Medical charities and prevention

Today's main killing diseases are due to the way we live. Each year in Britain cancer kills over 120 000 people, and many of these cancers are known to be due to environmental factors. Cigarette smoking causes not only 30 000 deaths from lung cancer but even more from coronary heart disease. Diet is known to play an important part in coronary disease and probably in diabetes, diverticulitis, and bowel cancer, and possibly also in breast cancer. Hypertension causes strokes, some at least of which can be prevented by control of the raised blood pressure. The money and research invested in better treatment of these ills have led to improvements in chemotherapy for cancer, bypassing occluded coronary arteries, and the rehabilitation of patients after strokes; but these measures are usually applied too late, when irreversible damage has already occurred.

Logically the main thrust of medical research should be directed at the prevention of these common, lethal, and disabling conditions. Yet in Britain—unlike many other developed countries—efforts at prevention receive lower priority than efforts at cure, as is clearly shown by the annual reports of the main grant-giving bodies. The policy of the British Heart Foundation, which spent nearly £2·5m last year, has always been to support clinical and laboratory-based research. It does not seem to consider either public education or prevention to be its responsibility. Over £800 000 was spent in 1978 on establishing and maintaining chairs in cardiovascular diseases and a similar amount on grants for specific research projects. In the past five years under 4% of these have been grants for epidemiological or preventive studies —though this may in part reflect a lack of interest in prevention by British cardiologists. No specific allocation is made for public education on the prevention of heart disease, though the foundation has excellent opportunities for this through its 80 active fund-raising branches.

This policy contrasts strongly with other national heart foundations. For example, the Canadian Heart Foundation spends 17% of its budget (amounting to £850 000) on community education; the National Heart Foundation of Australia spends 13% of its funds (about £160 000) on public education as well as another 33% on community services. Of the other heart foundations, the Irish spends 31%, the French 24%, and the New Zealand one 9% of the budget on health education and prevention. The Dutch and Danish Heart Foundations are also very active, while the American Heart Foundation has a major commitment to prevention. Epidemiological studies have clearly shown that coronary heart disease is linked with the way we live—our smoking, our diet, and our physical inertia in particular. It is here that we must look for the main answers instead of relying on laboratory-based investigations, however successful these have proved in infectious, metabolic, and nutritional diseases.

Preventing several types of cancer, especially of the lung, is well within our grasp. In the words of Lord Zuckerman, "Lung cancer, which now accounts for about 25% of the total cancer mortality in the United Kingdom, is largely a preventable disease, and that action which reduces cigarette smoking would be more immediately effective in reducing mortality from lung cancer than that aimed at finding a cure for the established condition." Cancer charities seem to take a different view. The Cancer Research Campaign and the Imperial Cancer Research Fund have between them assets amounting to £44 million, and their yearly expenditure is over £13 million. The CRC has as one of its objects "to attack and defeat the disease of cancer in all its forms." The ICRF works for "research into the causes, prevention, and cure of cancer." Yet prevention plays a minute part in their activities. The CRC spends less than 2% of its funds on cancer education (£41 248 in 1978). The ICRF does fund the Cancer Epidemiology and Clinical Trials Unit at Oxford but this accounts for only 2% of its expenditure. The two charities give virtually no direct support to preventive cancer education.

By contrast, the American Cancer Society spends 17% of its funds on public education about cancer (about £10 million each year). Its stated objectives include the reduction of America's 50 million adult smokers by 25% and halving smoking among teenagers, and it is mobilising two million volunteer workers to achieve these aims. The Canadian Cancer Society spends 17% of its budget on public education (£1·5m). The Israel Cancer Association spends 17% of its funds on public professional training in cancer prevention. The Ulster Cancer Foundation is the one exception in the United Kingdom, spending 34% of its budget on public education, particularly about smoking.

The British heart and cancer charities collect large sums from individuals to fund research into the cause and cure of cancer and heart diseases. These bodies have many distinguished council members both from the medical profession and from public life to guide their affairs, and we must be concerned that they pay so little attention to prevention compared with similar organisations in many other countries. Since the charities should be accountable to the public, should not the public have more say on how the money is to be spent?

On line but off course

As the might of Britain's navy sank beneath the waves at Jutland, Admiral Beatty observed that "there is something wrong with our bloody ships today." The same feeling of baffled incomprehension has become commonplace among consultants confronted with squalid, uncleaned wards and outpatient clinics. No longer can they go to the ward (or outpatient) sister and ask that something be done: no doubt she has spent frustrating hours on the phone asking for action from the domestic supervisor or the domestic manager. The dirt, the resulting irritability, and the frustration of the medical and nursing staff are all attributable to the failure of the management system in NHS hospitals.

Experts in social behaviour may be able to explain why it is that amalgamation of many small units into one large system always seems to result in a fall in cleanliness. In practical terms, doctors have seen the change from the old days before "line management" became the watchword. When the ward sister had total managerial control of the ward she had a direct working relationship with *her* cleaning staff. Between them, the nurses and the cleaners kept the ward clean and did not argue about who did what.

Nowadays the ward sister can no longer ask the ward domestic, who used to be one of the worried patient's friends, to empty the bins or fill up the soap dispensers: the domestic supervisor is the only one who can instruct the domestics. In turn, the domestic supervisor is responsible to the assistant domestic manager and the domestic manager of the hospital.