uses current investment to defray dividends owing to past investors, which can possibly work only in an expanding economy (and is a questionable business practice). This is now being questioned.

The famous buck referred to by Heginbotham stopped with Harry Truman, not some anonymous purchaser health authority. Truman did not avoid uncomfortable decisions, even in 1948 when he fought for his political life. It is in this spirit of personal integrity and accountability that the experimental Oregon scheme should be viewed.

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1 Heginbotham C. Rationing. *BMJ* 1992;304:496-9. (22 February.)

Support for suspended surgeon

SIR,—As consultants in Dewsbury, we wish to express our support for the suspended consultant Philip Lyndon, whose case Clare Dyer reports.¹ We regard him as a capable and conscientious surgeon who has given valuable and much appreciated service to the local community. We are not aware of any good reason for his lengthy suspension and would welcome his return to work at the earliest opportunity.

Mr Lyndon's treatment casts doubt on the adequacy of safeguards in existing disciplinary procedures and suggests that a consultant's right to work is at the whim of his or her health authority. Yorkshire Regional Health Authority makes much of allegations of substandard work, but, even after the so called surgical review, Mr Lyndon was allowed to continue unrestricted practice for six months before being abruptly banned from the hospital. We know that the report on the surgical service in Dewsbury refers at some length to interviews that Mr Lyndon has given to the press. It even refers to the way he wears his operating hat, but it contains no sustainable data on morbidity or mortality at all.

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1 Dyer C. Surgeon accused of high mortality. *BMJ* 1992;304:733. (21 March.)

Problems of the NHS reforms

SIR,—With regard to the recent rows over the NHS in the run up to the election I wish to make several observations.

Firstly, if the government has succeeded in cutting (only some) waiting lists (for those waiting two years) before the election it is hardly surprising: regional health authorities were ordered to cut specific lists at specific hospitals, at any cost, as part of the task of implementing the patient's charter by April. This is hardly devolved management reflecting a purchaser-provider split.

Secondly, fundholding general practitioners are allocated much more money per head of population than are purchasing districts in their budgets. The grave financial consequences of this are being concealed until after the election.

Thirdly, seeking self governing trust status, like

fundholding in general practice, is increasingly popular because of the financial, managerial, and political consequences of not doing so. In many regions the approach to these matters is utterly autocratic. The constitutions of trusts, as well as Tory preference for tax cuts over social spending, make suspicion of privatisation perfectly reasonable.

Fourthly, the new system of contracts between purchasers and providers is the old system of cash limits by any other name. Providers often cannot do more to earn more money as no money is available in the purchasing budget. The patient follows the money.

Fifthly, the NHS reforms have been supported by some commentators on the dubious grounds that they allow new priorities to be set through needs assessment by health authorities. This is exactly what the government's short termism has prevented. Others who oppose the Tory reforms argue for even more radical change, such as giving health budgets to local authorities. Yet such approaches would cause huge disruption and continuing political interference.

Finally, the Labour party's health policy would actually liberate managers to address longer term priorities, with considerable devolution to provider managers yet responsibility for performance resting with local health authorities; incentives for good performance linked to longer term plans; and appropriate reimbursement to providers for patients from outside the local district. General practitioners would be given a voice in local health authorities to help determine priorities.

Partly through exhaustion from implementing the current rigmarole, managers are wary of yet more change. But this should not deflect anyone from the task of designing a more sensible health policy.

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Cold comfort for carers

SIR,—Forbes H Norris's editorial on motor neurone disease highlights the lack of interest and care shown by doctors, "including neurologists," to patients with this disorder; as the wife of someone with the disease I would say "particularly neurologists." It is therefore surprising that Tony O'Brien and colleagues find it "remarkable that at the time of referral 91 patients (73%) were being cared for in their own homes."

Most patients with motor neurone disease have no choice but to stay in their own homes: many hospices will not admit them (probably because they take so long to die), and private nursing homes can cost upwards of £400 a week, which puts them beyond the reach of most people. O'Brien and colleagues' tribute to the "courage . . . of patients and the dedication . . . of families and friends" is little comfort to people who have been left to manage as best they can.

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1 Norris FH. Motor neurone disease. *BMJ* 1992;304:459-60. (22 February.)

2 O'Brien T, Kelly M, Saunders C. Motor neurone disease: a hospice perspective. *BMJ* 1992;304:471-3. (22 February.)

Writing left handed

SIR,—As a left handed person born in 1920 and educated in England, during my schooldays I never saw a left handed child hook the hand holding the pen.¹ The reason for hooking is that

left handed children are taught by right handed teachers, who use a dogma that was created after I had left school and after ballpoint pens first became available. This dogma states that a left handed person will smear the paper unless it is tilted and unless he or she hooks the hand. This is simply not true.

When I was at school we were permitted to write only with steel nibbed pens, although fountain pens were available. If you had tried to hook your hand while using a steel nib it would have been impossible as the tip of the nib would have stabbed the paper. In my schooldays the left handed were ridiculed by teachers, and attempts were made to convert us to right handedness. When I was in medical school I joined the fencing club and had to hold the foil in my right hand as otherwise I would have an unfair advantage over my opponents. Although I rarely won a bout, at least it taught me to use my right hand.

Hebrew and Arabic are written from right to left rather than from left to right, yet right handed writers in these languages do not hook their hand.

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1 Dunea G. Left hands. *BMJ* 1992;304:579. (29 February.)

Hype from journalists and scientists

SIR,—Richard Smith may be right in general when he criticises exaggerated claims about medical advances.¹ It is, however, ingenuous to couple this with unwarranted criticism of those who are prepared to take on the necessary and sometimes difficult, and even risky, task of explaining science to the public through the media.

The human genome project is a most exciting project with extraordinary promise for improved prevention and treatment of disease. Identification of the position of genes conferring susceptibility to particular diseases, which is the most direct outcome of genome mapping and sequencing, has already led to some outstanding advances. The genes for cystic fibrosis, retinoblastoma, Duchenne muscular dystrophy, and familial polyposis have been identified, and these discoveries are already influencing medical practice and promise to do so even more in future.

It was in my capacity as president of the Human Genome Organisation that I was asked to comment on the importance of the human genome project in general and relate this to the asthma family study. My comments were therefore directed not only at the gene for asthma but at the value of the project in general, and this may not have come across in a short article. That is a risk that is always attached to communication with the media, and I make no apologies for continuing to explain the importance of this work to the public. Nothing I said could have been used to endorse a suggestion that eradicating genetic disease is easy—a term I would in any case be most hesitant to use.

"Designer drugs," as Smith describes them, are likely to be found eventually once this particular gene for asthma is discovered, as undoubtedly it will be. But even before that, giving simple prophylactic treatment with current anti-inflammatory drugs with minimal side effects to people identified as being at risk by genetic markers may well prove effective.

The public should be made aware of the excitement and promise of current medical research, including in particular analysis of the human genome. The intelligence and commonsense of patients should not be underestimated. Patients often seem to support the need for long term research to deal with their diseases more than some