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Appeasement 1977 style

Any future historian looking at the National Health Service is likely to see the 1970s as the decade of the decline of the hospital service. Mrs Barbara Castle shattered the political confidence of consultants as effectively as Henry II slighted his opponents' strongholds. Next came the war of attrition in which the hospital unions undermined the medical authority, a long-drawn-out and covert process helped by the administrator's appeasing tactics which kept as many incidents hidden as possible. Finally, freedom itself was eroded, not only by the clamour of numerous pressure groups and watchdog associations but also by the intrusion of an ombudsman into areas where he had neither knowledge nor competence. The effect of the campaigns, the historian will find, was the destruction of one of the main pillars of the NHS as it had been proudly built between 1948 and 1970; and the first to crumble was the district general hospital.

But is it too late to prevent such a decline? Though many might think that the contractual right to do private practice given to consultants on appointment could not be restored to its pattern only three years ago, doctors could still reverse the take-over by the unions if they realised how serious the problem is. Union power has been an ever-present feature of the admirable television series *Hospital*, and some of the incidents have reinforced different anecdotal accounts of filthy hospitals where the cleaners have refused to clean; of porters as union officials claiming the right to decide which patients could be classified as emergencies for surgery; and of ambulance men deciding whether or not to agree to a doctor's request for an ambulance, or during an industrial dispute unloading maternity patients in a totally unsuitable part of the hospital. Furthermore, some nurses have exceeded their authority in preventing consultants admitting patients to hospital.

Some of the problems linked with the erosion of clinical responsibility were discussed at a recent *BMJ* symposium (17 December, p 1584). In last week's discussion on health teams Dr John Bennett was forthright in his advocacy for the doctor as *primus inter pares*. "Let the leader be the one professional whose knowledge and perspective extends across the whole range and whose advice has usually been sought by the patient in the first place: the doctor." No equivocation there, but he did identify three areas where uncertainty could arise over clinical responsibility. Firstly, when the doctor delegates to another professional; secondly, when the patient's problems are largely social (battered babies, for example); and, thirdly, patients who come to the doctor via a third party such as preventive screening.

While, as Dr Anthony Clare described (p 1637), relations between doctors and nurses in psychiatry are strained, one of the most serious clashes is that going on between technicians and doctors in hospital laboratories and x-ray departments. Two motives may reasonably be deduced in the concerted drive to upgrade the status to that of scientist: better pay—already enhanced by some formidably advantageous overtime arrangements¹—and a bigger say in running the NHS. This union policy is already causing difficulties and even dangers in laboratories, as is clear from a recent report to the Association of Clinical Pathologists by Professor Roger Dyson.² Some technicians are refusing to have their results checked by consultants and even initiating changes in laboratory routine without advising, let alone obtaining approval from, the doctors who are responsible for the service. This makes nonsense of clinical or even departmental responsibility. Radiology departments are also a target for technicians aspiring to control budgets or be departmental heads.

At what point do the reasonable aspirations of technicians with considerable skills become a hazardous usurping of responsibilities for which they have not been trained? Not all pathologists or radiologists necessarily make ideal departmental heads but they have all had a long, rigorous professional training, including clinical work, which makes them best placed to assess clinical and technical requirements. Even junior hospital staff, whose requests may be challenged by experienced non-medical laboratory staff, have the advantage of knowing the clinical condition of the patient concerned. Admittedly, some of the more complicated laboratory procedures may be carried out only by trained technicians, but their title describes their role and does not imply that they are competent to make clinical judgments. Surgeons are not trained to maintain air-conditioning plant or anaesthetists piped gases, but both services are essential to modern operating theatres and no one would suggest that maintenance staff are capable of doing surgical operations. Doctors should carry the clinical responsibility in all medical departments, including those undertaking investigations. Even if resisting the unjustified advance of technicians into the medical arena provokes—as it will—conflict, such action is in patients' best interests. Why, future generations of doctors will wonder, did they spend 10 years or more training if as consultants their advice and actions are subject to the opinions of those knowing far less over the span of medicine than they do?

The encroachment of technicians into clinical medicine may call for some subtlety in agreeing on spheres of influence. No

subtlety is needed, however, in dismissing the attempts by some other hospital staff to influence or control doctors' professional activities. Porters, for example, have no place in clinical medicine; nor can ambulancemen be allowed to usurp a doctor's judgment. It is time for doctors and administrators to say this loud and clear. And if general practitioners think that there are only hospital problems they may be disturbed to know that unions are now recruiting members from among the staff of privately owned practice premises.

