services and the teaching arrangements in the metropolis need reforming than an acceptance that the controversial report had proffered exactly the right answer. The demand to keep consultants’ contracts at regional level in the reorganised NHS has been motivated not by Luddism but by a conviction that one of the greatest benefits of the NHS—a countrywide distribution of good quality specialist services—could be jeopardised if they are not.

Medical manpower cannot be considered in isolation and the most effective use of expensively trained doctors depends to an extent on the skills, availability, and co-operation of other health professions in the NHS. The ARM asked for a review of nursing administration, with more emphasis on the value of clinical nurses such as the ward sister and district nurse. It was clearly unhappy about relations with the social services and wants them to come under the aegis of the DHSS.

And in a move that could have far reaching and constructive implications for the NHS, representatives invited the Council to examine the formation of an association of health care professions. Interprofessional relations in the NHS have not been good during the past year or two, to the detriment of patient care, so this proposal should not be relegated to a committee backwater.

Despite the vicissitudes of the NHS the public’s confidence in doctors has remained high. This confidence should have been reinforced by the ARM’s strong defence of medical confidentiality and of its concern about commercially advertised medical services, which could undermine Britain’s tradition of personal doctoring, while not necessarily fulfilling patients’ expectations. On the other hand, the profession’s opposition to community health councils and to any intrusion by the Ombudsman into clinical matters may strike members of the public as straight medical protectionism. But the profession is divided on CHCs—as the vote at Newcastle showed—and opinions are largely dependent on doctors’ local experience of their workings. Clearly some CHCs have co-operated usefully with the profession, thwarting some of the sillier economy proposals from health authorities; others, however, have adopted a combative posture towards doctors which has inevitably soured relations.

Such behaviour or any attempt to introduce retrospective lay assessment of clinical decisions is, as several speakers warned, bound to push doctors into practising defensive medicine, which will not improve patients’ treatment and will certainly mean higher costs. Even so, doctors will need to persuade the public that their opposition to CHCs and to any wider responsibilities for the Ombudsman is rooted in their concern for patients, for the profession’s most potent ally in the fight for better health facilities is public opinion.

That is a campaign which the BMA’s experienced Press Information Department will, no doubt, orchestrate with skill, along with a presentation of the ARM’s other policy decisions on improving the NHS.

Finally, what of the BMA itself? Despite what critics inside the profession may say, the Association is in good shape, with its reorganised headquarters, growing regional structure, rising home membership, and, considering the economic recession, remarkably sound finances. After several years of major constitutional reforms and refinements it has found the right formula—with the five craft conferences and the Representative Body—to enable doctors to give their opinions, debate policy options, and emerge with a coherent medico-political strategy. The Newcastle meeting was well run and the quality of debate commendably high, with representatives showing a respect for the chair and for the rules of debate that was an example to Westminster. Paradoxically, however, the Association’s heroic efforts to be as democratic as possible can endanger democracy. The 600 or so motions and amendments on the agenda are a healthy sign that medicopoliticians are still active in divisions and local craft committees; but many useful motions get arbitrarily left by the wayside, while other less substantial items are discussed, so perhaps an even more positive selection procedure than the present one with its priority and composite motions is desirable.

It is clearly impossible to cover such a large agenda in 26 hours of debating time, which some representatives think is too long anyway, and one consequence is that valuable time is spent on the “process” of debate to the detriment of the policy “outcome.” To achieve a more manageable agenda the Organisation Committee might consider stronger selection powers for the agenda committee, a ballot for “other motions,” and, perhaps, a limit on the number of motions from each local electoral unit. A reasonable objective might be to have two major debates on priority motions, each session on four half days, leaving, say, two sessions specifically for balloted “other motions” on subjects initiated by divisions and local craft bodies.

That said, let no one think that the Newcastle ARM was just a talking shop. Several good debates, many sensible decisions, and the absence of noisy controversy contributed to a constructive occasion that should benefit the patients, the NHS, and the BMA.


Correction

Emphysema: beginning of an understanding

We very much regret that the references to the leading article on “Emphysema: beginning of an understanding” (5 April, p 961) were wrongly numbered. These should read: