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Medicine as a Monopoly

In January 1967 the Board of Trade requested the Monopolies Commission to report on restrictive practices affecting professional services. Until then the Commission had been employed on investigating trading monopolies and restrictions in a variety of commercial organizations, so that the requirement to examine the professional scene must have posed some unfamiliar problems. To the unfamiliarity of the task may have been added some doubt about its purpose, for *The Times*[1] has declared the origin of the reference lay "in a little campaign by Labour backbenchers in the last Parliament." This is not to suggest that the Conservatives, now in power, will show any greater understanding of the differences between restrictions for personal profit and restrictions for the patient's benefit. But the Commission[2] itself was evidently puzzled by what should be its field of inquiry and decided to restrict detailed summarization of the evidence to that provided by no fewer than 130 bodies. If that restriction is readily understandable, the decision not to invite any representatives of professional journals to the press conference on the report's publication last week is less so. For that omission, as well as being a discourtesy, exposes the Commission, perhaps unjustly, to the accusation that it did not care to be questioned by people specially familiar with the problems it had been studying.

The conclusions the Commission has been able to reach from such a disparate field of inquiry are of so general a nature that it ends by recommending a whole series of further inquiries as the best way of "maintaining momentum in what will inevitably be a lengthy process." Thus does bureaucracy keep the wheels of State turning. The Department of Employment and Productivity, it recommends, should refer to the Commission "the supply of a number of particular professional services where the practices are known to prevail," so that detailed inquiry can be made, and "the Government would have power to deal with them by Order." It suggests that the Government could at the same time invite the professions "in general" (why not in particular?) to examine their own practices in the light of the report.

In its comments on medicine as a monopoly the Commission seems to be in a dilemma. It smells a monopoly, but cannot see it. As it correctly points out, only registered medical practitioners may sign death certificates and perform certain other functions, but unqualified people are not debarred from treating patients provided they do not hold themselves out as medical practitioners. The report then adds, "The proviso is, however, all important . . . it seems likely that deprivation of the title was always sufficient virtually to keep out the unqualified." The fact that unregistered practitioners of many kinds continue to flourish everywhere, and even that many highly trained non-medical people such as psychologists treat patients, apparently never came to the notice of the Commission.

The unsuitability of the Monopolies Commission to undertake this particular inquiry is nowhere clearer than in its comments on advertising.

It acknowledges that in certain ways professional people may advertise their existence or services to the public—for instance, a doctor's plate showing his qualifications. But it goes on from a commercial analogy to say that greater freedom to advertise in the professions may be expected to have various advantages. "New entrants might be able to build up their practices more quickly than at present," though "freedom to advertise might serve to entrench established practitioners." "The introduction of new methods and of new kinds of service might be expected to take place more quickly and at lower cost." In other words Dr. X arrives in town, advertises in the local paper that he offers the latest treatment for leukaemia, to be countered next week by an advertisement from the established firm offering an experience based on 20,000 man-hours in the treatment of bronchitis. "We doubt whether," the Commission adds from its considerable experience of the commercial world, "the cost of advertising would outweigh the greater efficiency likely to flow from more effective competition."

On the restricted access of patients to consultants through general practitioners the Commission contents itself with quotations from the B.M.A.'s *Handbook*[3] and written evidence,[4] adding the uncomprehending remark that "it has apparently been found desirable for reasons of administration to build the access rule formally into the State medical service." The great benefits this practice brings to the patient go without comment.

Having spent more than three years on the inquiry the Commission must be disappointing its sponsors when it concludes that "without more investigation than is possible in a general inquiry under section 5 of the Monopolies and Mergers Act 1965 we cannot say how far the practices of particular professions are justifiable in the light of these considerations." One reason for this inability, as the report goes on to point out, is that no profession has had an opportunity of justifying its practices to the Commission.[5] Hence the recommendation for a further series of inquiries into, presumably, some 130 professions in all their variety.

