given intravenously may induce fatty liver, novobiocin and rifampicin may interfere with the conjugation of bilirubin, griseofulvin may precipitate attacks of acute intermittent porphyria in susceptible people, and penicillin may produce hepatic granulomas.

Some antimicrobial drugs produce both acute and chronic liver disease. In one survey of almost 14 000 patients treated with isoniazid, 114 patients developed hepatitis and, of these, 13 died from liver failure.[4] Symptoms usually developed within three months of starting treatment. Histological studies in 33 patients most often showed features of acute hepatitis, but three patients had chronic active hepatitis and one patient had cirrhosis. Some of these patients may possibly have had chronic liver disease even before taking isoniazid. One patient has developed chronic active hepatitis after having taken several courses of sulphonamides over three years.[5] Again, the occurrence of chronic liver disease could be coincidental, but the serum transaminase activities rose slightly when the patient was challenged with a single dose of the drug.

Several reports have appeared of patients found to have chronic active hepatitis while having long-term treatment with nitrofurantoin. Sharp *et al* reviewed 15 cases already published and added a further five of their own.[6] All the patients were women and they had been taking nitrofurantoin for between one month and four years. They usually had jaundice and enlargement of the liver with raised serum concentrations of globulin and transaminases and positive tests for smooth muscle antibody and antinuclear factor. Liver biopsy specimens were taken from 17 patients: all showed chronic active hepatitis and four had superimposed cirrhosis. Most patients improved when treatment with nitrofurantoin was stopped, but reintroducing the drug provoked relapse, which in two cases proved fatal. Chronic active hepatitis may complicate treatment with other drugs such as methyldopa, propylthiouracil, and perhexiline.[3]

What precautions are reasonable? A recommendation that liver function tests should be performed routinely during treatment with isoniazid[7] seems unnecessary; though an asymptomatic rise in serum transaminase activities occurs in one-fifth of patients, the risk of developing serious liver disease is small. Indeed, enzyme activities may return to normal even if treatment is continued. Certainly the risk that long-term treatment with some drugs can produce chronic active hepatitis needs to be recognised, since continued administration of the drug to patients with hepatomegaly or jaundice will allow the hepatic necrosis to become more extensive and increase the risk of progression to cirrhosis.[8] Liver function will, however, usually improve when the drug is discontinued, and any persisting small rise in serum transaminase activities or minimal inflammatory changes in the liver biopsy specimen may be safely ignored.[8] Treatment with corticosteroids has not been shown to be beneficial, but probably these should be given to those few patients who continue to deteriorate after the drug has been withdrawn.[8]

[1] Perez V, Schaffner F, Popper H. Hepatic drug reactions. *Prog Liver Dis* 1972;**4**:597-625.

[2] Zimmerman HJ, Fang M, Utili R, Seeff LB, Hoofnagle J. Jaundice due to bacterial infection. *Gastroenterology* 1979;**77**:362-74.

[3] Zimmerman HJ. Drug-induced chronic hepatic disease. *Med Clin North Am* 1979;**63**:567-82.

[4] Mitchell JR, Zimmerman HJ, Ishak KG, *et al*. Isoniazid liver injury: clinical spectrum, pathology and possible pathogenesis. *Ann Intern Med* 1976;**84**:181-90.

[5] Tönder M, Nordoy A, Elgjo K. Sulfonamide-induced chronic liver disease. *Scand J Gastroenterol* 1974;**9**:93-6.

[6] Sharp JR, Ishak KG, Zimmerman HJ. Chronic active hepatitis and severe hepatic necrosis associated with nitrofurantoin. *Ann Intern Med* 1980; **92**:14-9.

[7] Byrd RB, Horn BR, Solomon DA, Griggs GA. Toxic effects of isoniazid in tuberculosis chemoprophylaxis. Role of biochemical monitoring in 1000 patients. *JAMA* 1979;**241**:1239-41.

[8] Maddrey WC, Boitnott JK. Drug-induced chronic liver disease. *Gastroenterology* 1977;**72**:1348-53.

Priorities at Newcastle

The dominant themes in the Health Service during the 1979-80 session have been those ubiquitous three Ms—money, management, and manpower. Yet the profession's collective response to cash limits, further NHS reorganisation, and threatened medical unemployment has so far been remarkably restrained, with no demands for special representative meetings or militant action. This can reasonably be judged as a responsible rather than an apathetic posture, for doctors have been well aware of the problems, while in their first year of office the BMA's new Chairman of Council and Secretary have brought commendably analytical skills to bear on trying to solve them. In contrast to some unions, which have reacted with reflex hysteria to the consequences of Britain's struggles to live within its means, the BMA has preferred to await firm evidence on which to act. But the time has come for the profession to define its attitude to the Government's policy on NHS resources and the Annual Representative Meeting's first priority motion, which expresses "grave concern" at the NHS's financial problems and the inevitable consequences on standards of patient care,[1] will give the Representative Body an opportunity to do this. The effects of the cuts vary widely and a constructive Association policy sensitive to local needs is more likely if speakers bring facts rather than rhetoric to the rostrum; emotional blunderbuss decisions will not help the profession's leaders in the difficult year ahead.

One welcome event this year has been the Review Body's award,[2] which should mean that more time at the ARM and craft conferences can be devoted to other matters—though the hospital junior staff conference will have to decide whether to return to the Review Body's fold—and the range of controversial topics competing for time is catholic: alcoholism, audit, career structure, certification, complaints procedures, confidentiality, the Flowers Report, related ancillary help, smoking, and work load, to name but a few. While the 586 motions on the agenda at Newcastle Civic Centre on 7 to 11 July will disappoint those who hoped that flourishing craft conferences would reduce ARM agendas to manageable proportions, one encouraging aspect is the strength of the science section. That will maintain the notable scientific tradition of the Association's four Tyneside meetings since 1870, described by a former chairman of the Representative Body, Dr J S Noble, at p 1550.

