfer of the NHS to local authorities at present, though I was disquieted to see their view that transfer to the local authorities was the logical development from the present

CHANCE, COINCIDENCE, SERENDIPITY

Serendip was the former name of Ceylon, now Sri Lanka, and Horace Walpole narrated a fairy tale of *The Three Princes of Serendip* where the three heroes of the story roamed the countryside. Whether by accident or through their own sagacity, they made repeated discoveries—on one occasion, for instance, they inferred that a mule, blind in the right eye, had recently travelled along the road because the left side had been grazed leaving the right verge untouched.

In her book *Emma*, Jane Austen remarked, "Depend on it, a lucky guess is never merely luck, there is always talent in it too." Although this is true, it should be recognised that serendipity can happen to the common man as well as to somebody trained in one of the sciences, provided he contemplates the meaning of words that fall, and events that take place, every passing day, always pausing to consider, listening attentively to understand, and looking critically to perceive.

In the history of medicine, instances abound where chance has played a part, often a prominent part, either in the diagnosis, aetiology, or treatment of disease. Clinicians will recall such examples where the circumstances of a chance discovery have enlisted their interest when dealing with some malady or other in their patients.

Maggots galore

Close to the school which I attended as a small boy was a cottage where the local fisherman Dai Lewis lived. I visited him there occasionally during a playtime interval. Some years before, when riding a fractious horse, he had been thrown on to a stony road and had sustained a compound fracture of his femur. At the emergency operation, in the absence of any form of anaesthesia, a crude amputation was carried out leaving some three-quarters of an inch of the bone projecting beyond the flesh. It remained in this state through the years.

Whenever he gained his corner seat by the fireside, he would discard his peg-leg and settle to tie trout-flies, and, should he have company, to spin adventurous yarns. What fascinated me during my visits was to watch maggots fall from the end of the femur on to the floor. (I cannot vouch for the truth of the rumour that he collected them for fishbait.)

Years later, and in pre-penicillin days, Professor Trueta of Spain, and later of Oxford, introduced a poultice of maggots as the means of dealing with inflammation in bone. Certainly, the grub appeared to contribute to longevity in the case of Dai Lewis as the ensuing story seems to testify.

When Lloyd George introduced his Bill to award 5/- a week to those aged 70 years or over, it was obvious that Dai would qualify for the pension, but he was unable to produce a birth certificate in support of his claim. A local magistrate and the district excise officer attended Dai's cottage to endeavour to gain a fair estimate of his age. The following dialogue took place. Where were you born, Dai? In the county of Cork. You don't know when? No, it's a long time ago. When did you leave Ireland? I ran away from home when a boy of 13 to a farm in the north of Scotland where I stayed for 19 years. After that? I served as a gillie to a laird in the south of Scotland for 25 years. After that? I was a gamekeeper to Pryse-Rice of Llandovery for 17 years. After that? I came here to Tregaron. How long have you been here, Dai? He shouted to his wife in the kitchen: How long have we been married, Mary Anne? 34 years. The two officers turned to do their sums, and finding that both answers coincided, the magistrate spoke. According to your record you must be 108 years old. Straightway came the remark from Dai, "Good God, how time flies!"

So, through chance, the Tregaron fisherman had discovered the virtue of maggot therapy for osteitis a quarter of a century before the Oxford professor gave it official sanction.—WILLIAM EVANS.

structure. Several objections to transfer are set out but the most important is omitted—that is, the generally poor quality of local authority membership and officers and the likelihood that administration would be inefficient and improperly responsive to locally organised party political pressures.

Postscript

The report is a rather sad document. The commission, with a distinguished, intelligent, and perceptive membership, was

established in May 1976 but the changes in thinking since then, and particularly the deterioration in the economic climate, have made much of what it says difficult to implement. If a commission were to be established today its main task would be to suggest how to maintain a skeleton service with diminishing real resources. Much of what the report recommends is sensible and constructive but the conclusions do not take sufficient account of the distinctive long-term needs of the teaching hospitals, the universities, and research; nor do they place sufficient emphasis on the maintenance of personal freedom in the provision of health care.

Living with its disabilities

RUDOLF KLEIN

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After reading the report of the Royal Commission on the National Health Service,¹ the medical profession now knows what patients feel like when their doctors tell them that they have got to learn to live with their disabilities. There is no heroic surgery which can cure their ailments, but only ways of relieving some of the stresses and helping them to cope. Inevitably, the result is a feeling of disappointment and anticlimax. The royal commission has sat for more than three years and spent nearly £1m. The commissioners received evidence from 2400 organisations and individuals, talked to nearly 3000 others, and toured extensively in this country and abroad. Yet, in the words of the report, there is no "blinding revelation which would transform the NHS." Instead the commissioners reassure the patient by telling him that his condition is not nearly as critical as he imagines and prescribing a mixed bag of 117 recommendations designed to make life more comfortable.

Was the whole exercise a waste of time? In trying to answer that question it is important to be clear about the job of royal commissions and their limitations. Royal commissions are not in the "revelation" business. It is not their function to come up with new, ground-breaking discoveries, which might or might not be acceptable. The point may be simply illustrated. If the Royal Commission on the NHS had decided that the only way to increase expenditure on health care in Britain was to scrap the existing structure and adopt an insurance-based system—a perfectly respectable intellectual position in the abstract—its report would have gone straight into the ministerial wastepaper basket. Even given that a Conservative Secretary of State might have been sympathetic to such a radical change, and had carried it out, the next Labour Government would, of course, have immediately reversed the decision. In other words, the job of a royal commission is consensus engineering: to recommend changes which do not stretch the limits of the generally acceptable too far: to create support for incremental adaptation of existing institutions, rather than to stir up controversy and create instability.

Strategy of adaptive change

In this respect, the royal commission's report can be rated a considerable success. Its proposed strategy of adaptive

organisational change may seem timidly unadventurous. It is, however, preferable to recommending yet another wholesale reorganisation with all its consequent uncertainty and demoralisation. Again, it is by no means unimportant that the report—signed by a member of the TUC's staff and a former leading official of NALGO—accepts private practice as a fact of life and recognises the irrelevance of the whole pay-bed issue. This is precisely the kind of educational function which royal commissions are designed to perform. It is unfortunate that—as a kind of ideological quid pro quo—the commission recommends the abolition of all charges. But then it has to be accepted that such reports, if they are not to splinter into a series of minority, dissenting notes, must inevitably represent compromises among the views of the members.

To make this point is also to underline a specific weakness of the Royal Commission on the NHS. Its appointment was, quite clearly, a political expedient. It was set up to defuse an explosive political problem and not—as its general terms of reference, which only just stop short of reforming the universe, indicate—to address itself to a set of discrete, clearly defined issues. Moreover, its membership reflected the circumstances of its birth. Royal commissions have, in the past, tended to fall into three categories.^{2,3} There have been representative commissions—that is, those whose membership reflects the various interest groups concerned. There have been expert commissions—that is, those whose membership is based on demonstrated skill in the particular subject. Lastly, there have been impartial commissions—that is, those whose membership was picked on the jury principle of selecting dispassionate laymen. The Royal Commission on the NHS does not fall neatly into any of these categories. Not surprisingly, its heterogeneous membership—reflecting some idiosyncratic choices by Mrs Barbara Castle and Mr Harold Wilson—has produced a rather heterogeneous set of recommendations. And the stature of its membership—the chairman, Sir Alec Merrison, apart—is not such as to ensure automatic respect for its proposals. Unfortunately for the commission, and perhaps unfairly, it cannot claim the authority of representativeness, skill, or impartiality.

There is a further limitation on the royal commission's report, which, it might be argued, is self-imposed. This is its reliance on what might be called sturdy commonsense rather than research-based analysis. The royal commission did commission several research papers. But none of these begins to measure up to the quality of analytic work carried out for the Guillebaud inquiry into the NHS 23 years ago by Abel-Smith and Titmuss.⁴ Indeed, implicit in the royal commission's whole approach is a decision that the big questions about the NHS are not likely to be solved in the near future by more research. There are two

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