Such restrictions as the medical profession exercises on entry into its ranks, on the relationships between doctor and patient and one doctor and another, and such as the State too imposes on medical men and women—all these are the subject of frequent comment and criticism in the medical press and at widely reported meetings. It is right that they should be openly discussed, since public confidence in the profession depends on the knowledge that doctors do not abuse the intensely personal trust reposed in them. Professional privileges are an expression of the rights of the patient, not of the doctor. For the profession to continue to examine these matters and to ensure that the public is fully acquainted with them can only be beneficial. But as this has for some time been its practice the advice from the Monopolies Commission may be thought superfluous.

[1] *The Times*, 29 October 1970, p. 11.
[2] The Monopolies Commission, *Report*, Parts 1 and 2, Cmnd. 4463. London, H.M.S.O., 1970.
[3] *Members' Handbook*, British Medical Association, London.
[4] *British Medical Journal Supplement*, 1968, **2**, 38.
[5] *British Medical Journal*, 1969, **3**, 5.

Purulent Neonatal Meningitis

Neonatal meningitis remains a challenging problem. There is no other month in life in which the disease is so common, and yet early diagnosis remains difficult. We usually cannot prevent it, and the results of treatment are still disappointing in spite of the increasing number of broad-spectrum antibiotics.

J. C. Overall[1] in the United States recently reported the results of a prospective co-operative study in which 14 centres took part. Over the period 1959 to 1966 they studied 54,533 live births. Twenty-five cases of neonatal meningitis occurred, an incidence of 0·46 per 1,000, cases with congenital malformations of the central nervous system being excluded. Their figure agrees with the 0·4 per 1,000 found earlier by R. V. Groover and co-workers.[2] The incidence was greater in premature infants: 1·36 per 1,000 as compared with 0·37 per 1,000 in full-term babies. This difference has long been recognized, and it is known that premature infants have a low concentration of transplacentally acquired immune antibodies, especially against *Escherichia coli*.[3] If the unstated number of cases associated with spina bifida cystica had been added, the numbers would have been substantially increased.[4]

Practically any pyogenic organism may cause meningitis in the newborn, but in all larger series Gram-negative enteric organisms have predominated. *E. coli* is by far the commonest and is responsible for about one-third of all cases.[2 5 6] This and other enteric organisms are especially important in the first two weeks of life, and in the series described by J. S. Yu and A. Grauaug[5] they were responsible for the meningitis in 23 out of 26 patients under 2 weeks of age.

Neonatal meningitis is often part of a septicaemic process, and infection is frequently present in other parts of the body. The same organism was discovered in blood culture in 11 of 18 cases in Overall's series. Prenatal or immediately postnatal pneumonia often preceded the meningitis. Others of these babies had otitis media, gastroenteritis, or intestinal obstruction leading to peritonitis.

Maternal infection is an important predisposing cause of the disease. Ten of 25 mothers had peripartum infection, and in six of these the same strain of organism was recovered from mother and child. The infection in the mother was usually in the genitourinary tract.

Complications during labour and delivery, especially fetal distress, were also commoner than in matched controls. The infants with obstetric complications developed meningitis in the first fortnight. The importance of complications during labour and delivery was shown by Groover.[2] Of 17 babies whose meningitis began before the sixth day of life 15 were born after obstetric complications. Histological study of the

[1] Overall, J. C., jun., *Journal of Pediatrics*, 1970, **76**, 499.
[2] Groover, R. V., Sutherland, J. M., and Landing, B. H., *New England Journal of Medicine*, 1961, **264**, 1115.
[3] Vahlquist, B., *American Journal of Diseases of Children*, 1960, **99**, 729.
[4] Lorber, J., Kalhan, S. C., and Mahgrefte, B., *Archives of Disease in Childhood*, 1970, **45**, 178.
[5] Yu, J. S., and Grauaug, A., *Archives of Disease in Childhood*, 1963, **38**, 391.
[6] Chevrie, J. J., and Aicardi, J., *Clinical Pediatrics*, 1969, **8**, 562.
[7] Watson, D. G., *Journal of Pediatrics*, 1957, **50**, 353.
[8] Ziai, M., and Haggerty, R. J., *New England Journal of Medicine*, 1958, **259**, 314.
[9] Lorber, J., and Bruce, A. M., *Developmental Medicine and Child Neurology*, 1963, **5**, 146.
[10] Berman, P. H., and Banker, B. Q., *Pediatrics*, 1966, **38**, 6.