"Scientific activities" open with a priority motion on audit in which the Sheffield Division, with Yorkshire bluntness, asks the meeting to instruct "Council and the Chairman of the Representative Body to stop surveying any method of medical audit." The Junior Members Forum, following up their demand at Liverpool for Council to produce a practical scheme for audit,[3] asks for audit to be "introduced forthwith." This debate will be a test of the profession's nerve and foresight. The Representative Body should avoid the trap of accusing the Government of cutting standards of care for patients in one breath while in the next refusing the oppor-

tunity offered by professionally controlled audit to make the best use of existing resources. This is an occasion when professional experience and objectivity should override defensive union instincts. Admittedly, audit could be manipulated by an unscrupulous Government but if doctors voluntarily adopt it they could well enhance their professional status and strengthen their authority in the NHS. Antagonism to audit among doctors may be based, in part, on a misunderstanding of its aims and procedures. The current series in the *BMJ* (p 1509) should help to remedy this and contribute to the ARM basing its decision about whether to back medical audit on facts.

The opportunity that audit offers for doctors to regain their influence in management should not be missed, for a demoralising feature of the NHS in the 'seventies has been the proliferation and deterioration in its administration. This Government's preliminary ideas for simplifying management[4] have been broadly accepted by the profession[5] and the Secretary of State's post-consultation conclusions should be available in a White Paper about the time of the ARM. The profession is unlikely to quarrel with him if, as seems likely, he sticks to the theme in his foreword to *Patients First*—namely, the importance of decisions being taken close to those who work directly with patients and that management's purpose is to support doctors and nurses looking after patients. Some argument, however, is inevitable over the fate of community health councils, which several ARM motions propose should be abolished. The profession's worry about the activities of CHCs has probably been aggravated by one serious weakness of the 1974 reorganisation: the complex medical advisory machinery, which has often produced conflicting and delayed advice. As a section of the agenda shows, doctors want to get it right this time, with several divisions demanding a recognised place for the BMA in the statutory advisory processes. It does seem paradoxical that the Association has a workable marriage with craft committees in their dealings with the DHSS in Tavistock Square yet is unable to achieve such a union locally. With the growth of the BMA's secretariat outside London—a development strongly endorsed in the agenda—local co-ordination should be a priority. As power in the NHS is about to be devolved the profession cannot afford to be without a united and authoritative medical voice at local level. Strengthening the BMA locally is costing and will cost a great deal of money. Four motions call for a £100 BMA subscription—£10 more than the Council has proposed—so the expense of proper representation is clearly understood. But as well as increasing the annual subscription the BMA will need to examine its internal priorities to establish whether the present balance between headquarters and the regional structure is the right one for coping with a reformed NHS in which more decisions will be taken locally.

Although BMA membership is holding up well, measured as a proportion of the increasing number of doctors it is less satisfactory. For the BMA to make its voice even more effective centrally it needs to attract and keep a high percentage of qualifying doctors. Not least, strengthened political muscle will be needed to cope satisfactorily with the problems of manpower. Indeed, manpower, or more precisely "possible unemployment of doctors," is the third priority motion at Newcastle. In a composite motion by the Agenda Committee the meeting will be asked to support urgent consideration of the "monitoring and control of the number of students entering medical school and of overseas doctors entering this country." This falls short of a demand to control the entry of overseas doctors, already rejected by the Government, but there is a strong feeling in the profession that it is as wrong for Britain to admit doctors on a false training prospectus as it is to drain poorer donor countries of expensive and scarce medical skills. It would be no surprise if the RB decided to strengthen this motion.

As the several reports on manpower in recent years show, doctors are divided on the question of medical student numbers, with some hospital doctors worried about how the recent expansion will affect career prospects, while their colleagues in general practice argue that many more doctors are needed in the community to cope with the demands from patients and to improve preventive medicine. Strongly held opinions have made compromises hard to find, as the Council's manpower working party has discovered.[6] The joker in the manpower pack is the destination of the women graduates. Will the NHS be prepared to offer them the employment flexibility they deserve and will the women respond if this happens? Once again the Junior Members Forum leads the way with a motion calling for proposals within a year on arrangements for part-time training and NHS service posts for women. There should be no argument about this sensible proposal, which in any case should be easily accommodated by the BMA's permanent committee on manpower.[7] But women doctors—and overseas graduates, too—could do much to advance their own cause if they use the existing machinery to improve their representation on NHS and BMA committees. Both groups fall well short of reflecting their potential strength in the profession.

One of the BMA's great assets is that it is an open and democratic voluntary organisation of doctors in which all groups, whatever their size or influence, can declare their views and contribute to policy decisions. As an example of what the BMA can do, its members in the North of England are an outstanding example. It is a region where the BMA has been the traditional vehicle for doctors to wield their influence, and powerful this has been—inside the profession and out. Whatever lessons the representatives take home with them from Newcastle one at least should be the secret of what makes "BMA North" so effective. Spread that message around and the Association could direct more of its resources to representing the profession and less on having to persuade non-member doctors to join.

1 *Br Med J* 1980;**280**:1465.
2 Review Body on Doctors' and Dentists' Remuneration. *Tenth Report*. Cmnd 7903. London: HMSO, 1980.
3 *Br Med J* 1979;ii:143.
4 Department of Health and Social Security. *Patients First*. London: HMSO, 1979.
5 *Br Med J* 1980;**280**:957-8.
6 *Br Med J* 1979;i:1365-76.
7 *Br Med J* 1980;**280**:955.