Some of these unhappy problems have resulted from years of low pay, poor management, and understaffing of the NHS, with industrial action seen as the only way of achieving improvements. Doctors are no longer in such a strong position to criticise that. But having discovered the power they wield, the nursing, technicians, and other health workers' unions are using it to develop their influence on the management of the NHS, with administrators generally unwilling or even frightened to confront them when this influence is clearly detrimental to patient care. The patient is being used as a pawn, with militant unionists arguing that their actions are for his long-term benefit, a travesty of the ethic that the patient comes first. Thus decisions on closing hospitals, on improving departments' efficiency, or on allocating funds according to rational priorities are being stalled or even stopped by threat of militant action. While rational discussion in committee does not always achieve satisfactory results, surely it is preferable to the anarchy of arbitrary obstruction, when any decisions are taken along the line of least resistance.

This path will lead to demoralisation, chaos, and a breakdown of the Service. What is particularly depressing in this jungle of industrial relations in the NHS is the lack of any leadership from the DHSS. Health authority administrators may be criticised for their role in appeasement, but the silence of the DHSS in union-initiated disputes can give them no encouragement. The dangers of these internecine differences and battles for power and influence in the NHS are clear: the patient is at risk of being forgotten. So let us restate the obvious: the NHS exists to look after sick people. Its objective is not to guarantee employment for those who work in it—whether they stoke obsolescent boilers or do research into obscure diseases. Hospitals are there to serve the patient, who should not have to depend on a porter's whim for the time he arrives at the operating theatre.

What the patient needs is to be seen, diagnosed, treated, and cured by a competent doctor. All other activity and planning in the NHS are secondary to this end. Future generations will not forgive us for condoning appeasement in the 1970s, any more than we forgive those of our forebears who hailed the Munich agreement.

¹ *British Medical Journal*, 1977, 2, 1610.

² Dyson, R, *The Management of Pathology Laboratories*. London, Association of Clinical Pathologists, 1977.

Hidden hazards of cremation

In recent years the number and variety of metal and plastic objects implanted in patients have increased steadily. These include joint prostheses, nails and splints for fractured bones, heart valves, and cardiac pacemakers. At one time pacemakers were occasionally removed post mortem for later reimplantation, mainly for reasons of cost. Nevertheless, nowadays in Britain it seems to be the rule that when a patient with a prosthesis dies no attempt is made to recover it, even though

metallic prostheses generally show no evidence of structural defect.¹ In some less wealthy countries prostheses are still recovered and reimplanted with considerable saving in cost, and the time may come when we may have to adopt the same practice here. Meantime, however, non-combustible objects are being found more and more often among the remains after cremation: indeed, one survey¹ found that 5% of bodies undergoing cremation contained metallic objects—and, though most were orthopaedic implants, a Spencer-Wells forceps and a bowel clamp were also found.

Little notice was taken of the presence of surgical hardware post mortem until September 1976, when the mercury zinc batteries in a pacemaker left in a body exploded during cremation² with force sufficient to damage the brickwork lining of the cremation chamber. The strength of the explosion had possibly been increased by the presence of hydrogen produced in near-exhausted batteries. In the course of their duties those working at the crematorium periodically observe the process of cremation, and an explosion on this scale could cause injuries or even death. A further risk is that such an explosion could release toxic gases or even infectious material from the corpse.

Lithium batteries may well replace zinc mercury batteries in pacemakers, and when heated to a high temperature these are even more explosive. Moreover, since 1970 pacemakers powered by plutonium-238 have been tested clinically in several centres and have proved their worth. Since these contain up to 3 Ci of the isotope patients have been closely supervised and as a routine the pacemaker is removed after death. It takes about one hour at 800°C to cremate a body, and the latest models of plutonium pacemaker have now to pass a very stringent "cremation test" of withstanding 1300°C for 1½ hours. This should ensure that they could not leak during cremation, but it is also an admission that recovery post mortem may not be invariable. Possibly the same cremation test may eventually be demanded for all types of pacemakers. Even so, in the meantime, their federation has advised cremation authorities to ask area health authorities to add, as an interim measure, two questions to the statutory cremation form B, which is completed by the doctor who attended the deceased in his last illness. The questions ask the doctor signing form B whether a pacemaker (or any radioactive material) was present in the body and whether it had been removed. Coroners are expected to take similar action with form E. The federation has also advised medical referees to consider refusing to accept for cremation any body containing a pacemaker.

The 1972 code of practice³ lays down that there is no contraindication to cremating corpses containing up to 30 mCi of yttrium-90, iodine-131, or gold-198 or 10 mCi of phosphorus-32 (on the assumption, presumably, that a radioactive isotope in the tissues would be expected normally to disperse harmlessly up the smoke stack). Nevertheless, the Federation of Cremation Authorities is also concerned about possible hazards from radioactive substances left in bodies brought for cremation. There is a possibility that an explosion (or some other event) during the cremation of a radioactive corpse could produce a blow-back releasing radioactive smoke or fumes into the crematorium. This risk seems to be largely theoretical, but a more serious cause for concern arises when the radioactive isotope is confined within a sealed container. Isotopes such as caesium-137 or iridium-192 are available for therapeutic use in amounts up to 75 mCi in the form of needles, tubes, grains, and pins. Moreover, radium itself, which has a very long half life, is also still used in needle form.