could also, if used excessively, cause acne. He has shown that many acneform eruptions are due to local factors such as mechanical pressure, cosmetics, and pomades. He has even delineated a type of acne that becomes worse in the summer. Kligman was among those who noted that topical steroids could induce acne, and systemic corticosteroid therapy is known to have the same effect. Paradoxically, however, there have been recent reports of a severe type of acne which responds dramatically to systemic steroids but defies long-term antibiotics. This “acne fulminans” is a rare disorder affecting teenaged boys, who show inflamed, tender, ulcerative and crusting lesions of the upper trunk and face, without the large numbers of cysts seen in conglobate acne. The condition starts suddenly and is characterised by fever, leucocytosis, and a raised sedimentation rate. Half of the patients have inflammation of several joints. The pathogenesis of the condition remains obscure: an immunological basis is possible, though this has defied proof.

Indeed, so far immunological studies of acne have proved unrewarding. Nevertheless, Shuster’s thoughts were running along immunological lines when he turned acne back to front again with his idea that it might be so common because it is biologically useful. Acne lesions contain large numbers of Corynebacterium acnes organisms, ran the argument; the adjuvant properties of the corynebacterium group are well known; possibly the organisms in acne lesions confer a selective advantage by enhancing the ability to develop delayed immune hypersensitivity. This attractive theory raises other possibilities: for example, is treating acne harmful immunologically? Perhaps the remaining acne icons should now take cover.

11 Kelly, P, and Burns, R E, Archives of Dermatology, 1971, 104, 182.
13 Shuster, S, Lancet, 1976, 1, 1328.

Inquest on extravagance

The extraordinary saga of Liverpool’s new teaching hospital continues. In its most recent report the Committee of Public Accounts has once again returned to this financial horror story of rapidly rising costs and unexpected bills.

When work started in 1968 the new hospital was expected to cost £11 800 000 and to be open by the spring of 1974. But the latest estimate given by the Department of Health and Social Security to the committee is that the cost will be over £54m and the hospital will not be completed much before the end of 1978. Even allowing for inflation the bill for the new hospital will have doubled in terms of the real resources invested in the building. At a time when the NHS has cut right back on its construction programme the inquest on this scandalous failure to control costs is of more than local interest: it raises some general questions about the way in which scarce resources are being used and about the policies of the DHSS.

Many of the problems at Liverpool—as is clear from the report of the Public Accounts Committee—were local and specific. The Board of Governors which planned the hospital and placed the original contract lacked staff with relevant experience. The building firm responsible for the work collapsed, and a new contractor had to be found. There was a history of bad industrial relations on Merseyside: productivity was poor and strikes were frequent. But these factors only help to explain—though they do not justify—the rise in costs up to 1976, when the Committee of Public Accounts last looked at the Liverpool Teaching Hospital. At that stage the estimated bill was a mere £41 million. Now there has been a further rise to £54m, and the committee’s latest report raises some new conditions.

The main reason for the latest rise is the cost—put at £11m—“of making the building safe against fires by current standards,” in the words of the DHSS memorandum to the committee. In particular, the podium roof of the tower block is now considered to pose an unacceptable risk and therefore is being expensively modified. Not surprisingly, the committee proclaims its “outrage” that such a state of affairs should have been allowed to develop. But there is a further question which perhaps ought to be raised: whether the DHSS may not be giving an excessive degree of priority to expenditure on fire precautions.

To ask this question is not to suggest that staff and patients should be exposed to fire hazards, but to ask whether the level of expenditure accurately reflects the degree of risk. In its evidence to the committee the DHSS pointed out that “statistically speaking, a person is significantly less likely to die from fire in a hospital during a given period than he would in the same period at home, and the risk in an hotel is 15 times as great.” Moreover, against the risk from fire there must surely be set the opportunities for actually preventing deaths by spending the equivalent millions on improving medical care. It is an extremely difficult calculation and one which raises sensitive issues, but it is far from clear that the DHSS has struck the right balance.

The report of the Public Accounts Committee highlights yet another problem. The decision to continue with the construction of Liverpool Teaching Hospital (and to incur new costs equivalent to the bill for two small hospitals) can be justified only if the new building is fully used, once open. That will mean closing old hospitals and redeploying staff in order to free the required resources, as the DHSS emphasised to the committee. But on recent history it is difficult to be optimistic on this score: in Liverpool, as described in detail recently, there is trade union resistance to be overcome among other factors inhibiting change. The Public Accounts Committee might therefore do well to investigate the experience of other new hospital projects and the problems that have been encountered in making them fully operational. It is no use financing the construction of new buildings without also creating conditions in which they can be used, and the committee would serve the NHS well if it could identify the DHSS’s responsibilities.

1 World Medicine, 3 October 1977.